

CF OPERATING PROCEDURE  
NO. 140-4

STATE OF FLORIDA  
DEPARTMENT OF  
CHILDREN AND FAMILIES  
TALLAHASSEE, July 17, 2020

### ADULT PROTECTIVE SERVICES PROTECTIVE INTERVENTION

This operating procedure establishes program procedures and provides instructions for the provision of services through the Department of Children and Families, Adult Protective Services Protective Intervention Program.

BY DIRECTION OF THE SECRETARY:

*(Signed original copy on file)*

ROBERT K. ANDERSON  
Assistant Secretary for  
Operations

#### SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

In Chapter 1, added a sentence to the end of paragraph 1-4c, and added new paragraph 1-7h. These changes allow for protective intervention cases to be opened following an initial staffing for court ordered protective supervision.

In Chapter 3, added the phrase "case management and services pending court ordered protective supervision" to the second sentence in paragraph 3-5a; added the phrase "such as court ordered protective supervision" to the last sentence in paragraph 3-5b; added the phrase "including court ordered protective supervision while awaiting the court order" to the first sentence in paragraph 3-8; and, added a sentence to the end of paragraph 3-8d. These changes allow for early intervention short term case management cases to be opened pending court ordered protective supervision and require contact with the client within 1 day of the protective supervision staffing.

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This operating procedure supersedes CFOP 140-4 dated May 13, 2020.

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## Chapter 1

## INTRODUCTION

1-1. Purpose. This operating procedure provides information and procedures for the provision of services through the Department of Children and Families, Adult Protective Services Protective Intervention Program. The purpose of the Protective Intervention Program is to identify and provide information, referrals, supportive services, and/or placement, on a voluntary basis, to vulnerable adults, aged 18+, who are determined to be unable to complete activities of daily living or instrumental activities of daily living. The Protective Intervention Program also strives to prevent abuse, neglect, or exploitation from initially occurring, and prevent the recurrence of abuse, neglect, or exploitation through the provision of these services.

1-2. Legal Basis. The Legislative intent of section 415.101(2), Florida Statute, is to create a program to detect, correct, and prevent abuse, neglect, and exploitation of vulnerable adults. Sections 415.102(20) and 415.102(21), and 415.106 (3) Florida Statutes, and Florida rule 65C-1 and 65C-2 allow for services through this program, which include, but are not limited to, community-based services provided in-home by the Department or other agencies, and in a placement setting.

1-3. Types of Protective Intervention Cases. Services are provided to vulnerable adults through specific types of cases, such as those listed below:

- a. Short Term Case Management;
- b. Supportive Services for vulnerable adults, aged 18+; and,
- c. Placement for all vulnerable adults without age restrictions (if 60 or older, please consult with local Department of Elder Affairs office).

1-4. Overview of the Protective Intervention Program.

a. The Protective Intervention Programs assists vulnerable adults, aged 18 and over, to live safely in their own homes or in the least restrictive setting. If independent living is no longer possible, the Adult Protective Services (APS) Counselor may assist the vulnerable adult in locating appropriate and cost-effective living arrangements such as assisted living facility, adult family care home or skilled nursing facility (see Chapter 6). The APS Counselor may assist the vulnerable adult with applying for financial assistance through Florida Automated Community Connection to Economic Self-Sufficiency (ACCESS). If the vulnerable adult is already residing in an assisted living facility or adult family care home, the APS Counselor will arrange for additional services not provided by the facility and arrange for necessary financial assistance (when available). Placement in a nursing home, in some cases, may also be appropriate.

b. The Protective Intervention Program also provides for the delivery and coordination of in-home and community-based services to assist vulnerable adults, aged 18+, to remain in their home and complete activities of daily living and instrumental activities of daily living. APS Services Counselors ensure that arrangements and referrals are made for appropriate services for vulnerable adults, ages 18+, through an assessment of the client's situation, care plan development, and case management. Adult Protective Services Counselors are encouraged to arrange services for these clients through referrals to community service providers. Vulnerable adults, ages 60 and over, in need of services to remain in their homes are referred to the local Department of Elder Affairs; Area Agency on Aging, or lead agency for coordination of services.

c. Protective Intervention Program services are offered to vulnerable adults who have the capacity to consent to services. If the vulnerable adult does not have the capacity to consent to

services, the legal guardian/caregiver may consent for the vulnerable adult. If a vulnerable adult or legal guardian/caregiver does not consent to services or initially consents to Protective Intervention services but later withdraws consent, services will not be continued. A Protective Intervention case may also be opened immediately following an initial staffing for court ordered protective supervision and a court order has not been obtained yet.

d. The Protective Intervention Program is not meant to take the place of existing programs. Priority is given to vulnerable adults who are not eligible for comparable services funded by other Departmental programs and who are victims or at risk of becoming victims of abuse, neglect, or exploitation. Comparable services include but are not limited to those provided by: Department of Children and Families, Substance Abuse and Mental Health; Agency for Persons with Disabilities programs; Department of Education, Division of Vocational Rehabilitation; Department of Health, Brain and Spinal Cord Injury Program; and Department of Elder Affairs.

1-5. Objectives of the Protective Intervention Program. The objectives of the Protective Intervention Program are to provide assistance, which may include information and referrals, supportive services, or placement of vulnerable adults who are:

a. Referred with verified findings of abuse, neglect, or exploitation, and are determined to need less intensive supervision than Protective Supervision, to prevent the recurrence of abuse, neglect, or exploitation; or,

b. Referred with not substantiated findings [with less than a preponderance of evidence] of abuse, neglect or exploitation, who are in need of services, and without the services the vulnerable adult's living situation may deteriorate and lead to abuse, neglect, or exploitation, or may require institutionalization; or,

c. Referred by a community source for an individual who meets criteria.

1-6. Protective Intervention vs. Protective Supervision. Protective Intervention and Protective Supervision have some program components that are similar. However, the clients in these program entities present very different problems or are addressing their problems in very different ways or on different levels. When a protective investigation verifies the findings of severe abuse, neglect, or exploitation, the case is referred to Protective Supervision, which provides intensive oversight, including frequent and regular contact with the vulnerable adult. If the verified findings of abuse, neglect, or exploitation are less severe or infrequent, the case is referred to Protective Intervention for routine oversight of the vulnerable adult. When Protective Supervision has accomplished the goal of preventing another occurrence of abuse, neglect, or exploitation, the Protective Intervention Program can assume responsibility for on-going services if such services are still needed and the client meets other eligibility requirements.

1-7. Indicators of Protective Intervention. The following indicators are to be used as a guide for determining Protective Intervention:

a. The client's living situation may lead to abuse, neglect, or exploitation, and intervention is necessary to keep the situation from deteriorating;

b. Abuse, neglect, or exploitation has occurred, but does not appear to be chronic or constitute an obvious pattern;

c. Abuse, neglect, or exploitation has occurred, and services are needed, but the client does not need the intense level of supervision as required with Protective Supervision;

d. Abuse, neglect, or exploitation has occurred, but appears to be unintentional due to lack of knowledge on the part of the caregiver;

e. The vulnerable adult has the capacity to consent to Protective Intervention, and consents to the needed services which have been decided on by the vulnerable adult and the APS Counselor;

f. The vulnerable adult's legal guardian/caregiver consents on behalf of the vulnerable adult who is unable to consent, to receive needed services which have been determined by the legal guardian/caregiver and the APS Counselor; and,

g. The vulnerable adult has a support system in place.

h. Following an initial staffing for court ordered protective supervision and pending a court order to begin services to a vulnerable adult who has been abused, neglected, exploited or is self-neglecting.

1-8. Protective Intervention Services. Protective Intervention is the provision and coordination of in-home and community-based services that may include, but are not limited to:

a. Providing case management for the purpose of planning and securing needed services;

b. Assisting with information and referral options that may be provided directly or arranged for through available community resources or public-funded agencies;

c. Assisting in obtaining instruction in consumer education to assist with daily routine personal financial management and protection from financial exploitation;

d. Assisting in obtaining appropriate out-of-home placement and financial assistance to maintain the placement;

e. Arranging for professional counseling;

f. Arranging for escort services to and/or from service providers for needed services;

g. Securing health support for necessary medical treatment and training in the use of prosthetic devices, special health aides, and appliances;

h. Arranging for home management services for educating and training in adult functioning, maintaining and caring for the home, and planning and preparing meals;

i. Obtaining homemaker services to help the vulnerable adult remain in his/her home;

j. Seeking non-financial assistance to improve or maintain the vulnerable adult's home or housing needs;

k. Seeking legal services; and,

l. Arranging for transportation to and/or from service providers for needed services.

## Chapter 2

## INTAKE, INFORMATION, AND REFERRAL

2-1. Purpose. This chapter provides an overview of intake, including a definition and description of the intake process, and a description of the criteria for establishing client eligibility for short-term and on-going case management. This chapter also describes the process for providing a vulnerable adult and the legal guardian/caregiver with information and referrals.

2-2. Intake Process.

a. The intake process begins with a request for information or services by or on behalf of a vulnerable adult. The request for services generally comes (to the APS Counselor, Family Support Worker, or other appropriate staff) via office visit, telephone call, or written referral. Upon receiving a request for services, the following steps will be taken:

(1) The APS Counselor or other staff member accepting the referral provides general programmatic information to determine if services provided by APS are appropriate, or whether a referral to another Departmental program or community/service agency is more appropriate to serve the needs of the client.

(2) The APS Counselor or staff member accepting the referral completes PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022; unless the referral comes from an Adult Protective Investigator (API) by way of form CF-AA 1099). Although this screening instrument is used by the APS Counselor to screen individuals for placement on an APS programmatic waiting list log, PART I is used as the intake instrument for the Protective Intervention Program. PART I assists the APS Counselor in reviewing the income eligibility, establishing some basic demographic, physician/caregiver, and problem-specific information, and determining what type of Protective Intervention services are appropriate for the vulnerable adult.

(3) If the APS Counselor, or any other staff member participating in the intake process, suspects that the vulnerable adult is being abused, neglected, or exploited, the case is referred immediately to the Florida Abuse Hotline (1-800-96ABUSE) or by going online at [www.dcf.state.fl.us/abuse/report](http://www.dcf.state.fl.us/abuse/report) via the internet.

(4) The Unit Supervisor reviews PART I and assigns the request for Protective Intervention services to an APS Counselor within one working day from the date the request was received. The APS Counselor must make contact (telephone or face-to-face) with the vulnerable adult within three working days from the date the request for services was received by the APS Program.

(5) If the request for services is received (by telephone, in writing, or by an office visit) from an individual other than the vulnerable adult, contact (telephone or face-to-face) with the vulnerable adult will be initiated by the assigned APS Counselor within three working days from the date assigned by the Unit Supervisor. For example: Date Request for Services Received – Monday, 2/23/XX; Date Assigned By Supervisor – Tuesday, 2/24/XX; Contact Date would be no later than Friday, 2/27/XX. Contact with the vulnerable adult may be face-to-face or by telephone, depending on the initial information received during the intake process. Although it is not possible to describe every situation that requires face-to-face contact and those that require telephone contact, the following table will provide guidance.

Situation	Suggested Type of Initial Contact
Vulnerable adult in need of placement (see Chapter 6)	Face-to-face
Vulnerable adult in need of supportive services (see Chapter 5)	Face-to-face
Vulnerable adult in need of early services intervention (see Chapter 3, paragraph 3-9)	Face-to-face
Case referred by Protective Investigations after staffing with Protective Intervention staff (see Chapter 3, paragraph 3-8)	Face-to-face
Vulnerable adult currently in placement and in need of Optional State Supplementation (see Chapter 6, paragraph 6-7)	Telephone
Vulnerable adult on waiting list for in-home supports, and in need of supportive services (see Chapter 5)	Telephone

b. Verification of the vulnerable adult’s eligibility for short-term and on-going case management may be completed during the initial intake or at a later date after the request for services is assigned to the APS Counselor by the Unit Supervisor.

c. Eligibility criteria include:

(1) Vulnerable adult, aged 18+ (CCDA and HCDA are ages 18-59), whose permanent physical, mental, emotional, sensory, or developmental disability impairs his/her capacity to live independently or with relatives without assistance/services or requires alternative placement in a licensed facility. Documentation of age, such as from the Social Security office or birth certificate, and documentation of the disability must be provided, as verified by a statement from a health professional, psychological reports, Social Security disability award letter, etc.

(2) Vulnerable adult, aged 18+, in need of alternative placement in a licensed facility to prevent a situation of abuse, neglect, or exploitation from occurring initially or deteriorating, and who is receiving or eligible to receive an Optional State Supplementation (OSS) payment (see Chapter 6, paragraph 6-7), as determined by ACCESS Adult Payments. Verification of age must be obtained. The client, relative, or legal guardian/caregiver may furnish verification of age by providing proof of Social Security benefits for the client, birth certificate, census reports, family Bible, or through other official records. This information may also be obtained by the APS Counselor through the Social Security Administration Third Party Query (TPQY) or Florida Medicaid Management Information System (FMMIS).

(3) Income at or below the prevailing Institutional Care Program (ICP) rates, or eligible/receiving Supplemental Security Income (SSI) (applies only to on-going case management cases, and not placement or Short-Term Case Management) – documentation of income or SSI eligibility for benefits must be obtained. This may be provided by the client or his/her legal guardian/caregiver or may be obtained by the APS Counselor through TPQY. Also, if the client is receiving Medicaid, this will be noted on PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022).

(4) A client can be placed in the least restrictive environment in a licensed facility without regard to income. These requests usually come from an API in the form of a 1099 referral for services. An application for OSS or Assistive Care Services can be completed after the initial placement. If the client has sufficient income to cover the costs of the placement and services, these are paid for by the client or the client’s legal guardian/caregiver. The APS Counselor provides case management to the client with sufficient income to cover the costs of placement and services.

(5) Financial eligibility is reviewed. Additionally, the majority of the eligible vulnerable adults should receive Supplemental Security Income or have income at or below the existing institutional care program income limit. However, it may be appropriate to place a vulnerable adult who



is the victim of abuse, neglect, or exploitation, but does not meet the income qualifications, in an assisted living facility, adult family care home, or nursing home. In these cases, the APS Counselor provides case management; all services are paid for by the client or his/her legal guardian/caregiver.

(6) Existence of a need which falls within the purview of the Protective Intervention Program.

### 2-3. Information and Referral, No Case Established.

a. If the APS Counselor determines that a full assessment or case management is not necessary, a request for information and referral can be handled expediently with minimal documentation by the APS Counselor:

(1) Provide the requestor with general programmatic information; and,

(2) Determine if services provided by the program are appropriate or whether a referral to another service agency is more appropriate.

b. Many requests for information are received by telephone and the APS Counselor simply provides the requestor with the appropriate information, telephone numbers, etc. However, if a request results from an office visit, and the requestor appears independently capable of accessing the services, and the APS Counselor determines that both information and/or a referral will facilitate the individual's receipt of assistance from another agency, the following steps will be taken:

(1) PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022) is completed.

(2) For active clients, the top and middle portions of the Referral for Services (CF-FSP 5065 form) are completed by the APS Counselor and the form is provided to the referral provider/agency. The APS Counselor makes a copy of the completed form for the file. The APS Counselor may also give a copy to the client/guardian/caregiver to take to the referral provider/agency directly or mails the form to the referral source.

(3) PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022) and original Referral for Services Form (CF-FSP 5065 form) are placed in a "unit referral folder."

(4) After meeting with the client, the referral agency should complete the bottom portion of the Referral for Services Form (CF-FSP 5065 form) and return a copy of the form to the APS Counselor.

(5) This type of situation does not constitute a "case;" therefore no case record is created. However, once the activity is completed, the completed Referral for Services (CF-FSP 5065 form) from the service provider is attached to the existing documentation previously filed in the unit referral folder.

(6) If a misunderstanding or unexpected barrier results in an incomplete service referral and the service is not obtained by the vulnerable adult, the referral may need to be clarified or re-directed by the APS Counselor. At this point, it is appropriate for the APS Counselor to move the client into short-term case management (see Chapter 3, paragraph 3-6), until the referral is completed. When moved to short-term case management, a case record is established, which includes all documentation to date.

## Chapter 3

## MANAGEMENT OF A CASE

3-1. Purpose. This chapter provides a definition and describes the concepts of case management and defines the roles and professional obligations of the Adult Protective Services (APS) case manager. The chapter also provides information about short-term and on-going case management, case staffing, and early services intervention.

3-2. Case Management Principles/Concepts. The principals and concepts of Protective Intervention case management for vulnerable adults are listed below.

a. Case Management is “Client Centered.” Clients must be involved in the development of intervention strategies to meet their needs and optimize independence and self-sufficiency. Services will be designed to fit the unique and individual needs of the client in a personalized approach to providing services that coincide with the objectives of case management. It is important that services are identified and designed to meet the assessed needs of each client and updated as needs change or when new needs are identified.

b. Case Management Involves Problem Solving. The Protective Intervention Program was established to assist vulnerable adults with specific problems. The case manager must have the skills necessary to assist clients in identifying and overcoming difficult problems in order for services to be effective.

c. Case Management Involves Coordination. Often, the issues that the client is experiencing are multi-faceted and may require a number of different key players in intervention strategies. Services from other Departmental programs, such as the Substance Abuse & Mental Health Program or the Agency for Persons with Disabilities, may be included in these intervention strategies. The case manager must be able to quickly access a continuum of care ranging from in-home services to out-of-home placement. This is accomplished by coordinating with other Departmental programs and providers to ensure that each client receives all services necessary to protect the client from the occurrence or recurrence of abuse, neglect, or exploitation. The case manager must ensure that services are delivered within a reasonable period of time and in the sequence that will be most beneficial to the client. Gaps in the delivery of services must be documented to provide information for program planning and budgeting. Duplication and overlapping of services must be avoided. In cases that involve Protective Intervention and other Departmental programs, the APS Counselor will determine with the other program’s case manager which program will be responsible for providing primary case management. If it is determined that it is more appropriate for another program to provide primary case management, this is documented in the case record, and the case is closed to Protective Intervention.

d. Case Management May Involve Participation of Others. Family members and/or significant others may participate in the case management process, if the client desires and agrees to their participation. Although family members are sometimes involved as alleged perpetrators of abuse, neglect, or exploitation, they often desire to work through their problems with the client. Therefore, it is often necessary for the case manager to work with these family members as part of the client’s interventions. It is important for the APS Counselor to pursue involvement of individuals who have established relationships with the client while maintaining the client in an environment that protects the client from further occurrences of abuse, neglect, or exploitation.

e. Case Management Ensures the Maintenance and Confidentiality of Materials in Client Records. The case manager maintains accurate, confidential materials, and up-to-date client records, so that clients’ rights are respected and services can be continued in the absence of the primary case manager (see Chapter 3, paragraph 3-4, and Chapter 7).

3-3. Roles of the APS Counselor as a Case Manager. The APS Counselor's role as a case manager is a facilitator between the vulnerable adult and the services he/she needs. As a case manager, the APS Counselor performs a number of duties that accomplish the specified case management goals. For example, an APS Counselor may assess that the client has a need for professional counseling and will make a referral to an individual or agency that specializes in counseling. The APS Counselor does not provide this counseling to the client. Other duties performed by the case manager include:

- a. Identifying Community Resources. APS Counselors maintain knowledge of community resources and agencies, basic eligibility requirements for services from various agencies, and how to access these services. The case manager will formally or informally establish a network with these agencies so that referrals and follow-up activities are facilitated.
- b. Accepting Referrals. APS Counselors receive referrals directly from the vulnerable adult through an office visit, telephone request, written request, or indirectly through a referral from others.
- c. Determining Eligibility. APS Counselors determine the individual's programmatic eligibility for short-term case management and on-going (support services and placement) case management and assists ACCESS with obtaining the necessary documentation to determine financial eligibility.
- d. Completing the Appropriate Forms and Assessments. APS Counselors collect basic information on clients, assess clients' physical and mental well-being, determine clients' service needs, and make referrals using the appropriate forms, assessments, and care plans.
- e. Communicating with Other Agencies and Coordinating Service Delivery. APS Counselors arrange and coordinate the delivery of services for clients, and maintain adequate follow-up contact with providers to ensure that quality services are being delivered. Effective coordination is important in meeting the needs of the client.
- f. Providing Guidance to the Client. APS Counselors provide guidance and serve as a resource to the client in implementing care plans and measures to reduce the risk of abuse, neglect, or exploitation.
- g. Maintaining Contact with the Client. APS Counselors monitor their clients by engaging in personal or telephone contact. This includes visits to the home, assisted living facility, adult family care home, or nursing home, and may include contact with the client in the office setting.
- h. Documenting Activities Involved in Providing Services. APS Counselors document in the case record all care plan activities that are involved in providing services to their clients.
- i. Maintaining Case Records. APS Counselors maintain case records for all clients in short-term or on-going case management.

3-4. Professional Obligations of the APS Counselor as a Case Manager. As professionals in the field of social services, case managers must adhere to certain legal and professional obligations. Three major legal obligations are described below.

- a. Mandatory Reporting. The APS Counselor has a responsibility to report instances when individuals are at risk of being neglected or otherwise harmed by themselves, or by another individual. Section 415.1034, Florida Statutes states, "Any person... who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the Florida Abuse Hotline."
- b. Confidentiality. The APS Counselor must respect the rights of clients and is responsible for protecting client confidentiality. Certain information received through files, reports, inspections, or

otherwise by Departmental employees, individuals who volunteer their services, or individuals who provide services through contracts with the Department, is **confidential** and exempt from the provisions of section 119.07(1), Florida Statutes. Sharing of client information among Departmental programs serving mutual clients is basic to the Department's system of integrated service delivery. However, disclosure of client information, including medical or psychological reports, financial information, legal documents and related materials, and materials which contain the client's social security number, outside the Department shall only be made with the informed, voluntary, written consent of the client or his/her legal guardian, by court order, or as otherwise provided by law. In order to meet the Health Insurance Portability and Accountability Act (HIPAA) and Departmental regulations, the Confidential Information Release (form CF-AA 1113) must be completed, initialed, kept up-to-date, signed, and dated by the client or his/her legal guardian, providing permission for APS staff to obtain financial, medical, and/or psychiatric information, and share medical, psychiatric, and specific financial information necessary for the client to receive services. Refer to CFOP 15-4, Records Management, for more information on public records requests and access to confidential information.

c. Ethical Considerations. The Department has a Code of Ethics, which must be adhered to by all Departmental employees. The principles of the Code of Ethics are listed below. For additional specifics on the department's Code of Ethics, refer to CFOP 60-05, Chapter 5.

(1) Departmental employees use the powers and resources of the Department to further the public interest and not for financial or personal benefit or privilege.

(2) The compensation, employee benefits, and reimbursement received from the State of Florida are the sole financial or material benefit derived through employment with the Department.

(3) Departmental employees will not accept gifts, benefits, or privileges that might appear to influence or reward a future decision.

(4) The Code of Ethics foremost concern is to promote public interest and maintain respect and trust of the people in government. This is generally achieved by prohibiting certain actions and requiring that certain disclosures be made to the public.

### 3-5. Short-Term Case Management.

a. Short-term case management is often referred to as "one-shot" referrals or services for vulnerable adults, ages 18+. These may include, but are not limited to, case management and services pending court ordered protective supervision; requests for services from vulnerable adults themselves, from caregivers, out-of-town inquiries, ACCESS staff, and letters from legislators, etc. Information provided or referrals completed in approximately one hour or less are considered as information and referral(s) only and not as short-term case management. Short-term case management of services for vulnerable adults is distinguished from on-going case management by the length of time the client is in contact with the service delivery system and the extent of the contacts. Short-term case management does not exceed 60 calendar days. For example, a caregiver caring for a vulnerable adult living in the home may need assistance with a referral for a service needed for a three-week period. The APS Counselor may assist with making this referral for the vulnerable adult, and follow-up for the three-week period, at which time the case is closed.

b. Determination is made during the first visit or telephone contact, or as soon thereafter as possible, whether the client's needs can be met through short-term case management or if on-going case management is more appropriate. Some short-term case management clients may eventually become on-going case management clients, if the client's service needs surpass 60 calendar days and they meet eligibility criteria. When a client receiving short-term case management is identified as requiring on-going case management, such as court ordered protective supervision, the case is closed

under short-term case management in the current electronic APS case management system and a new case opened under the appropriate on-going case management program component.

c. The APS Counselor may make referrals for clients in short-term case management to service providers/agencies using the Referral for Services Form. After meeting with the client, the referral agency should complete the bottom portion of the Referral for Services Form (CF-FSP 5065 form) and return a copy of the form to the APS Counselor. This will assist the APS Counselor in determining whether closure is appropriate or whether the case will be moved into on-going case management.

d. Cases open for short-term case management generally do not require comprehensive service planning. Completion of a comprehensive client assessment and care plan may occur at the discretion of the APS Counselor, but it is not a requirement. The intent of short-term case management is to give APS Counselors flexibility in evaluating the individual's condition by not requiring the lengthy APS Client Assessment (form CF-AA 3019) and the setting of the Care Plan (form CF-AA 1025) goals when it is unwarranted (see Chapter 4). However, if a comprehensive client assessment is not completed on the individual, the APS Counselor will document in the field notes/narrative specifically why this was not necessary. A case record with minimal documentation is required (see Chapter 3, paragraph 3-6f).

e. Re-determination of OSS eligibility is required when the client's status changes or the client moves to another facility. ACCESS staff will notify the APS Counselor of the need for OSS re-determination. If APS assistance is required, the APS Counselor will open a Short-Term Case Management (STCM) case to process the CF ES 1006 form. If necessary, the APS counselor will schedule and meet face-to-face with the client or legal guardian/caregiver to complete a new Alternative Care Certification for Optional State Supplementation (CF-ES 1006) form. This form is forwarded to ACCESS staff for processing. The APS Counselor will also notify ACCESS staff of changes identified during the OSS re-determination. After processing the form, ACCESS staff will send the client or legal guardian/caregiver notification of the amount of OSS benefit received and the amount payable to the facility operator.

f. In addition to documentation necessary to establish the client's eligibility for short term case management, the following are required (see paragraph 2-2c of this operating procedure):

(1) PART I of the APS Screening for Consideration for Community-Based Programs (forms CF-AA 1022 or 1099);

(2) Field notes/narrative of contacts (see Chapter 7);

(3) Referral for Services form(s) (form CF-FSP 5065), or documentation of referrals, as appropriate;

(4) Documentation that the case has been entered correctly in the current electronic APS case management system;

(5) Confidential Release of Information; and,

(6) HIPAA Form.

g. Short-term case management cases are closed:

(1) Within 60 calendar days of initial contact from requestor;

(2) If the APS Counselor determines that intervention is no longer needed because the client's situation has changed or the client is now receiving all necessary on-going services to meet his/her needs; or,

(3) If the APS Counselor determines that further intervention (under on-going case management) is necessary for the client.

h. The Services Supervisor reviews and approves every case at the onset, at staffing, and prior to closure. The reviews can be documented in the electronic case management system's notes or using the Supervisor's Case Record Review Log (form CF-AA 1023) which must then be uploaded into the electronic case management system.

### 3-6. On-Going Case Management.

a. On-going case management is appropriate for clients who require interventions for more than 60 calendar days to address their needs. This includes clients in need of supportive services and clients in placement who are receiving OSS/ICP, regardless of whether they are victims of abuse, neglect or exploitation (see Chapter 5 and Chapter 6). The APS Counselor may also determine the client's eligibility for programs that offer necessary services that meet the client's needs.

b. All clients in on-going case management require a comprehensive assessment using the APS Client Assessment (form CF-AA 3019), a comprehensive Care Plan (form CF-AA 1025), and a detailed case record (see Chapter 4 and Chapter 7.)

### 3-7. Case Staffing.

a. A case staffing is a combined effort of individuals to identify the vulnerable adult's needs and problems, identify barriers to solving problems, determine solutions to barriers and problems, identify services and identify individuals who will assume responsibility for each task to meet the needs of the vulnerable adult. A case staffing may occur between Protective Intervention staff and staff from the Protective Investigative unit, between Protective Intervention staff and staff from a referral agency/source or internally. The case staffing with the Protective Investigation Unit allows staff to agree on the appropriateness of the case for Protective Intervention and share information. An informal telephone or formal face-to-face case staffing is required for all vulnerable adults who are in situations of abuse, neglect, or exploitation, and are being referred to the Protective Intervention Program by the Protective Investigation staff (see CFOP 140-2, paragraph 17-7h).

b. The API is responsible for scheduling an abuse, neglect or exploitation staffing, and may occur at any point during the investigation, or upon completion of the investigation. If the staffing is held prior to the completion of the investigation (see Chapter 3, paragraph 3-8), the APS Counselor will report to the assigned API all specifics about the referrals and delivered services. Once the staffing is completed and the APS Counselor has accepted the responsibility of assisting the client with obtaining needed services, the APS Counselor will schedule a face-to-face interview with the vulnerable adult within three working days following the staffing. Details regarding the case staffing, (i.e., participants present, decisions regarding case management, and other pertinent information), must be documented in the case narrative or field notes (see Chapter 7).

c. Form CF-AA 1099, entitled "Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or HCDA/HCE Services" is used by the API to refer vulnerable adults to the Protective Intervention Program. This form will be completed and given to the APS Counselor during the staffing. The API may also provide the APS Counselor with his/her field notes pertaining to the case, a current safety assessment, consent for services form, and other information deemed necessary in understanding the client's situation to assist in the development of the Care Plan (form CF-AA 1025). Even though the investigative record will not be transferred to the APS Counselor during the referral

process, APS Counselors will have access to the investigative record to obtain any useful information regarding service needs and possible resources.

d. The staffing between Protective Intervention staff and a referral agency/source may occur at any point, once the client's needs and necessary services are identified by the APS Counselor. The APS Counselor will contact the individual(s) either by telephone or face to face from the referral agency/source and discuss the client's service needs. The APS Counselor will ensure that a completed and signed Confidential Information Release (form CF-AA 1113) is in the case record prior to discussing the client's situation with an external referral agency/source. The case staffing allows all parties to agree on the appropriateness of the referral agency/source's participation in the client's case.

3-8. Early Services Intervention. The APS Counselor can provide short-term case management, supportive or placement services to a vulnerable adult named in a investigation of abuse, neglect, or exploitation report prior to the close of the protective investigation, including court ordered protective supervision while awaiting the court order. This allows the vulnerable adult and his/her family to begin receiving services as soon as the API identifies the service needs. The responsibilities of the Protective Intervention staff for a case requiring services prior to completion of the protective investigation include:

a. The Supervisor assists in planning and scheduling a staffing with the Protective Investigation unit;

b. The Supervisor assigns the case to an APS Counselor;

c. The Supervisor and the APS Counselor participate in the staffing;

d. The APS Counselor makes an initial face-to-face contact with the client within three working days from the date of the completed staffing (contacts by Family Support Workers or Direct Service Aides (see Chapter 5) are considered additional and supplemental, and do not meet the compliance standards for required contacts). For cases opened while awaiting court ordered protective supervision, the counselor will make an initial face-to-face contact with the client within one (1) day of the completed staffing for protective supervision.

e. The APS Counselor determines whether the client will require services through short-term or on-going case management, and establishes the case record with the appropriate documentation (see Chapter 3, paragraph 3-6; Chapter 6, paragraph 6-10; and Chapter 7);

f. The APS Counselor documents the progress of the case toward meeting the goals in the case narrative;

g. The APS Counselor provides frequent verbal or written updates to the API regarding the status and progress of the case; and,

h. The APS Counselor establishes a case record within three working days from the completed staffing. The case record includes all documentation that has been forwarded by the API to the APS Counselor.

## Chapter 4

## ASSESSMENT AND PLANNING

4-1. Purpose. This chapter discusses general aspects of assessing a client's needs and planning appropriate services to meet those needs. The specifics of the Adult Protective Services (APS) Client Assessment (form CF-AA 3019) and Care Plan (form CF-AA 1025) are outlined.

4-2. Objectives of an Assessment. The objectives of an assessment are to:

- a. Determine the client's needs, strengths, limitations, capacity to cope with his/her problems, and level of motivation;
- b. Identify the client's health and functional capabilities;
- c. Identify the client's presenting difficulties and concerns;
- d. Identify the external systems impacting the client that may need to be strengthened, mobilized, or developed; and,
- e. Provide a foundation for a plan of intervention that addresses the client's needs.

4-3. Sources of Information. A key aspect of developing an assessment involves gathering information. Information may be obtained from a variety of sources in addition to the client, and is important in conducting a thorough client assessment. Some of the sources of information are described below.

a. Background Information or Other Client Information. Background documentation and other types of client information forms provide documentation of the name, address, and other client demographic information.

b. Client Interviews. The APS Counselor interviews the client in order to obtain useful information.

c. Observation of Nonverbal Signs. Frequently the client conveys his/her feelings through nonverbal acts such as facial expressions, gestures, or body movements and the APS Counselor will be alert to these signs.

d. Observation of Client Interactions with Others. Observing how a client behaves when interacting with others can provide information about the client's relationships with others. For example, a talkative elderly client who becomes quiet when his/her adult child enters the room may suggest that the client is fearful of that individual. It is important to clarify the incident with the client at a time when the client is comfortable discussing the matter.

e. Collateral Contacts with Family, Medical Professionals, Service Providers, or Friends of the Client. Talking with a client's family members, friends, or service providers can provide useful information about the client. In cases where the client is unable to provide information, the APS Counselor needs to obtain other sources of information.

f. Psychological Tests. Psychological tests provide information about the mental functioning of the client. Information obtained from psychological tests is very practical for use in mental health assessments.



g. Professional Experiences. Utilizing experiences gained from working with other individuals can be helpful in conducting assessments. Although clients must be viewed as individuals, the APS Counselor's professional experience can be helpful when determining patterns or similarities in certain situations.

#### 4-4. APS Client Assessment (form CF-AA 3019).

a. APS Counselors use the APS Client Assessment (form CF-AA 3019) to collect and record uniform and organized information gathered from all sources. The completion of the assessment form allows the APS Counselor to evaluate the vulnerable adult's current health, functioning, support system, overall safety, and well-being. The completed client assessment provides the APS Counselor with information to assist in determining the vulnerable adult's needs and the means, frequency, and duration of services necessary to meet these needs. This information is then used to develop a Care Plan (form CF-AA 1025) (see Chapter 4, paragraph 4-5) that is best suited to each individual receiving services.

b. When completing the APS Client Assessment (form CF-AA 3019), the APS Counselor must:

- (1) Involve the vulnerable adult and/or legal guardian/caregiver in making decisions regarding services;
- (2) Determine what services the vulnerable adult is currently receiving;
- (3) Determine what services the vulnerable adult has previously received; and,
- (4) Be familiar with the services available in the area in which the vulnerable adult lives;

c. Listed below are the main sections of the APS Client Assessment (form CF-AA 3019). Professional observation, direct questioning, and professional judgment are used in determining the score for each section.

(1) Health Assessment. Assesses whether the client is experiencing health problems and how the client perceives his condition. This section also examines whether the client is receiving proper medications, medical care, and maintaining a healthy nutritional status.

(2) Functional Assessment. Determines the client's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). This section is useful for determining the level of assistance the client may need to perform everyday activities.

(3) Client Support Assessment. Assesses the client's formal and informal support systems, and whether they are sufficient to assist the client in completing ADLs and IADLs.

(4) Environmental Assessment. Evaluates the client's physical environment for safety and accessibility.

(5) Cognitive Assessment. Addresses the client who is suspected of having difficulty with cognitive functioning. This section focuses on communication patterns, thinking processes, memory, and concentration.

(6) Mental Health/Substance Abuse Assessment. Assesses the mental health, emotional well-being, memory, and use of alcohol/substances of clients with indications of mental health/substance abuse problems. The purpose of this evaluation is to assess the client for appropriate professional treatment in an effort to keep the client safe from harming him/herself or others.

(7) Caregiver Assessment. Evaluates the level of hardship that is placed on the individual responsible for the care of the client. This assessment enables the APS Counselor to determine whether alternative plans are necessary to ensure the well-being of the client and the caregiver.

d. Completion of the APS Client Assessment (form CF-AA 3019) must be in accordance with departmental guidelines provided in the Adult Protective Services Client Assessment Instructions booklet. The primary requirements for completing the APS Client Assessment (form CF-AA 3019) are outlined below.

(1) An APS Client Assessment (form CF-AA 3019) is completed for all clients receiving on-going Protective Intervention services. An APS Client Assessment (form CF-AA 3019) for clients in short-term case management is optional.

(2) The APS Client Assessment (form CF-AA 3019) is administered at the point that the vulnerable adult asks for services (may be during intake), or during the first face-to-face visit, and will be completed within 14 calendar days from the date that the case was assigned to the APS Counselor by the Unit Supervisor. If a client is initially provided information and referral(s) or short-term case management, but is in need of additional services, and consequently is moved into on-going case management, the 14 calendar days for completing the APS Client Assessment (form CF-AA 3019) is counted from the point of the decision to move the case.

(3) The APS Client Assessment (form CF-AA 3019) will be completed on-site at the client's residence (home or facility) with the client, family members, and/or other significant individuals. The visit will provide the APS Counselor an opportunity to provide information to the client, family members, or other significant individuals. In addition, the visit will allow for the evaluation of the client's living environment, social situation, physical and emotional endurance, resilience, adaptability, and attitude toward in-home services or out-of-home placement.

(4) Information from other service providers may be obtained with written authorization from the client. Health professionals, psychological professionals, or other professionals involved in the provision of services to the client may be appropriate sources to provide statements or documentation concerning the client that will assist in the assessment.

(5) Any significant changes occurring in the client's situation will require a new or updated APS Client Assessment (form CF-AA 3019) and a revised Care Plan (form CF-AA 1025) reflecting the necessary changes, as the facilitation of more or different services to meet changing needs may be necessary.

(6) At least annually, the client's total needs will be re-assessed and the APS Client Assessment (form CF-AA 3019) updated to reflect the results of this process. If termination is before the annual re-assessment date, the APS Client Assessment (form CF-AA 3019), though not required, may be completed to assist the APS Counselor in reviewing the client's health and living situation, determining whether the client's goals have been met and in making the decision to close the case. In an on-going case, the re-assessment must be completed within a 12 month-period from the previous assessment or re-assessment.

(7) All completed APS Client Assessments (form CF-AA 3019) must be filed in the case record.

#### 4-5. Development of the Care Plan (form CF-AA 1025).

a. Based on the information collected using the APS Client Assessment (form CF-AA 3019), a written Care Plan (form CF-AA 1025) for services is developed within 14 calendar days from the assignment of the initial request for services by the Unit Supervisor to the APS Counselor. Services recommended and provided will be those which assist the client in achieving the stated and agreed upon goals. Services can be referred, contracted for, or provided by staff. Services may include, but are not limited to case management, chore services, homemaker services, consumer education, professional counseling, transportation services, health support, home management, and out-of-home placement.

b. Setting goals and specifying desired outcomes are essential aspects of developing the Care Plan (form CF-AA 1025). A goal is the overall desired achievement, and desired outcomes are more specific objectives related to handling the stated problems and ultimately reaching the goal. Identifying goal(s) and desired outcomes allow the APS Counselor and the client to establish what each expects from the intervention. Goal(s) and desired outcomes in the Care Plan (form CF-AA 1025) provide all persons involved with an understanding of what is to be accomplished, a basis for evaluating the client's progress, and a basis for determining the effectiveness of the services provided. It is important for the APS Counselor to be specific in stating the problem(s) and the desired outcome(s), so that all parties will know when the outcome is met, or if it is necessary to revise the Care Plan (form CF-AA 1025) because a desired outcome is not being met.

c. The Care Plan (form CF-AA 1025) will be developed with the client's participation and agreement. This allows the client to play an important role in resolving his/her problems. It also allows the client an opportunity to determine what services, if any, he/she is willing to accept. In addition, it provides the client with choices and a voice about what decisions will be made in regard to his/her life. In situations where the client does not have the capacity to express him/herself or make decisions about services, the Care Plan (form CF-AA 1025) will be developed with the permission and participation of the client's legal guardian/caregiver. As previously stated, Protective Intervention services are provided to the client on a voluntary basis.

d. Developing the Care Plan assists the APS Counselor in identifying:

(1) Difficulties, concerns and needs to be identified and addressed during the client assessment;

(2) Desired outcome(s) for addressing the difficulty(s), concern(s) and goals that must be reached to stabilize the situation;

(3) Services and providers needed to address the problem(s) and concern(s);

(4) Frequency at which the services will be provided, and for what length of time;

(5) Beginning and ending dates of the services;

(6) A needed service that is unavailable, and service needs outside the authority of the Department;

(7) Whether another individual/agency is meeting the needs of the client;

(8) A review date; and,

(9) The client's acceptance or rejection of the Care Plan (form CF-AA 1025).

e. The Care Plan (form CF-AA 1025) is complete when the above information has been entered, signed and dated by all parties. In the event that the client is unable to sign the Care Plan (form CF-AA 1025), the APS Counselor will document this information on the plan. If the client signs using a mark (i.e., "X"), the APS Counselor or other individual must witness the signature.

f. If the client refuses to sign or participate in developing the Care Plan (form CF-AA 1025), the APS Counselor must document on the plan the client's explanation for his/her refusal, if known. A client who lacks capacity to agree to services and refuses to sign the Care Plan (form CF-AA 1025) can be provided services if his/her legal guardian/caregiver signs the Care Plan (form CF-AA 1025). Because Protective Intervention services are provided to a client voluntarily, a refusal for services by a client who has capacity or by the legal guardian/caregiver of a client lacking capacity is sufficient reason to terminate the case.

g. The Care Plan (form CF-AA 1025) for clients in supportive services or in placement is reviewed and updated quarterly to ensure that services continue to be appropriate. The APS Counselor initials and dates at the top of the Care Plan (form CF-AA 1025) at the time of the review. The Care Plan (form CF-AA 1025) may be revised more often if the service needs change.

h. A new Care Plan will be completed annually for on-going case management cases using a new form and modified based on the reassessment of the client's needs and situation as identified on the updated APS Client Assessment (form CF-AA 3019). The APS Counselor will include an assessment of the appropriateness of services being provided and the client's progress toward achieving the stated goals. All case records for clients receiving on-going Protective Intervention services must contain a complete, current, and signed copy of the Care Plan (form CF-AA 1025), as well as previous Care Plans (form CF-AA 1025).

i. If during the Care Plan (form CF-AA 1025) review, it is determined that services are no longer needed or appropriate, services will be terminated and the client notified in writing using the Notice of Ineligibility or Change in Service Status (form CF-AA 1114). This form provides the client with the reason for the change in service status and advises the client of his/her right to appeal the determination and the procedure for requesting a hearing.

j. The unit supervisor will review and approve every case prior to closure using the supervisor's case record review log (form CF-AA 1023).

4-6. Determination of Service Provider(s). After the assessment of the client's service needs, the APS Counselor must determine what service provider(s) are most appropriate and consistent with the services indicated on the client's Care Plan (form CF-AA 1025). In determining a service provider, the APS Counselor considers the following:

a. The provider's ability to meet the needs of the client in the most efficient and effective manner;

b. The provider's ability to implement the services immediately or whether the client must be placed on a waiting list;

c. The provider's availability to provide needed services in accordance with the Care Plan (form CF-AA 1025), for the required length of time;

d. The client's willingness to accept services from the agreed upon provider; and,

e. The client's ability to secure transportation to and from the provider's location, if applicable.

## Chapter 5

## SUPPORTIVE SERVICES

5-1. Purpose. This chapter defines supportive services, identifies eligibility criteria for clients receiving supportive services, describes the referral process for moving clients into supportive services, and describes the types of referrals and supportive services.

5-2. Definition of Supportive Services. Supportive services are services (not placement) that encourage and assist eligible vulnerable adults to remain in the least restrictive environment and to maintain their independence as long as possible. This support and assistance is designed to prevent abuse, neglect, and exploitation initially; prevent a situation from deteriorating into more severe abuse, neglect, or exploitation; and/or prevent or delay the placement of the vulnerable adult into an assisted living facility, adult family care home, or nursing home.

5-3. Eligibility Criteria for Clients Receiving Supportive Services. To be eligible for receiving supportive services to remain in the home, the individual must:

- a. Be a vulnerable adult, as defined in Chapter 2, paragraph 2-2c(1) of this operating procedure;
- b. Be unable to perform, or need assistance with performing, at least one activity of daily living or instrumental activities of daily living, as indicated through the APS Client Assessment (form CF-AA 3019); and,
- c. Be in need of services to maintain his/her health and well-being in his/her own home.

5-4. Referrals for Supportive Services.

a. Based on the completed Care Plan (form CF-AA 1025), the APS Counselor may arrange and/or coordinate supportive services with community providers, or services can be provided directly by departmental APS Family Support Workers/Direct Service Aides. In most cases however, the APS Counselor provides instruction or information, arranges and/or coordinates, establishes delivery/appointment time(s) and dates(s) for all supportive services, and provides case management on behalf of the client. Frequently the APS Counselor must explore and locate providers to donate supportive services to accommodate clients' needs. It is imperative that APS Counselors possess comprehensive knowledge of services and service providers within their local areas. Staff responsible for community and volunteer services may provide resources which assist the APS Counselor with locating volunteer services and supplies.

b. To initiate a referral, the APS Counselor contacts the service provider/agency that the APS Counselor and client or legal guardian/caregiver have determined is most appropriate to meet the client's needs. If the referral provider/agency is able to accommodate the client, the APS Counselor completes the Referral for Services (CF-FSP 5065 form) and gives the copies to the client or legal guardian/caregiver to take to the referral provider/agency. The APS Counselor can also mail copies of the Referral for Services (CF-FSP 5065 form) to the referral provider/agency. The APS Counselor retains a copy for the case file. After meeting with the client, the referral provider/agency should complete the bottom portion of the Referral for Services (CF-FSP 5065 form) and return a copy of the form to the APS Counselor. If the APS Counselor has not received the completed Referral for Services (CF-FSP 5065 form) from the referral provider/agency within 30 calendar days of the initial referral, the APS Counselor must contact the provider/agency to obtain a status report on the delivery of services. This follow-up contact ensures that services are being/were delivered as arranged, and as indicated on the Care Plan (form CF-AA 1025).

c. The APS Counselor will obtain the Confidential Information Release (form CF-AA 1113), completed and signed by the client or, if appropriate, his/her legal guardian/caregiver, so that necessary information can be shared with the referral source and staff involved in providing appropriate services. The Confidential Information Release (form CF-AA 1113) will be updated annually.

d. Contact with clients who receive supportive services will be quarterly at a minimum. The Services Supervisor reviews all supportive services case records within 30 days of opening, quarterly and at closure. The supervisor uses the Supervisor's Case Record Review Log (form CF-AA 1023) to document each review, recommend additional or corrective action pertaining to the APS Counselor's performance specific to the case, and document any action taken. Additional or corrective action is completed by the APS Counselor within 30 calendar days of the record review date.

e. If a client is placed on a waiting list by the referral provider/agency, the APS Counselor may try to arrange other means to provide the services, if they are available. This may include temporary services by departmental staff. However, the APS Counselor, Family Support Worker, or Direct Service Aide should **NEVER** attempt to directly provide services that are not described in his/her position description or that he/she is not completely qualified to provide (see paragraph 5-8 of this operating procedure).

f. When a prospective client is pulled from a waitlist (for Home Care for Disabled Adults [HCDA] or Community Care for Disabled Adults [CCDA]) and up to the point where they are either approved for services or determined ineligible for services, all activities will be documented in a Supportive Services case management record. A Supportive Services case will be opened immediately upon an individual being pulled from a waitlist and maintained in an "open" state until the individual is either approved for services and moved into case management or determined ineligible for services, at which point the Supportive Services case will be terminated and appropriately end-dated in the electronic case management system.

#### 5-5. Quarterly Visits.

a. Quarterly face-to-face visits with the client are required for the APS Counselor to review the client's health and living situation and revise the Care Plan (form CF-AA 1025) as necessary to meet newly discovered or unmet needs. Quarterly visits, as specified on the Care Plan (form CF-AA 1025) and the field notes/narrative direct the APS Counselor and client toward meeting the desired outcome(s) to identified problems. The APS Counselor will review with the client the delivery of services that were scheduled during the previous quarter(s). Are the services actually being delivered? If so, what is the client's impression of the services and the service provider(s)? Are there newly discovered barriers to receiving a service? Is there a problem with a service/provider or the delivery of a service? Have the client's needs changed? If "yes," the APS Counselor must address the barrier(s)/problem(s) through revisions to the Care Plan (form CF-AA 1025).

b. The APS Counselor must be mindful of any physical and/or mental health changes that the client may have experienced since the previous face-to-face visit. Health problems and the overall status of the client's health must be reviewed visually or through questioning. The APS Counselor uses the APS Client Assessment (form CF-AA 3019) as a guide for questioning the client about health changes. If there have been changes in the client's health, these may have precipitated changes in medical treatments, therapies, and/or medications. It is also important to be aware of cognitive changes or changes in the client's mental health. These may affect the client's functional abilities and/or necessary supports, therefore necessitating a review of these two areas. Changes in the client's health or mental health usually necessitate revisions in the Care Plan (form CF-AA 1025), as new services may be necessary.

c. The APS Counselor will review with the client services received from other community services. Other community services may have started providing new services since the APS

Counselor's previous quarterly visit with the client. It is important that the APS Counselor contact staff from other community services to ensure service coordination.

d. If a client is receiving services in his/her own home from the Department, and homemaker services are being provided, the Homemaker Activities Plan (form CF-AA 1036) is developed cooperatively by the homemaker, client, and the APS Counselor in accordance with the Care Plan (form CF-AA 1025) (see Chapter 5, paragraph 5-8g). A revision in the Care Plan (form CF-AA 1025) may necessitate a change in the Homemaker Activities Plan (form CF-AA 1036) or visa versa. Chapter 5, paragraph 5-8g, Homemaker Services, provides detailed guidelines regarding the qualification, duties, and responsibilities of the homemaker. The APS Counselor will utilize the quarterly visits to ensure that these are being met.

e. If there have been significant changes in any of the above, these will be noted on the APS Client Assessment (form CF-AA 3019) and in the field notes/narrative. These significant changes may also necessitate a change in the Care Plan (form CF-AA 1025), as additional services or revision in the provision of services may be necessary. It is important to identify any unmet needs the client may have surrounding significant changes and these must be addressed in the Care Plan (form CF-AA 1025). It is also important for the APS Counselor to identify his/her next course of action toward meeting the desired outcome. It is not necessary to complete a new APS Client Assessment (form CF-AA 3019) or Care Plan (form CF-AA 1025); notations can be made on the current forms.

f. The purpose of the quarterly visit, accomplishments, observations and discoveries made, revisions to the APS Client Assessment (form CF-AA 3019) and/or Care Plan (form CF-AA 1025), and necessary follow-up, are documented in the field notes/narrative.

5-6. Screening for Home and Community Based Services. The Community Care for Disabled Adults (CCDA) and the Home Care for Disabled Adults (HCDA) programs are distinctly separate from the Protective Intervention Program; however, the APS Counselor can appropriately refer eligible vulnerable adults to these programs to assist them in remaining in a home-like environment and preventing institutionalization. There may be waiting lists of individuals who are requesting services from CCDA or subsidies from HCDA but are not receiving these because of lack of funding. Eligible vulnerable adults may be provided case management and supportive services until funding is available through CCDA or HCDA for eligible services/subsidies. (See Rules 65C-1 and 65C-2, F.A.C.)

5-7. Community Care for the Elderly Lead Agency Referrals. An individual, age 60 and over, is referred to the local Area Agency on Aging lead agency for case management and referrals to programs that provide supportive services. These programs provide the same or similar services as those described above for eligible clients age 60 or over. At least 3 months prior to a current APS client turning 60 years of age, the APS Counselor completes the Referral for Services (CF-FSP 5065 form) with the client and initiates a staffing (may be a telephone staffing) to discuss the client's needs with lead agency staff.

5-8. Types of Supportive Services.

a. Case Management. Case management (see Chapter 3, paragraph 3-2) is provided to all clients receiving supportive services. Case management is provided by the APS Counselor but is not provided by Family Support Workers/Direct Service Aides. The APS Counselor case manages the coordination of referrals to programs/agencies to provide the following services or may provide information, as appropriate, to the client and/or legal guardian/caregiver.

b. Chore Services. Chore services include minor home repairs, heavy cleaning, yard maintenance, errands, shopping, and other tasks which clients may not be able to do for themselves.

(1) When chore services are needed by a client, the APS Counselor will be responsible for arranging for the provision of these services and providing case management to ensure that the necessary services are provided as arranged. The APS Counselor will make every effort to obtain these services for the client from volunteers or other community agencies.

(2) When the need for continuous chore services has been identified, the APS Counselor will arrange for on-going provision from a single provider, when possible. (Direct Service Aides or Family Support Workers can shop or run errands, as necessary.)

c. Consumer Education and Protection. Consumer education and protection consists of formal or informal instruction and counseling in budget management, sensible purchasing habits, sound consumer practices, utilizing available financial resources, preparing shopping lists, and personal financial management practices necessary to make optimum use of limited financial resources and avoid financial exploitation. APS Counselors may provide basic information on consumer rights and advocate for client's consumer rights. If the APS Counselor identifies clients who have inquiries about or have been exploited in purchasing consumer items, the client may need legal assistance. If legal assistance is necessary, a referral to a local legal resource will be made. The APS Counselor may also provide basic, informal consumer education/information or clients can be referred to consumer organizations for formal education and consumer protection. The APS Counselor will provide case management to ensure that the necessary services are provided as arranged.

d. Counseling and Guidance. Counseling and guidance refers to the exploration of clients' interests and skills, problem identification and resolution, identification of feasible goals, provision of emotional support and guidance, information about community resources, exploration with clients of possible alternative behavior patterns, diagnosis and structured treatment of psychological and/or social problems, professional consultation, crisis intervention, individual, family, and group therapy. When professional mental health counseling is required, the APS Counselor will refer to mental health professionals. APS Counselors provide case management to ensure that counseling is provided as arranged.

e. Escort Services. Escort services are provided to accompany clients to and/or from service providers and to assist clients in obtaining necessary health, social, and rehabilitative services. Escort services play a determining role in the receipt of a service by a client. The focus of escort services is not to transport the client. However, in many cases personal accompaniment will involve transportation. The focus is on the assistance the escort renders to the client. Escort services can be provided by a referral agency, or directly by the APS Counselor or Family Support Workers/Direct Services Aides. The APS Counselor also provides case management to ensure that the escort services are provided as necessary. Assistance may include, but is not limited to:

- (1) Accompanying the client to service providers' offices;
- (2) Helping the client fill out forms required by the service provider;
- (3) Helping the client obtain needed verification or documentation;
- (4) Acting as a language, speech, or hearing interpreter;
- (5) Assisting the client in explaining problems and needs; and,

(6) Serving as an advocate for a non-assertive client who may or is experiencing difficulty obtaining services from an organization.



f. Health Support Services. Health support services are among the services most frequently requested by clients. Securing appropriate medical attention can be difficult under any circumstance, but it can be more difficult for low-income individuals with limited resources. People covered by Medicaid, in many instances, are faced with having to locate a Medicaid provider in a short time frame. Likewise, non-Medicaid eligible adults may have limited insurance or cash to obtain medical care.

(1) Health support services are services which assist the vulnerable adult in securing and using necessary medical (including preventive) treatment, nursing care, occupational, physical, and speech therapy, and other personal care and assistance needed to obtain and/or train in properly using prosthetic devices, special health aids, and appliances. Health support services enable clients to identify and remedy health conditions that present barriers to self-support and self-sufficiency, which may threaten the client's life, health, or well-being, thus, reducing the likelihood for the client to remain in his/her own home or community. Health support services include, but are not limited to:

- (a) Locating health and medical facilities;
- (b) Obtaining appointments for treatment;
- (c) Accessing health and medical facilities;
- (d) Obtaining therapy;
- (e) Obtaining clinic cards;

(f) Acquiring prosthetic devices, special health aids, appliances, and training in the use of these devices or medical equipment; and,

- (g) Receiving services through the Medicaid program.

(2) Health support services are not to be interpreted as the actual provision of health care to clients. The APS Counselor will not provide health care prescriptions, treatment, or advice. Such activity will be the responsibility of health professionals only. The APS Counselor will, however, provide the support services and the case management to ensure that necessary health services are obtained.

(3) Some circuits/regions maintain community resource directories which assist APS Counselors in locating information and referring clients for services. The community resource directory may include some of the following information:

- (a) Names and addresses of local Medicaid providers;
- (b) Names and addresses of local health and medical clinics;
- (c) Resources for free or low-cost health care (for example: Lions Club provides glasses to certain eligible individuals);
- (d) Resources for borrowing or renting, at low cost, certain health aids and appliances (for example: crutches and hospital beds);
- (e) Resource groups or organizations willing to provide financial assistance with health care and prosthetic devices;
- (f) Special transportation facilities for medical care (for example: wheelchair buses and contracted Medicaid transportation providers); and,

(g) Agencies that provide various kinds of health and medical care (for example: the Kidney Foundation, Easter Seal, and Vocational Rehabilitation).

g. Homemaker Services. Homemaker services are provided by individuals who assist the client by completing household tasks such as housekeeping and routine household activities. Services are provided to vulnerable adults in order to help them maintain, strengthen, and safeguard their personal functioning in their residence.

(1) In some regions, Homemaker Services are performed by Direct Service Aides/Family Support Workers or a trained homemaker or housekeeper employed by a provider agency for informal services. APS Counselors provide information, informal counseling, and instruction relating to the homemaker services and case management to ensure that the necessary homemaker services are provided.

(2) APS Counselors will be aware of local agencies that provide homemaker services as a referral source for clients. When the family situation requires the services of a trained homemaker, and arrangements are made for homemaker services to be provided by a community agency, APS staff will continue to provide the remaining supportive services until those services are no longer needed.

h. Home Management Services. Home management services include formal or informal instruction and training that impact the lives of clients by maximizing the potential of an adult's functioning while providing for optimum use of available resources. The APS Counselor can provide informal instruction on home management, however formal instruction and training must be provided by experts in the field. The APS Counselor will case manage referrals for home management services to ensure that referrals are completed.

i. Housing-Related Services. Housing-related services are services (other than financial) that assist in enabling clients to improve or maintain a home situation suitable for their needs.

j. Legal Services. The provision of legal advice and counseling is not provided by APS staff, but by attorneys and/or legal paraprofessionals. This service is usually made possible through referrals to Federal agencies subsidizing legal services programs or local bar organizations. The APS Counselor provides case management to ensure that the client is aware of available legal services.

k. Transportation Services. Transportation services are the provision of transportation to and/or from service providers or community resources. Transportation of a client by Family Support Workers/Direct Service Aides will be provided only when no other source of transportation is available to the client. APS staff will not transport clients needing emergency medical services. In such instances, emergency medical transportation will be arranged. APS Counselors will attempt to arrange for transportation of clients through existing resources such as contract providers, county transit authorities, or private providers. Transportation can also be arranged through Medicaid transportation providers for clients receiving Medicaid. The APS Counselor will provide case management to ensure that necessary transportation is available to the client.

## Chapter 6

## PLACEMENT SERVICES

6-1. Purpose. This chapter describes the goals and objectives of adult placement, placement procedures, service provision, and referrals. The Assisted Living for the Elderly Waiver, Optional State Supplementation (OSS), transfer of OSS clients between facilities, and the Assistive Care Program are described. Clients in facilities who are referred for Protective Intervention services, supervision of a client in placement, and maintenance of the case record are also discussed.

6-2. Goals and Objectives of Adult Placement. The primary goals of placing vulnerable adults in Assisted Living Facilities (ALFs), Adult Family Care Homes (AFCHs), or skilled nursing facilities (SNF) are to assist vulnerable adults in placement in a facility to prevent potential abuse, neglect, exploitation or self neglect. The objectives of the adult placement program are:

- a. Assist clients who are currently living independently in the community to relocate to the least restrictive placement alternative in order to ensure their continued safety;
- b. Facilitate clients moving from skilled nursing facilities (SNF) to alternate care living situations in the community, when appropriate; and,
- c. Arrange nursing facility placement when the client's situation requires a skilled level of care, as determined by the form 3008 completed by the client's personal physician and the Department of Elder Affairs Comprehensive Assessment, Review, and Evaluation Services (CARES) unit.

6-3. Placement Procedures. The procedures described below will be followed when placing a vulnerable adult in an ALF, AFCH or SNF.

a. Assess the Referral for Eligibility. Clients in need of placement services may meet eligibility requirements for financial assistance through the ACCESS program. Some of the eligibility requirements can be determined during the initial intake, which can be by telephone or face-to-face, or at a later date, after the referral has been assigned to an APS Counselor (the Unit Supervisor assigns the referral to an APS Counselor within one working day of receipt of referral). The APS Counselor is responsible for ensuring that the placement is appropriate for the vulnerable adult, and that the facility has the appropriate license to provide needed care and services. Chapter 400, Florida Statutes, provides that the facility operator is responsible for determining whether the facility can accommodate the needs of the vulnerable adult, even though the appropriate license may be in place.

b. The vulnerable adult may be financially eligible in that his/her income is at or below the prevailing institutional care program rates, or he/she is eligible for/receiving Supplemental Security Income (SSI), Optional State Supplementation (OSS) or the Institutional Care Program (ICP). Financial eligibility is established by ACCESS for clients receiving OSS/ICP for placement (see Chapter 6, paragraph 6-6). However, the APS Counselor completes the documentation necessary for establishing OSS eligibility. This documentation includes:

(1) The Request for Assistance (CF-ES 2337 form) is completed by the APS Counselor during the initial visit with the client and/or his/her legal guardian/caregiver (if not completed by an outside source). The Request for Assistance (CF-ES 2337 form) is sent to ACCESS for eligibility determination, and a copy is kept in the client's record. This form documents the client's income amounts, types, assets, and insurance. Although this form is used to establish financial eligibility, a case may be opened on the current electronic case management system pending the determination of eligibility. If ACCESS staff establish that the client is not financially eligible for OSS/Assistive Care, ICP or SSI, and the client was placed in a facility prior to this determination, the APS Counselor will

negotiate with the facility operator to keep the client in the facility at a reduced payment amount or attempt to locate another facility that will accept a reduced payment amount from the client.

(2) The Alternate Care Certification for Optional State Supplementation (CF-ES 1006 form) is completed by the APS Counselor with the client or legal guardian/caregiver.

(3) The vulnerable adult is determined to be in need of placement services. All formal and informal services and alternative living arrangements have been explored by the vulnerable adult and/or significant others and documented in the case record.

(4) The vulnerable adult is in agreement to placement in an ALF, AFCH or SNF.

(5) The vulnerable adult is capable of self-preservation, with assistance from staff or the facility operator, in an emergency situation involving the immediate evacuation of the facility.

(6) The vulnerable adult is free of apparent signs of communicable diseases, or not likely to transmit a communicable disease, as per a physician's statement. Prior to admission in an AFCH or no later than 30 calendar days after admission in an ALF, the client must be examined by a physician or advanced registered nurse practitioner who completes the Resident Health Assessment for Adult Family Care Homes (AHCA 3110-1023 form), or Resident Health Assessment for Assisted Living Facilities (AHCA 1823 form), as appropriate. In addition to documenting the communicable disease concerns, these health assessments are used to review and document the individual's physical and mental status, and to determine the level of supervision, nursing or therapy services required, dietary and medication requirements. The assessment form, as appropriate for the facility, is filed in the case record. Prior to admission to a SNF, the client must be examined by a physician who completes the Transfer to Skilled Nursing Facility form 3008.

(7) The vulnerable adult is capable of performing, with supervision or assistance, activities of daily living. (There are exceptions to this requirement in facilities with limited nursing services and extended congregate care licenses. See Chapter 400, Florida Statutes.)

(8) The vulnerable adult is capable of taking his/her own medication with assistance from staff, unless the facility employs staff who are licensed to administer medication to residents.

c. It is not appropriate for some vulnerable adults to be placed in an ALF or AFCH. Generally, this includes vulnerable adults who:

(1) Have been diagnosed with acute mental illness or habituation to alcohol or drugs to such a degree that the individual is causing, or may cause, danger to him/herself or others, or is interfering with the care and comfort of other residents;

(2) Require 24-hour nursing care or 24-hour licensed professional mental health treatment;

(3) Have special dietary needs that cannot be met by the provider;

(4) Are bedridden or require chemical or physical restraints;

(5) Have stage 2, 3, or 4 pressure sores (there are exceptions to this requirement in facilities with limited nursing services and extended congregate care licenses. See Chapter 400, Florida Statutes.); or,

(6) Have personal care or nursing needs, which exceed the capability of the provider to meet or arrange for such needs.

d. A client with a terminal illness who is in a facility and might otherwise be considered an inappropriate placement because of the level of care necessary may remain in the facility and in the Protective Intervention Program if Hospice becomes involved with the case. Usually facility staff refer the client's case to Hospice, who will then provide care and services to the terminally ill client, in addition to what is being provided through the facility.

e. Assess the Client. Within three working days of the Services Supervisor assigning the referral, the APS Counselor will conduct a face-to-face visit to the client in need of immediate placement, the APS counselor will assess the client's eligibility and complete the appropriate documentation, if necessary. Telephone contact by the APS Counselor may be made within three working days to clients not in need of immediate placement.

(1) The APS Counselor will provide information to the client, family members and/or legal guardian/caregiver, and initiate or complete the APS Client Assessment (form CF-AA 3019) (must be completed within 14 calendar days from the assignment of the case by the Unit Supervisor).

(2) During the visit, the APS Counselor will assess the client's social situation, physical and emotional endurance, resilience, adaptability, and attitude toward the possibility of placement.

(3) The APS Counselor will explain different placement alternatives, the ALF and AFCH programs, procedures for placement, rights and responsibilities of the client, and rights and responsibilities of the ALF or AFCH operator.

(4) The APS Counselor will explain the availability of in-home services and decide with the client and/or significant others if the client is to be placed or would be better served with supportive, in-home services.

(5) If in-home services are to be provided, the APS Counselor will make the necessary referrals and/or arrangements for service provision.

(6) If placement services are necessary, the APS Counselor will continue with the placement process.

f. Develop the Care Plan (form CF-AA 1025). Within 14 calendar days from the assignment of the case by the Unit Supervisor to the APS Counselor, an individual Care Plan (form CF-AA 1025) is developed with the client based on the completed APS Client Assessment (form CF-AA 3019). Services recommended and provided will assist clients in achieving the stated and agreed-upon goals (see Chapter 4).

g. Select the Appropriate ALF, AFCH, SNF. Frequently, the client and/or the client's legal guardian/caregiver will ask the APS Counselor for a list of ALFs, AFCHs or skilled nursing facilities and will visit and evaluate the facilities on their own. The APS Counselor can provide this list or refer the requestor to the Agency for Health Care Administration's facilities web site for the list. If the client and/or legal guardian/caregiver does not seek a facility independently, the APS Counselor will review the Agency for Health Care Administration's web site and determine which facility appears to be the most appropriate, based on the available information pertaining to the client, facility, and facility operator. The APS Counselor uses the information obtained during the client assessment, interviews with family members and/or significant others, medical information and personal knowledge to help with this decision.

(1) Before the APS Counselor can place a vulnerable adult in an ALF, AFCH or SNF, the following must be verified and completed.

(a) The ALF, AFCH or SNF must be currently licensed, at the appropriate level to meet the vulnerable adult's needs, in accordance with the Agency for Health Care Administration regulations. This verification must be noted by the APS Counselor in the case record. If a facility license has expired, it is the responsibility of the APS Counselor to verify that a renewal application has been submitted to the Agency for Health Care Administration.

(b) The selected facility must have space available, which does not exceed its licensed capacity.

(c) The client must be completely assessed to determine appropriateness of placement and to explore in-home services.

(2) The APS Counselor will attempt to match the client with the most appropriate facility available. The APS Counselor determines the unique aspects of the facility as well as those of the client. Consideration for matching may include, but is not limited to, the neighborhood and social strata; ethnic, religious and cultural affiliations; living standards; educational background; personality; and preferences of the client and facility operator.

(3) If a potential facility is found that appears to meet the specific needs of the client, the APS Counselor will obtain the Confidential Information Release (form CF-AA 1113) signed by the client or his/her legal guardian/caregiver, if appropriate, so that necessary information can be shared with the facility operator, other agencies, and staff involved in providing appropriate services. The Confidential Information Release (form CF-AA 1113) will be updated annually. The APS Counselor will then contact the facility operator to review basic referral information including current medical, psychological, and social data pertinent to the placement of the client.

(4) Prior to placement, the APS counselor must check the client's name on the Florida Department of Law Enforcement (FDLE) Sexual Offenders/Predators public registry and will notify the facility administrator if the client is listed on the registry. The long-term care facility must develop an appropriate and individualized care plan for any known sexual offender. The decision to admit a sexual offender or predator should rest with the administrator, as does any other resident admission on a case-by-case basis.

(5) If the facility operator tentatively agrees to placement of the client, the APS Counselor will arrange for the client and his/her family, or legal guardian/caregiver, if appropriate, to visit the facility prior to placement.

(6) The APS Counselor will confer with the facility operator and the client and/or legal guardian/caregiver, individually, for their agreement to the placement. Either party may refuse the placement.

(7) If the facility operator, the client, or the legal guardian/caregiver does not agree to the particular placement, the APS Counselor will seek other placement options, until all parties are in agreement.

(8) When both the facility operator and the client or legal guardian/caregiver agree to the particular placement, the APS Counselor negotiates the placement date and informs all parties.

h. Make Arrangements for Placement. The APS Counselor determines a date for placement acceptable to both the client and the facility operator. If the client does not have family members or a legal guardian/caregiver, the APS Counselor may assist the client with disposal or storage of property with friends or neighbors, make address changes, arrange transportation, and assist with other moving arrangements. Family members or significant others will be utilized as much as possible in making packing and moving arrangements. The APS Counselor should **NEVER** take possession of a client's property.

6-4. Providing Services or Arranging Referrals. APS Counselors will assist clients in arranging and coordinating services, which are not provided by the ALF or AFCH operator. If a referral provider/agency is able to accommodate the client, the APS Counselor completes the top and middle sections of the Referral for Services (CF-FSP 5065 form) and gives the original and one copy to the client or legal guardian/caregiver to take to the referral provider/agency. The APS Counselor can also mail the copies of the Referral for Services (CF-FSP 5065 form) to the referral provider/agency. The APS Counselor retains a copy for the case file. After meeting with the client, the referral provider/agency should complete the bottom portion of the Referral for Services (CF-FSP 5065 form) and return a copy of the form to the APS Counselor. If the APS Counselor has not received the completed Referral for Services (CF-FSP 5065 form) from the referral provider/agency within 30 calendar days of the initial referral, the APS Counselor will contact the provider/agency to obtain a status report on the delivery of services. Guidelines for providing services and arranging referrals are listed below.

- a. Services provided will be consistent with the Care Plan (form CF-AA 1025).
- b. Referrals will be made as needed to other agencies providing services to clients.
- c. Services which are provided by ALF or AFCH operators will not be referred to other agencies.
- d. Effort will be made to avoid duplication of services.
- e. Problems obtaining services will be documented in the case record and addressed.
- f. A diligent effort should be made for placement within 14 days.

6-5. Assisted Living for the Elderly Waiver Services. Clients who are 60 years of age or older, are Medicaid eligible, and meet the functional criteria as determined by the Department of Elder Affairs CARES Unit, may be eligible for Assisted Living for the Elderly Waiver services. This provides additional services that will assist the client in remaining in the ALF, or the client who is determined to be at risk of nursing facility placement but can live in an ALF with these additional services. This program is administered by the Department of Elder Affairs.

6-6. Optional State Supplementation (OSS) and Assistive Care Services for ALF or AFCH Care.

a. The OSS program provides a supplemental income to assist in paying for community-based care and services for eligible persons living in an ALF, AFCH, or other approved residence (such as a mental health residential treatment facility) that is licensed by the Agency for Health Care Administration. Optional State Supplementation is provided in the form of a direct assistance payment

to eligible clients or their designated representatives. The OSS payment is intended to supplement the client's income, to aid in providing for the client's room, board, and basic personal needs, not to meet the total cost of the alternative living arrangement. The client or designated representative is responsible for ensuring payment to the facility each month.

b. Eligible OSS clients will qualify for Medicaid benefits for specific Assistive Care Services provided by Medicaid facilities (i.e. facilities which have an Assistive Care Services provider number). These services are billed directly to Medicaid by the facility and may be received in addition to an OSS payment, or in certain cases, will be the sole assistance provided. Assistive Care coverage is for services provided by a Medicaid ALF or AFCH and includes:

- (1) Health support;
- (2) Assistance with ADLs;
- (3) Assistance with IADLs; and,
- (4) Assistance with medication as needed by the client.

c. When applying for OSS, the APS Counselor may assist the client and/or legal guardian/caregiver in completing the Request for Assistance (CF-ES 2337 form) during the initial visit, if not completed by the facility operator or ACCESS. The appropriate copy is sent to ACCESS for eligibility determination. The APS Counselor retains a copy of the Request for Assistance (CF-ES 2337) for the case record.

d. The Alternate Care Certification for Optional State Supplementation (CF-ES 1006 form) is also completed by the APS Counselor in conjunction with the facility operator, client, and/or legal guardian/caregiver during the initial visit with the client or legal guardian/caregiver. Part 3 of the OSS form applies to mental health clients living in an ALF with a limited mental health license and requires completion and signatures of mental health professionals. The APS counselor never completes Part 3. The purpose of the Alternate Care Certification for Optional State Supplementation (CF-ES 1006 form) is to assure that the vulnerable adult meets the placement criteria and to authorize ACCESS to process the individual's application for OSS. It is imperative that the APS Counselor be sensitive to a facility's specific license (extended congregate care, limited nursing services, or limited mental health) when determining the client's appropriateness for placement in the facility. The APS Counselor must ensure that the facility is licensed to address the client's needs. The original form is sent to ACCESS. The APS Counselor files a copy in the case record, and copies are given to the client and facility operator. This form documents the client's financial information, the medical appropriateness for placement/residing in the facility, the amount of allowable OSS payment, and the amount the vulnerable adult or legal guardian/caregiver will pay the provider. After processing the Alternate Care Certification for Optional State Supplementation (CF-ES 1006 form), ACCESS staff will send the client or legal guardian/caregiver notification of the amount of OSS benefit received and the amount payable to the facility operator. APS Counselors, in cooperation with ACCESS staff, assist the vulnerable adult in providing necessary documentation in order to be determined eligible to receive OSS benefits. This includes vulnerable adults placed in an ALF or AFCH via Protective Intervention, Protective Supervision, and those already residing in these facilities and in need of OSS.

6-7. Vulnerable Adults in Placement Prior to Being Referred to Protective Intervention. The APS Counselor may receive referrals for Protective Intervention services on vulnerable adults who are residing in ALFs or AFCHs prior to being referred for Protective Intervention services. The procedures are the same as those explained above in Chapter 6, paragraph 6-3a, Assess the Referral for Eligibility; Chapter 6, paragraph 6-3g, Assess the Client (by completing form CF-AA 3019); and Chapter 6, paragraph 6-4h, Develop the Care Plan. The referrals and services, Assisted Living for the Elderly



services, and OSS benefits, as described above, also apply to these clients, as well as Chapter 6, paragraph 6-9, Supervision of the Client in Placement, below.

6-8. Transfers and Movement of OSS Clients Between Facilities Within the Same Circuit/Region or Between Circuits/Regions. Transfers of OSS clients in placement from one facility to another within the same circuit/region or from one circuit/region to another will depend on whether or not a receiving facility has a vacant OSS bed and will accept the transferring client. Upon transfer, the following steps are completed:

- a. The case is closed in the current electronic case management system in the originating APS office.
- b. The case record is mailed by the originating APS office to the transferring office within 14 working days.
- c. Once the case record is received, the case is opened in the current electronic case management system in the transferred office within three (3) working days.
- d. A new Alternate Care Certification for Optional State Supplementation (CF-ES 1006 form) is completed and sent to ACCESS. If the new facility is a Medicaid provider, and the client is eligible to receive Medicaid, the client may receive Assistive Care Services in addition to an OSS payment, or Assistive-Care Services exclusively.

6-9. Supervision of the Client in Placement.

a. Initial Supervision. After the initial intake interview, the placement will be evaluated and follow-up visits will be provided according to the following schedule or more often, as determined necessary by the APS Counselor or Unit Supervisor (in cases where the client was placed by the APS Counselor. All other cases should comply with the quarterly contact requirement).

(1) Once the client is placed by APS staff, within 30 calendar days after the initial face-to-face contact with the client, the APS Counselor will visit the client in the facility to monitor the client's adjustment to the placement.

(2) The APS Counselor will determine if the client has accepted and adjusted to the new placement by interviewing both the client and the facility operator or appropriate facility staff member individually and privately.

(3) If a client is receiving services off the facility premises (e.g. in a day program), a collateral contact must be made with the off-site operator to assist in the determination that the client is adjusting to the placement, based on the operator's perception.

(4) The adequacy of the placement and the client's adjustment to placement, in view of the client's needs, will be documented in the field notes/narrative section of the case record.

(5) If the client is experiencing placement difficulties, a determination as to what is causing the problem will be made, with subsequent additional or corrective action taken and monitored by the APS Counselor.

(6) If the client is stable and has adjusted to the placement, the placement case may be closed. Otherwise, the next regular contact will be a quarterly visit (quarterly from date of APS Counselor's first face to face contact).

b. On-Going Supervision.

(1) APS staff will maintain contact with facility staff and other caregivers to ensure that changes in the client's health or placement situation are brought to the APS Counselor's attention in a timely manner. The client's safety and well-being must remain a priority in the on-going supervision responsibilities of case management. All contacts with the client, caregiver, legal guardian, and facility representative will be documented in the field notes/narrative, and if appropriate, on the Care Plan (form CF-AA 1025), along with follow-up actions and plans.

(2) At the quarterly visit, if the client has adjusted to the placement, and has an advocate or the client can advocate for him or herself, the case should be closed.

(3) If the client lacks capacity and does not have an advocate, the case should not be closed. The counselor will make diligent efforts to obtain an advocate/guardian for the client. Adult Family Care homes, Assisted Living facilities and Skilled Nursing facilities have an advocacy agency for these residents – the Long-Term Care Ombudsman Program. However, if the client lacks capacity to consent and there is no durable power of attorney in place, a referral for guardianship should be completed by the counselor. Once an advocate has been obtained, and the client is stable, the case can be closed.

c. Placement cases should not be open longer than 6 months unless reviewed and approved by the Regional Program Administrator or their designee.

6-10. Records of Clients in Placement. The APS Counselor will maintain a case record on each client in placement (see Chapter 7). Each placement case record contains the following forms and documentation.

a. If the vulnerable adult enters the system through the intake process, PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022) is included. If the vulnerable adult is referred from Investigations, the Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or HCDA/HCE (form CF-AA 1099) is included.

b. A copy of the ACCESS Florida Application (form CF-ES 2337) for a new OSS referral if completed by the APS counselor.

c. The Notice of Case Action (form CF-ES 2235) form is sent to the APS Counselor by ACCESS staff for inclusion in the APS case record. The Notice of Case Action (form CF-ES 2235) identifies the services/benefits available to the client, based on the client's eligibility status.

d. A copy of the Alternate Care Certification for Optional State Supplementation (form CF-ES 1006 form), if the client is OSS eligible.

e. The Resident Health Assessment for Adult Family Care Homes (form AHCA 3110-1023) or Resident Health Assessment for Assisted Living Facilities (form AHCA 1823), as appropriate for the facility.

f. A current APS Client Assessment (form CF-AA 3019), updated semi- annually.

g. A current Care Plan (form CF-AA 1025), signed by the client or his/her legal guardian/caregiver, if appropriate, and which has been completed semi-annually and reviewed quarterly or more often if needed.

h. Referral for Services (form CF-FSP 5065), as appropriate.

i. Field notes and/or a case narrative, updated within 10 working days during the months when activity occurs, which include documentation of services provided, referrals to other agencies, outcomes of referrals, follow-up contacts, and a summary of all client contacts (see Chapter 7).

j. A Confidential Information Release (form CF-AA 1113) signed by the client or his/her legal guardian/caregiver, if appropriate.

k. Correspondence relating to the client.

l. Verification of the client's financial eligibility, disability or age, including medical, psychological, and other similar information.

m. The original Supervisor's Case Record Review Log (form CF-AA 1023), which is used each time the Unit Supervisor reviews the case record to document the review, recommend additional or corrective action pertaining to the APS Counselor's performance specific to the case, and document any actions taken. The additional or corrective action is completed by the APS Counselor within 30 calendar days of the record review date. The case record is reviewed by the Services Supervisor at least quarterly.

n. A copy of documentation that the client's case information was entered into the current statewide APS electronic case management system within three (3) working days.

## Chapter 7

## MAINTENANCE OF CASE RECORDS

7-1. Purpose. This chapter provides a definition of case record and provides basic requirements about gathering information for case records. It also provides specifics on case record documentation, field notes, case narrative, and case record contents. Retention of case records is also discussed.

7-2. Definition of Case Record. The case record is the source documentation maintained by the APS Counselor for each client and is maintained in the Adult Services Information System (ASIS). It contains all of the information necessary to describe and justify the provision of services or determination of ineligibility for services. It is updated at specified intervals to allow for the availability of current and accurate information regarding the client's needs, medical and mental health status, next of kin, attending physicians, services provided by the department, and other agencies. The electronic case record provides a client history so that in the absence of the APS Counselor, services may continue without disruption.

7-3. Gathering Information for Case Records. The organization of a case record begins upon receipt of a referral for case management services (does not include requests for information and referral only). Once a case is accepted for case management services, there must be documentation of the events and delivery of services that occur from beginning to end. An electronic record must be kept to ensure that clients receive appropriate services. The information gathered for the case record comes from a number of different sources, including APS Protective Investigators, clients, family members, community sources, health care providers, and other state agencies.

7-4. Case Record Documentation. Documentation is an essential part of a client case record, and must be clear, legible, thorough, accurate, and concisely written and uploaded into the ASIS system within 5 working days of completion of an activity. If abbreviations or acronyms are used, the writer will provide a key or state what the abbreviation/acronym means. Counselors are expected to strive for best practices by maintaining up-to-date and complete documentation of case activities. Documentation demonstrates responsibility and competency in completing work tasks.

a. Falsification of Case Record Documentation. Any employee of the Department (or agent of, or contractor) who knowingly falsifies by purposely changing, destroying, overwriting, removing, or discarding information in an official record relating to an individual in the care of the department commits a third-degree felony. This charge is punishable as provided in sections 775.082, 775.083, or 775.084, Florida Statutes, if the act has the potential to detrimentally affect the health, safety, or welfare of that individual. Any employee (or agent of, or contractor) who commits a violation described above which contributes to great bodily harm to or the death of an individual in the care of the department, commits a second-degree felony, punishable as provided in the Florida Statute sections cited above. This does not apply to the disposing or archiving of records as provided by Florida Statutes (see Chapter 7, paragraph 7-7, of this operating procedure). This also does not prohibit any employee (or agent of, or contractor) from correcting or updating records. To avoid the appearance of changing, overwriting or removing information contained in the records, correction fluids or tapes must never be used in the case records.

b. What To Document. All activities that the APS Counselor does for an individual client will be documented in ASIS within 5 working days of completion of the activity. The APS Counselor must complete all notes, date and document all contacts and services in the ASIS notes section. If the counselor uses a chronological field note (on the Client Progress Notes [form CF-AA 1038]) those notes should be scanned and uploaded into ASIS within 5 working days. The documentation in the chronological section for non-required visits can be brief, if, during the visit, the APS Counselor did not identify any problems with the client or service, facility, or placement. It is not necessary to repeat all that is documented on the APS Client Assessment (form CF-AA 3019) and Care Plan (form CF-AA

1025), but the APS Counselor will make reference to these documents, as appropriate, in the case notes and/or case narrative. Activities that are documented in the APS Protective Intervention case record are described below. The time is also recorded for activities that are sampled for Random Moment Sampling (RMS) purposes. (Random Moment Sampling is a process to determine the average amount of time employees spend on Medicaid-related job functions. The amount of Medicaid funds received by the program is based on the sampling results.)

(1) Client Visits. All visits made to the client's place of residence must be noted in the electronic case record. The documentation must include at a minimum the date (and time, if a RMS activity) of the visit, name of individual(s) present, purpose of the visit, a brief summary of the outcome of the visit, statement that the current care plan was prepared or reviewed and subsequent planned follow-up contacts.

(2) Telephone Contacts. All incoming and outgoing telephone contacts with the client, service providers, family members, or other individuals regarding the APS Protective Intervention case must be noted in the electronic case record. The notation must include the date and time of the telephone contact, name of the individual contacted, and a brief summary of the content and outcome of the conversation.

(3) Arrangement for Services. Submission of forms to obtain services or determine eligibility for services or programs will be documented and uploaded into the electronic record ASIS. All face-to-face or telephone contacts with service providers to arrange services for the client must be noted in the electronic case record. The notation must include the date (and time, if an RMS activity), type of contact (for example: field visit, office visit, or telephone call), name of the individual(s) and agency contacted, and a brief description of the content and outcome of the conversation. In addition, the APS Counselor must note in the electronic case record the client's refusal of services, barriers or problems in the delivery of services, and other similar situations.

(4) Case Staffing. Any case staffing during which the client is discussed must be noted in the electronic case record. The notation must include the date and time of the case staffing, names of individuals attending the staffing, and a brief summary of the discussion and outcome of the staffing.

(5) Other Client-Related Activities. Any other contact made concerning the client must be documented in the electronic case record. For example, transporting a client, delivering goods (food, medical items, or donations) to a client, or contacting family members, friends of the client, medical professionals, staff from other agencies, or other individuals. A copy of all forms given/mailed to the client will be maintained in the electronic case record.

c. When to Document. When to document is just as important as what to document. APS Counselors will document/upload any activity into ASIS within 5 working days after the activity is conducted. The APS Counselor completes the field notes immediately following the activity, but it may not always be possible to document in the narrative immediately. However, all documentation must be completed within 5 working days of the performed activity. If an activity, such as completing the Care Plan (form CF-AA 1025), is not completed within 10 working days, the APS Counselor will document the reasons the counselor was unable to comply and the status in completing this activity.

7-5. Field Notes and Case Narrative. Field notes are typically written or typed during the time of the event or soon after, on the Client Progress Notes (form CF-AA 1038) and included in the electronic case record. If field notes provide a comprehensive description of the situation, are type written on a computer and follow the specified guidelines, they may stand alone without a narrative. If used exclusively in the electronic case record, the field notes must include the specifics described below in the case narrative section, as well as additional information described in the following field notes section. A narrative may be completed in the office and may be developed from field notes, if the notes

are not comprehensive enough to stand alone in the case record. In that case, the field notes and narrative must become part of the electronic case record.

a. Field Notes. Field notes are maintained in the electronic case record. Correctly written, field notes will answer the questions “who, what, when, where, why, and what’s next” as described below.

(1) Who. Who are you calling or contacting? Identify the person, agency, program, or other entity being contacted and present during the visit. If someone has contacted you, who is the person? Provide enough information so that the reader can easily understand who or what he/she is reading about.

(2) What. What is occurring that makes this contact necessary? What is happening in the client’s life, and what information needs to be conveyed? Identify the purpose and any concerns, needs, or other relevant information. How does the particular activity relate to the implementation of the Care Plan (form CF-AA 1025)? What was the client’s general health, welfare and living situation at the time of the contact.

(3) When. When are you making the contact or when did you receive the contact? The written date must be recorded for each contact. When will follow-up activities occur? Include the time of day that the activity occurred (if a RMS activity), or if the information makes the sequence of events easier to follow.

(4) Where. Where did the contact or case management activity take place? Note if the contact was an office visit, home visit, or telephone contact.

(5) Why. Why are you contacting this person or why has the person contacted you? It is important to document as much information as possible so everyone understands the information and its relationship to the Care Plan (form CF-AA 1025).

(6) What’s Next. Indicate what will happen next and who is responsible. What specific follow-up is needed? What case management activities will occur and who will do them?

b. Documentation Requirements. The following documentation requirements must be followed when writing field notes for all Protective Intervention cases:

(1) APS case management field notes must be legible and must be permanent entries on the Client Progress Notes (form CF-AA 1038) or typed and entered into ASIS notes section. The counselor must initial the field notes in ink. There will be no pencil written notes. These notes will then be scanned and uploaded into ASIS within 5 working days of completion.

(2) Field notes must be written at the time the service is provided (such as a home visit) or immediately after the service is provided. All completed and original entries must be filed in the client’s electronic case record within 5 working days of the documented activity.

(3) If scanned and uploaded timely (within 5 working days) into ASIS, the field notes will be filed chronologically.

(4) The first field note entry (if completed on Client Progress Notes form CF-AA 1038), then scanned and uploaded into ASIS, is followed by the APS Counselor’s full signature at the end of the entry. Thereafter, that same APS Counselor can initial the entries as he/she continues to document case management activities. If another individual (such as the Family Support Worker or Unit Supervisor) documents activities in the client’s field note portion of the case record, the full signature of the other individual is required to document the entry. After the first entry, the initials of the other individual can be used thereafter.

(5) Use quotation marks when indicating a direct quote by someone and include the name of the person who is speaking.

(6) If the completed handwritten Client Progress Notes (form CF-AA 1038) will be scanned and uploaded into ASIS, do not use correction fluids or correction tapes to correct any entry in the field notes. If an error is made, the APS Counselor will strike through the mistake with a single line and initial the change.

(7) Field notes contain non-judgmental observations and statements of what occurred, or will occur, as well as any pertinent case management actions, details or other information. Observations made by the APS Counselor, family members, or other people who know the client (collateral contacts/providers) are essential in order to get a complete picture of the client's situation. Accuracy is very important because field notes can be read by the client and potentially may also be used in a court of law. The APS Counselor's signature or initials at the end of each entry in the field notes attests to the accuracy of the information recorded in the client's case record.

(8) If completing handwritten Client Progress Notes (form CF-AA 1038), field notes must be continuous and sequential on each page. No extra lines are left blank between entries. This is to prevent additional information from being added to an entry at a later date. If a page is not filled with notes, mark the empty space with a large "X" so no other entries can be made on the page. All handwritten or typed client progress notes must be scanned and uploaded into ASIS within 5 working days of completion of the activity

(9) In the event that an entry is made out of sequence, it will be noted as a late entry such as "5/3/11 late entry...On 4/29/11 received a phone call from...."

(10) Every case management activity must be entered into the field notes as a separate entry. It is possible to combine multiple contacts into a single entry if the contacts relate to the same activity or service.

(11) A legend can be used to indicate what the abbreviations used in the field notes mean. The following is a list of acceptable abbreviations and their meanings:

(a) TC = Telephone Call. It is necessary to include in the field notes if the telephone call was placed by the APS Counselor or received by the APS Counselor. When making telephone calls to someone, it is good practice to include the telephone number being called. For example: "TC to J.B. Home Service, Carl Black (352) 495-1892." or "TC from Martha Smart, client's spouse, (850)376-6364."

(b) HV = Home Visit. This entry is used when the APS Counselor visits the home of the client.

(c) OV = Office Visit. This entry is used when the client, provider, or another individual associated with the case visits the APS Counselor in the APS Counselor's office.

(d) FV = Field Visit. This entry is used when the APS Counselor conducts case management activities outside of his/her office. A field visit may be made to a provider or the home of a family member to gather information pertinent to the Care Plan (form CF-AA 1025). (A visit to the home of a relative is not a home visit (HV), but a field visit (FV)). When making field visits it is good practice to record the address of the visit location along with the name and telephone number of the person being contacted, in order to make follow-up by letter or telephone easier.

(e) FF = Face-to-Face. This entry could be used in addition to those described above, to indicate that the client was seen during the HV, FV, or OV.

c. Case Narrative. Case narrative describes on-going occurrences and events in the case and reflects activities that relate either directly or indirectly to the Care Plan (form CF-AA 1025). Upon review of the case narrative, the reader will be able to ascertain if the Care Plan (form CF-AA 1025) is valid and subsequent services are appropriate and necessary to meet the client's needs. Changes in the client's situation, unmet needs, or reasons for variances from the Care Plan (form CF-AA 1025) must be described. Information included in the narrative describes the client's progress toward accomplishing the goals, and pertinent information relating to the client's overall situation. This includes notations specific to follow-up activities, problems encountered in service delivery, or unique circumstances which could affect the client. The narrative must be scanned and uploaded into ASIS within 5 working days, and each entry is signed or initialed by the writer (the writer's first entry is signed; follow-up entries can be initialed). Case narrative entries consist of:

(1) General Information. Date (and time, if a RMS activity) of the contact, type of contact (use the abbreviations listed above – OV, TC, HV, or FV), and source of contact.

(2) Initial Entries. The initial entry must include the following:

(a) Reasons and circumstances requiring Protective Intervention services;

(b) Results of the staffing held with the API if the referral is for suspected abuse, neglect, or exploitation; risk level of the client; and the plan for reducing or eliminating any further occurrences of abuse, neglect, or exploitation;

(c) Client's current situation, including living arrangements, financial status, family, and other information pertinent to the case;

(d) The client's or legal guardian/caregiver's consent to services, if appropriate;

(e) Additional information not covered in the APS Client Assessment (form CF-AA 3019) or Care Plan (form CF-AA 1025); and,

(f) Any other information that will be helpful or necessary during the provision of services to the client.

(3) What Initial Entries Reflect. Initial entries will reflect:

(a) Available resources explored, reasons for selecting the provider(s) indicated in the Care Plan (form CF-AA 1025), and involvement of family or significant others;

(b) The provider of arranged or referred services was advised of the client's service needs and goals, and the date the provider was advised of the client's goals;

(c) Follow-up activities to be completed within 30 calendar days from the date of referral; and,

(d) Any other information appropriate to the client's situation.



(4) On-Going Narrative. All on-going activities performed on behalf of the client are documented in the on-going narrative. On-going activities include, but are not limited to, telephone contacts with clients, family members or providers, home visits, and staff meetings pertaining to clients. The on-going narrative relates to the Care Plan (form CF-AA 1025) and the initial narrative summary by continuously evaluating the progress or lack of progress in reaching the client's goals. The on-going narrative also, in summary fashion, documents all activities that occurred during the reporting period, if activities occurred. On-going narrative will reflect:

- (a) Dates and times of contacts, activities, and services provided;
- (b) Changes in the client's status;
- (c) That services provided are consistent with the Care Plan (form CF-AA 1025);
- (d) Changes from the Care Plan (form CF-AA 1025), as well as the reason for change;
- (e) Description of status of meeting the Care Plan goals; and,
- (f) Any other information appropriate to the client's situation.

(5) Closing Narrative. A brief closing summary will be completed upon closure of a Protective Intervention case. The summary includes the reasons and circumstances for the closure, status of the completion of the goals and objectives as documented on the care plan, evaluation of the results of services provided, and the client's present level of risk and future risk for the occurrence of abuse, neglect, or exploitation. The closing summary will also include documentation of termination of services and that the client was provided information regarding the right to appeal the actions taken by the Department (see Chapter 8 of this operating procedure).

#### 7-6. Case Record Folders and Contents.

a. Organization of the Case Record. Circuit /regional offices organize their paper record folders in the manner that proves to be most efficient and most practical within their circuit/region. However, all paper case records must be scanned/uploaded into ASIS, the official repository for APS services records. Once the record has been successfully uploaded into ASIS, the paper record can be appropriately destroyed as it is a duplicate to the electronic record. No paper records may be destroyed without confirming those records are available in ASIS.

b. Information in the case record file folder will be updated, as appropriate. The APS Counselor will ensure that all necessary signatures are obtained when reviewing Care Plans (form CF-AA 1025) or other applicable documents and are uploaded into the electronic case file in ASIS.

c. The APS Counselor must ensure that documentation in the case record is maintained, thereby providing a current profile of the client's status and the delivery of services.

d. Types of Information. The electronic case record contains a variety of types of information and forms. When approving a new case, or a re-determination for services, the case is not complete and ready for processing until all required forms are in the APS Counselor's possession. This includes all forms signed by the client or legal guardian/caregiver and medical forms from a health care professional. If a required form is missing, the case is pending. As previously discussed, certain information pertaining to the client contained in the case record is confidential. This information, including medical or psychological reports, financial information, legal documents and related materials, and materials which contain the client's social security number will only be shared under specified conditions. The types of information contained in a case record are identified below.

(1) Client Demographic Information. Most client demographic information, such as address, date of birth, social security number, and other personal identification information, is collected during the completion of PART I of the APS Screening for Consideration for Community-Based Programs (form CF-AA 1022), or is included on proof of age or disability documentation. Medicaid eligibility will be documented. Client demographic information will be updated as needed.

(2) Assessments and Planning. Assessment and planning information is collected on the current and all previous APS Client Assessments (form CF-AA 3019) and Care Plans (form CF-AA 1025), as well as the Resident Health Assessment for AFCHs (form AHCA 3110-1023), and Resident Health Assessment for ALFs (form ACHA 1823).

(3) Services Provided to the Client. Information is documented relating to services provided by the Protective Intervention Program or by other programs, departments, or agencies. Written correspondence to or from service providers that address the provision of services, status of services, progress updates, termination of services, and other information are filed in the case record. Written communications to or from other programs, such as ACCESS, Substance Abuse and Mental Health (SAMH) and Agency for Persons with Disabilities (APD), are also filed in the case record. The Referral for Services (form CF-FSP 5065), and Homemaker Activities Plan (form CF-AA 1036) assist the APS Counselor to ensure that needed services are provided to the client.

(4) Medical Information. This includes medical reports, statements, information from hospitals and/or nursing homes, discharge notes, test results, recommendations, or relevant correspondence from professionals regarding the client's health. Psychological reports, other documentation, or relevant correspondence from professionals regarding the client's mental status are also included in the case record. The assessment form used to determine the client's capacity to consent is included.

(5) Financial Information. Information about the client's personal income and/or financial assistance received by the client is documented (including assistance received from the Social Security Administration and Medicaid). Although the Alternate Care Certification for Optional State Supplementation (form CF-ES 1006) is included as a document for obtaining financial information, it is also used to document the client's appropriateness for placement.

(6) Written Field Notes and/or Case Narrative. The field notes (Client Progress Notes, form CF-AA 1038) and narrative provide up-to-date chronological information about the current status of the client and the services received.

(7) Program Specific Information. This includes information or forms necessary for administering the program and services, such as the Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or HCDA/HCE Services (form CF-AA 1099), copies of the APS case management system print screen, Confidential Information Release (form CF-AA 1113), Supervisor's Case Record Review Log (form CF-AA 1023), Request for Assistance (form CF-ES 2337), Notice of Case Action (form CF-ES 2235), and Notice of Ineligibility or Change in Service Status (form

CF-AA 1114). Notification letters to clients and documentation that the client was informed of his/her right to appeal the decision are also filed in the client's case record.

7-7. Retention and Destruction of Case Records. Any records authorized for disposal that contain confidential information will be disposed of in a manner that will render them unreadable. Refer to CFOP 15-4, Records Management, and CFP 15-7, Records Retention Schedules Used by the Department of Children and Families (located on the Department's Internet site), for specifics on retention of Protective Intervention case records, specifics on conditions under which records can be destroyed, and the sanctioned methods of record destruction.

## Chapter 8

## CLOSING A CASE

8-1. Purpose. This chapter provides guidelines for the termination of Protective Intervention services and closure of cases. The chapter also describes the Administrative Hearings process.

8-2. Termination of Services and Case Closure. A case will no longer be considered appropriate for Protective Intervention when one or more of the following conditions exist:

- a. Services are no longer needed or are inappropriate;
- b. The client's goals have been achieved;
- c. Services are being provided appropriately and effectively through other community programs or agencies;
- d. The client no longer requests services;
- e. A family member or legal guardian/caregiver is willing and able to assume responsibility of ensuring the delivery of services or is willing to accept the placement of the vulnerable adult in the family member's or caregiver's home;
- f. Placement is considered to be stable by the client, APS Counselor, facility staff, and the caregiver; and the client does not require on-going monitoring, supervision, or service provision or APS' only role is to open the case (under short-term case management) in order to assist in establishing or re-establishing OSS eligibility;
- g. The client transfers to another APS program within the state (a referral and the case record will be transferred to the new area within the state, if continued services are needed);
- h. The client transfers to the Agency for Persons with Disabilities, Mental Health, or other Departmental program provider, and is case managed by staff from that program;
- i. The client is hospitalized for an extended period (60 days) or placed in a facility (if enrolled in one of the in-home programs such as CCDA or HCDA);
- j. The client is no longer eligible for services because of income, assets, or medical changes;
- k. The client's behavior is abusive, aggressive, or threatening to staff, the APS counselor, or other clients;
- l. The client moves out of state;
- m. The APS Counselor loses contact with the client; or,
- n. The client dies.

8-3. Procedures for Closing a Case. If, during an assessment of a current open case, the APS Counselor determines that any of the above conditions for closure exist, the following procedures will be completed:

- a. The case is reviewed, paying close attention to:
  - (1) The client's improved situation or environment;

- (2) The status of the goals specified in the Care Plan (form CF-AA 1025);
  - (3) Community service involvement and existing support systems;
  - (4) Family support system; and,
  - (5) Stability of the placement, as appropriate.
- b. A brief closing narrative is completed (see Chapter 7, paragraph 7-5c(5)).
  - c. If the case is being closed under unusual conditions, a staffing is scheduled with the Services Supervisor (e.g., the case is being closed because the client is threatening toward other clients).
  - d. The case closure is discussed with the client and his/her support system, and the client is given the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) explaining the reason for closure. This form is required for all closures except in situations of the client's death, if the APS Counselor is unable to locate the client, or if the client's request to withdraw from services is made in writing. If the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) is hand delivered, and the APS Counselor anticipates a problem with the case being closed, the APS Counselor will have the client sign a statement acknowledging receipt of the notice. Likewise, if the notice is mailed and a problem is anticipated, it will be sent by certified mail, return receipt requested. The return receipt will be placed in the case file.
  - e. If the client has moved and his/her new address and telephone number are not known to the APS Counselor, the counselor will make every effort to locate the client. This includes checking with family members, guardian, other agencies/programs providing services to this client, telephone information, and the post office for a forwarding mailing address. If the client cannot be located, all efforts to locate the new address/telephone number are documented in the case record, and the Notice of Ineligibility or Change in Service Status (form CF-AA 1114), if already completed, is not mailed, but the completed notice is filed in the case record.
  - f. The APS Counselor informs the client of his/her right to appeal the action being taken (if HCDA or CCDA) and provides the client with instructions to follow to request an appeal (see Chapter 8, paragraph 8-4).
  - g. The current electronic APS case management system is updated, and a copy of the print screen is placed in the case record.
  - h. The Unit Supervisor signs and dates the Supervisor's Case Record Review Log (form CF-AA 1023) to indicate agreement with case closure.

8-4. Due Process and Administrative Hearings. An individual has the right to due process if he/she does not agree with the actions taken by the Department respective to his/her CCDA or HCDA case.

- a. An administrative hearing is the method by which a client receiving services challenges decisions made by the Department or one of its service providers concerning eligibility or receipt of services. An administrative hearing is an appeal of the Department's action involving services funded through state general revenue dollars. Therefore, an administrative hearing is appropriate for a Protective Intervention client wishing to appeal an action, except OSS-related decisions/actions.
- b. Prior to closing the Protective Intervention case and upon completing the Client Assessment (CF AA 3019), the APS Counselor provides the client with the APS Due Process Rights pamphlet (CF/PI 140-43), which explains the rights of due process. In addition, the bottom portion of the Notice of Ineligibility or Change in Service Status (form CF-AA 1114) provides the client with instructions for

requesting an administrative hearing for ineligibility, termination, suspension, or reduction of CCDA or HCDA services.

c. When a request for OSS benefits has been denied or services are terminated, suspended, or reduced, the client will be notified by ACCESS via the Notice of Case Action (CF-ES 2235) of the decision, the reason(s) for such action, and the client's right to request a fair hearing. Fair hearings specific to OSS benefits are directed to the ACCESS program.

d. Any client wishing to appeal a CCDA or HCDA service denial, termination, suspension, or reduction, may do so by contacting the Department within 21 days after receiving notice of the Department's action. Written or oral requests made by a client or his/her legal representative are acceptable requests for a hearing. If an administrative hearing is not requested within 21 days of receipt of the notice, the client waives the right to request an administrative hearing.

e. The hearing may be informal or formal in nature. Hearings that do not involve disputed issues of material fact will be informal and are conducted by a Hearing Officer assigned to hear the case by the department's Agency Clerk. Hearings involving disputed issues of material fact will be formal hearings and are referred to the Division of Administrative Hearings (DOAH) to be heard by an Administrative Law Judge. Circuit/regional legal counsel must be notified immediately of any hearing request and shall file the hearing request with the Agency Clerk. The Agency Clerk shall assign the matter for an informal hearing or refer the case to DOAH for a formal hearing.

f. In the event of an appeal, the termination of services during administrative actions will be determined by circuit/regional legal services staff. It may not be appropriate to terminate medical services until administrative actions are completed; however, other types of services may be appropriately terminated. This will be determined on a case-by-case basis.



## DEFINITIONS

Abuse. Any willful or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts or omissions.

Activities of Daily Living (ADL). Per section 415. 102 (2), F.S.; "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

Administrator means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility or skilled nursing facility.

Adult Family Care Home (AFCH). A full-time, family living arrangement in a private dwelling. The person who owns or rents the dwelling resides on the premises and provides room, board, and personal care, on a 24-hour basis, for not more than five adults with disabilities or frail elders who are not relatives. Adult family care homes are licensed by the Agency for Health Care Administration.

Adult Protective Services (APS) Counselor. For the purposes of this Operating Procedure, APS Counselor refers to the Human Services Counselor III. As appropriate, it also refers to the Family Support Worker in circuits that utilize a Family Support Worker to implement or complete tasks when supervised by a Human Services Counselor III.

Adult Protective Services Client Assessment (form CF-AA 3019). A tool used by the APS Counselor to assist in the evaluation of the vulnerable adult's current health, medical treatments and therapies, medications, nutrition, functioning, support system, overall safety, and well-being

"Aging in place" or "age in place" means the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence and permit them to remain in a familiar, non-institutional, residential environment for as long as possible. Such services may be provided by facility staff, volunteers, family, or friends, or through contractual arrangements with a third party.

Assessment. A comprehensive process that examines the client's presenting problem(s), the current health and functional capabilities of the client, an analysis of the client's support system, and an evaluation of other factors that may impact the client.

Assisted living facility (ALF) means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator. Assisted Living Facilities are licensed by the Agency for Health Care Administration (AHCA.)

Automated Community Connection to Economic Self-Sufficiency (ACCESS). The ACCESS Florida program is the public assistance service delivery system that provides enhanced access to services through a combination of state staff and a community partnership network as community providers agree to serve as additional portals to Economic Self Sufficiency services for clients mutually served by the partner agency and the Department of Children and Families.

Capacity to Consent. A vulnerable adult has sufficient understanding to make and communicate responsible decisions regarding his/her person or property, including whether or not to accept Protective Intervention Services offered by the Department.



Caregiver. An individual entrusted with, or has assumed the responsibility for, providing frequent and regular care or services to a vulnerable adult on a temporary or permanent basis. A caregiver includes, but is not limited to, a relative, household member, guardian, neighbor, employee, and volunteer worker.

Care Plan (form CF-AA 1025). A tool used by the APS Counselor to identify the vulnerable adult's problems, desired outcomes of addressing identified problems, services and providers needed to address problems, and specifics relating to obtaining the services. The APS Counselor utilizes information collected through the APS Client Assessment (form CF-AA 3019) to develop the Care Plan (form CF-AA 1025).

Case Management. Case management is the means by which a vulnerable adult is provided one or more community services through the coordinated efforts of the APS Counselor, the vulnerable adult or legal guardian/caregiver, and service provider to achieve desired goals. Case management includes a functional assessment of the client's needs, the development of a care plan designed for and with the individual client, arrangement of services, periodic re-assessment, and on-going monitoring of the client's situation to ensure needed services are received.

"Community Living Support Plan" means a written document prepared by a resident diagnosed with a mental health condition and the resident's mental health case manager in consultation with the administrator of an assisted living facility with a limited mental health license or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.

"Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which residents diagnosed with a mental health condition are living. The agreement must specify directions for assessing emergency and after-hours care for the residents. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

Early Services Intervention. Early services intervention is a concept by which short term or ongoing case management services may be provided to vulnerable adults who are victims of abuse, neglect, or exploitation prior to the closure of the protective investigation.

Emergency means a situation, physical condition, or method of operation which presents imminent danger of death or serious physical or mental harm to vulnerable adults.

Exploitation. Exploitation is defined as a person who stands in a position of trust and confidence with a vulnerable adult and knowingly by deception or intimidation, obtains and uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult. Exploitation also includes the actions of a person who knows or should know that the vulnerable adult lacks the mental capacity to consent and commits the above act(s).

"Extended congregate care" A type of assisted living facility (ALF) that was developed in response to a resident's desire to be allowed to "age in place". Facilities offering these services are licensed by the Agency for Health Care Administration and meet standards in addition to those required by an ALF.

Guardian means a person to whom the law has entrusted the custody and control of the person or property, or both, of a person who has been legally adjudged incapacitated.

Institutional Care Program (ICP) This program is administered by the Department of Children and Families, ACCESS program and provides Medicaid benefits, which includes payment to nursing homes and certain other facilities, for aged and disabled individuals who are in need of institutional care. Once eligible, all of an individual's monthly income, except \$35 for his personal needs, must be paid to the facility for his cost of care. If there is a spouse living in the community, some of the income may be diverted to the spouse.

Instrumental Activities of Daily Living (IADL). Activities that show a person's ability to perform household tasks that are needed to meet his/her own needs. These activities include, but are not limited to, shopping, laundry, housekeeping, preparing meals, managing medication, managing money, and getting around in the community.

"Limited nursing services" means acts that may be performed pursuant to part I of Chapter 464, Florida Statutes by persons licensed there under while carrying out their professional duties but limited to those acts which the Department of Health (DOH) specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department for assisted living facilities and shall not be complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints. Assisted Living Facilities with limited nursing services are licensed by AHCA.

"Managed risk" means the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.

"Mental health resident" means an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

Neglect. Neglect is defined as the failure or omission on the part of a caregiver to provide the care, supervision, and services necessary to maintain the physical, mental health, and well-being of a vulnerable adult. Neglect also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. Neglect is a single incident or repeated carelessness that produces or could reasonably result in serious physical or psychological injury, or a substantial risk of death.

On-Going Case Management. On-going case management is provided to clients who are in need of services for a period exceeding 60 calendar days. On-going case management is appropriate for clients who receive supportive services.

Optional State Supplementation. An ACCESS program, designed to assist vulnerable adults who meet financial criteria and who need help paying for out-of-home placements and services in ALFs, AFCHs, or residential treatment facilities for mental health clients. Cash assistance may be provided and/or Medicaid benefits for assistive care services through Medicaid-accepting facilities.

"Personal services" means direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar services which the department may

define by rule. "Personal services" shall not be construed to mean the provision of medical, nursing, dental, or mental health services.

Placement. Refers to the physical relocation of a vulnerable adult, who can no longer live independently, into the most appropriate and cost-effective living arrangement in the least restrictive setting, such as licensed ALF, AFCH, or skilled nursing facility. These vulnerable adults receive on-going case management and needed benefits or other services to ensure their safety and well-being while residing in one of these licensed facilities. Although APS programs strive to keep clients in their communities and out of facility settings, there are instances when the most appropriate placement for a client is in a facility.

Relative means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister of an owner or administrator.

Resident means a person 18 years of age or older, residing in and receiving care from a facility.

Self-Neglect. Refers to a vulnerable adult who has been determined to be experiencing the ill effects of neglect not caused by a second party and is in need of intervention services to prevent further harm.

"Service plan" means a written plan, developed and agreed upon by the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, if any, and the administrator or designee representing the facility, which addresses the unique physical and psychosocial needs, abilities, and personal preferences of each resident receiving extended congregate care services. The plan shall include a brief written description, in easily understood language, of what services shall be provided, who shall provide the services, when the services shall be rendered, and the purposes and benefits of the services.

"Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

Short-Term Case Management. Short-term case management takes at least one hour but does not exceed 60 calendar days. Short-term case management is often referred to as "one shot" services for all vulnerable adults, age 18 and over. Short-term case management offers a flexible case management program that assures the availability of case management at the earliest contact with the client.

Supervision means reminding residents to engage in activities of daily living and the self-administration of medication, and, when necessary, observing or providing verbal or visual cuing to residents while they perform these activities.

"Supplemental security income," Title XVI of the Social Security Act, means a program through which the Federal Government guarantees a minimum monthly income to every person who is age 65 or older, or disabled, or blind and meets the income and asset requirements.

Supportive Services. Supportive Services are defined as services that encourage and assist eligible vulnerable adults, age 18+, to remain in the least restrictive environment. This support and

assistance is initially designed to prevent abuse, neglect, and exploitation; prevent the situation from deteriorating into more severe abuse, neglect, or exploitation; and/or prevent or delay the placement of the vulnerable adult into an assisted living facility, adult family care home, or nursing home.

"Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or the disease state or stage.

Vulnerable Adult. Per chapter 415, F.S., a "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

## FORMS USED IN THE PROTECTIVE INTERVENTION PROGRAM

All of the forms listed below are available in DCF Forms on both the Intranet and Internet.

ACCESS Florida Application (form CF-ES 2337)  
Adult Protective Services Client Assessment (form CF-AA 3019)  
Alternate Care Certification for Optional State Supplementation (OSS) (form CF-ES 1006)  
Care Plan (form CF-AA 1025)  
Client Progress Notes (form CF-AA 1038)  
Confidential Information Release (form CF-AA 1113)  
Homemaker Activities Plan (form CF-AA 1036)  
Notice of Case Action (form CF-ES 2235)  
Notice of Ineligibility or Change in Service Status (form CF-AA 1114)  
PART I, APS Screening for Consideration for Community-Based Programs (form CF-AA 1022)  
Referral for Protective Supervision, Protective Intervention, CCDA/CCE, or  
HCDA/HCE Services (form CF-AA 1099)  
Referral for Services (form CF-FSP 5065)  
Resident Health Assessment for Adult Family Care Homes (AFCH) (form AHCA 3110-1023)  
Resident Health Assessment for Assisted Living Facilities (ALF) (form AHCA 1823)  
Supervisor's Case Record Review Log (form CF-AA 1023)