Utah ADRC Standard Operating Procedures

Contents

211 Information and Referral

Procedure

1. ADRC staff will query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on issues not pertaining to older adults and/or adults with disabilities, then the ADRC staff member will refer the individual to 211 for assistance.

2. If appropriate, ADRC staff will identify possible resources to meet the individual's need. Resources for general information include, but are not limited to:

- Elder Care Locator: http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx

Assistive Technology

Procedure

1. Options counseling process suggests that assistive technology may be part of a plan for achieving the individual's goals.
2. Determine the nature of the assistive technology need, which may include, but is not limited to, any of the following:

    - Devices for Sensory Disabilities
    - Devices for Safety
    - Devices for Monitoring
    - Devices for Privacy
    - Durable Medical Equipment
    - Recuperative care

3. ADRC staff will identify possible resources to meet the individual's need. ADRC staff will research programs and information by using 211 Information and Referral or local resource lists. Such programs for assistive technology services could include, but are not limited to:

    - Assistive technology agencies/businesses
    - UCAT (801-887-9380)
    - Independent Living Centers
    - Utah/USU Assistive Technology Program (800-524-5152)
    - Recycling programs – CReATE (801-887-9398)
    - Division of Vocational Rehabilitation (801-538-7530)
    - Financial Support
        a. UCAT Funding Specialist (801-887-9380)
        b. USAF (800-524-5152)

4. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.

    - If the individual wishes to make the contact directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual.
    - If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.
    - If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the

- individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.
- If possible and warranted, staff will assist the individual in completing the application.

5. If the plan involves Medicaid, ADRC staff should determine the individual's Medicaid status:
    a. Medicaid recipient or
    b. Medicaid-eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the individual may be eligible) or
    c. Not Medicaid-eligible
        i. Private Pay
        ii. Medicare
        iii. Family
        iv. Veterans Services
        v. Other sources of income
            1. United Way
            2. Churches
            3. Non-profits
            4. Service groups
            5.
6. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
7. Assess the need for follow-up and carry out the follow-up plan.
8. Document all required information in the tracking database.

Assisted Living Facilities

Procedure

1. Options counseling process suggests that Assisted Living may be part of a plan for achieving the individual's goals. Is the person considering a move due to health, disability, frailty or safety issue?

2. ADRC staff should determine the individual's Medicaid status:
    - Medicaid recipient
    - Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible)
    - Not Medicaid eligible
        - Private Pay
        - Medicare
            - Checklist at www.Medicare.gov
        - Family
        - Veterans Services
        - Other sources of income
            - United Way
            - Churches
            - Non-profits
            - Service groups

3. If the individual is a Medicaid recipient, or is eligible for Medicaid, then discuss the New Choices Waiver. Disperse information about assisted living facilities in the area that accept the New Choices Waiver and if that is the individual's preferred option, proceed with in-house procedures for making a referral to New Choices. Explain 90-day qualifying NF stay. If the individual is not a Medicaid recipient or candidate, then proceed with dispersing information about all the area assisted living facilities.

4. When it is part of the plan, ADRC will recommend that the individual contact an agency that provides relevant resources. If warranted or if requested, staff should initiate a three-way call with the individual and agency. If the individual is in the office, use a speaker phone to make the referral. When possible, the individual should provide the information to the agency. If the person requests that the ADRC staff provide the information, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate. Staff should then:
    A. Contact the agency for a verbal referral, or
    B. Send the referral to the agency by fax, email, or regular mail, or
    C. Assist in completing an application, when applicable.

5. Document all information in the tracking database.

6. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.

7. Assess the need for follow-up. Document the necessary follow up in the tracking database and carry out follow-up as planned. For assisted living, consider the need to assure that the plan has been carried out, for example by contacting the facility.

Dental Assistance

Procedure

1. Options counseling process suggests that dental assistance may be part of a plan for achieving the individual's goals.

2. Determine the nature of the dental need, which may include, but is not limited to, any of the following:
   - Dentures
   - Dental Hygiene
   - Oral Surgery
   - Physician Referral

3. ADRC staff should determine the individual's Medicaid status:
   - Medicaid recipient
   - Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible)
   - Not Medicaid eligible

4. ADRC staff should determine what form of insurance (e.g. Medicare, Med Advantage, Medicare Supplemental, private policy, employer policy) the individual may have.

5. Research and discuss medical and/or dental assistance options with the inquirer, based on the information received. Use the RESOURCE DIRECTORY database, training manual or other methods of research to find applicable programs and services. Search for specific dental assistance programs, such as (in no particular order):
   - Health Clinics
   - Community Clinics
   - Physician Referral Hotlines
   - Dental Programs
   - Affordable Dentures

6. If the individual has or is interested in any of the programs discussed, continue by offering additional assistance, such as:
   - Completing applications for programs. If the individual will fill out applications, provide the individual with the relevant paperwork, if available.
   - If the paperwork to apply is not readily available, offer to contact the appropriate agency to obtain necessary applications. If calls are necessary, either initiate a three-way call with the individual and agency, or, if in an office or home, use the speaker phone to assure that the individual can participate in the process.

- If the individual does not want assistance, provide the person with the information needed to contact or apply for the program.

7. Exhaust all available dental options. Confirm with the inquirer that there is no other need or option to be discussed.

8. At the conclusion of the encounter, assure that all required documentation is recorded in the tracking system.

9. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone (i.e. assisted with applying for a dental program, referred to a health clinic, etc.).

10. Assess the need for follow up. Document the necessary follow up in the tracking database and carry out follow up as planned.

Medical Assistance

Procedure

11. Options counseling process suggests that medical assistance may be part of a plan for achieving the individual's goals.

12. Determine the nature of the medical need, which may include, but is not limited to, any of the following:
    - Physician Referral
    - Medical Examination
    - Recuperative care

13. ADRC staff should determine the individual's Medicaid status:
    - Medicaid recipient
    - Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible)
    - Not Medicaid eligible

14. ADRC staff should determine what form of insurance (e.g. Medicare, Med Advantage, Medicare Supplemental, private policy, employer policy) the individual may have.

15. Research and discuss medical assistance options with the inquirer, based on the information received. Use the RESOURCE DIRECTORY database, training manual or other methods of research to find applicable programs and services. Search for specific medical assistance programs, such as (in no particular order):
    - Health Clinics
    - Community Clinics
    - Physician Referral Hotlines

16. If the individual has or is interested in any of the programs discussed, continue by offering additional assistance, such as:
    - Completing applications for programs. If the individual will fill out applications, provide the individual with the relevant paperwork, if available.
    - If the paperwork to apply is not readily available, offer to contact the appropriate agency to obtain necessary applications. If calls are necessary, either initiate a three-way call with the individual and agency, or, if in an office or home, use the speaker phone to assure that the individual can participate in the process.
    - If the individual does not want assistance, provide the person with the information needed to contact or apply for the program.

17. Exhaust all available medical options. Confirm with the inquirer that there is no other need or option to be discussed.

18. At the conclusion of the encounter, assure that all required documentation is recorded in the tracking system.

19.If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone (i.e., referred to a health clinic, etc.).

20. Assess the need for follow up. Document the necessary follow up in the tracking database and carry out follow up as planned.

Services For Individuals with Physical Disabilities

Procedure

1. Options counseling process suggests that services for individuals with physical disabilities may be part of a plan for achieving the individual's goals.

2. Specifically consider:

   - Home Health Care
   - Care Management
   - Respite
   - Independent Living Skills Training
   - Therapy
   - Equipment
   - Housing
   - Home Modifications
   - Employment
   - Transportation

3. ADRC staff will identify possible resources to meet the individual's need. ADRC staff will research programs and information by using 211 Information and Referral or local resource lists. Such programs for physical disabilities services could include, but are not limited to:

   - Assistive technology agencies/businesses
   - Nursing facilities and/or other therapy centers
   - Local housing/home modification programs
   - Volunteer programs (camps, religious organizations, colleges/universities) to assist with ramps or other home modifications
   - Local disability housing apartments or homes
   - Peer Support
   - Individual and Systems Advocacy
   - Financial Support
   - Other Services

4. When a referral is part of the plan, ADRC staff will recommend that the individual contact the agency that provides the relevant resources. If calls are necessary, staff will either initiate a three-way call including the individual and agency. If ADRC staff and the individual are together, staff will use a speaker phone to include the individual in the call. The individual will be encouraged to provide background and information to the agency. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain

verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual is not capable of consenting. Staff will then:

a. Contact the agency to provide a verbal referral, or
b. Send a referral to the agency by fax, email, or US mail, or
c. Assist in completing the application, when needed.

5. If the individual is in need of medical services in the home, ADRC staff should determine
    a. The individual's Medicaid status:
        - Medicaid recipient
        - Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible)
        - Not Medicaid eligible
            - Private Pay
            - Medicare
            - Family
            - Veterans Services
            - Other sources of income
                - United Way
                - Churches
                - Non-profits
                - Service groups

    b. What form of insurance (e.g. Medicare, Med Advantage, Medicare Supplemental, private policy, employer policy) the individual may have.

6. Consider the Funding Home Care Options and/or Medicaid Prior Authorization SOPs.

7. At the conclusion of the encounter, assure that all required documentation is recorded in the tracking system.

8. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.

9. Assess the need for follow-up. Document the necessary follow-up in the tracking database and carry out follow-up as planned.

Services for Individuals with Developmental Disabilities

Procedure

- Options counseling process suggests that services for individuals with developmental disabilities may be a part of a plan for achieving the individual's goals
- If the plan involves referrals for resources or information on services for individuals with developmental disabilities, staff needs to identify the specific referrals, which could include
    a. Vocational Rehabilitation
    b. Transitioning to the Community
    c. Residential homes/Group homes
    d. Advocacy
    e. Respite services
    f. Financial Assistance
    g. Socialization
    h. Habilitation
    i. Life Skills
    j. Social Security
    k. Guardianship
- ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Programs for individuals with developmental disabilities may include
    a. DSPD
    b. Vocational Rehabilitation services
    c. Independent Living Centers
    d. Disability Law Center
- When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
    a. If the individual wishes to make the contact directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual.

b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

- If the plan involves Medicaid, ADRC staff should determine the individual's Medicaid status:
    a. Medicaid recipient or
    b. Medicaid-eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the individual may be eligible) or
    c. Not Medicaid-eligible
        i. Private Pay
        ii. Medicare
        iii. Family
        iv. Veterans Services
        v. Other sources of income
            1. United Way
            2. Churches
            3. Non-profits
            4. Service groups

- If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
- Assess the need for follow-up and carry out the follow-up plan.
- Document all required information in the tracking database.

Adult Endangerment

Procedure

1. Options counseling process reveals possible elder endangerment.
2. Query the individual or caller for accurate and descriptive information about the nature of the endangerment. Concerns of neglect or abuse can either be suspected or substantiated. It is not the responsibility of ADRC staff to substantiate whether a person is abused or neglected, however it is the responsibility and requirement by law to report any suspected abuse or neglect to APS. Examples of adult endangerment may include:
    - Abuse
    - Neglect
    - Domestic Violence
    - Financial Exploitation

To report abuse, neglect, or exploitation of an older or vulnerable adult, contact Adult Protective Services at 801-264-7669 (Salt Lake County), or 800-371-7897 (all other counties in Utah)

3. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Programs for individuals with developmental disabilities may include
    a. Crisis Intervention
4. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
5. Assess the need for follow-up and carry out the follow-up plan.
6. Document all required information in the tracking database.

Adult Endangerment: Immediate Emergency

Procedure

1. Options counseling process reveals probable elder endangerment.
2. Ask the contact the nature of the emergency, the level of risk involved and pertinent information about the emergency (location, contact information and who is/are involved).

3. After the determination has been made, follow one of the following procedures:

    a. For a medical or police emergency, ADRC staff will call 911 and stay on the line until the natural conclusion of the call. Do not tell the individual to hang up and dial 911; stay on the phone with the person and call 911 for them, or designate another ADRC staff member to call 911. If there is a doubt about the necessity of medical assistance, still call 911 and let the medical emergency personnel determine the medical necessity.

    b. If the individual is suicidal, remain on the line (or if the person is a walk-in, remain with the person) and call a local mental health agency, if available. If a mental health agency is not available, then call 911. Remain on the call until it is evident that the individual is receiving the assistance they need.

4. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
5. Assess the need for follow-up and carry out the follow-up plan.
6. Document all required information in the tracking database.

Blind or Visually Impaired

Procedure

1. Options counseling process suggests that services for individuals who are blind or visually impaired may be part of a plan for achieving the individual's goals.

2. Specifically consider:

   - Home Health Care; i.e., cooking, dressing
   - Banking
   - Independent Living Skills Training
   - Therapy
   - Equipment
   - Housing
   - Home Modifications
   - Employment
   - Transportation

3. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Programs for individuals with developmental disabilities may include

   - DSPD
   - Office of Blind and Visually Impaired
   - Orientation and Mobility Specialists
   - Rehabilitation Teacher of the Blind
   - Low Vision Specialist

4. When a referral is part of the plan, ADRC staff will recommend that the individual contact the agency that provides the relevant resources. If calls are necessary, staff will either initiate a three-way call including the individual and agency. If ADRC staff and the individual are together, staff will use a speaker phone to include the individual in the call. The individual will be encouraged to provide background and information to the agency. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual is not capable of consenting. Staff will then:

   a. Contact the agency to provide a verbal referral, or
   b. Send a referral to the agency by fax, email, or US mail, or
   c. Assist in completing the application, when needed.

5. Document all information in the tracking database.

6. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.

7. Assess the need for follow up. Document the necessary follow up in the tracking database and carry out follow up as planned. Consider the need to assure that the plan has been carried out, for example, contacting the facility.

Employment

Procedure

1. Options counseling process suggests that employment support may be a part of a plan for achieving the individual's goals.
2. If the plan involves referrals for employment services, staff will identify the specific referrals, which could include:
    a. Experience Works
    b. Vocational Rehabilitation
    c. Sheltered Workshops
    d. Work One/Workforce Development
    e. Veterans Service Offices
    f. Senior Employment Programs (Senior AIDES Programs, Foster Grandparent)
    g. Goodwill Industries
    h. U.S. Department of Labor
3. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Agencies may include:
    a. Disability Employment services
    b. Veteran Employment services
    c. Senior Employment Programs
    d. Benefits Counseling
4. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
    a. If the individual wishes to make the contact directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual.
    b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

5. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
6. Assess the need for follow up and carry out the follow up plan.
7. Document all required information in the tracking database.

Caregivers

Procedure

1. Options counseling process suggests that caregiver support may be a part of a plan for achieving the individual's goals
2. If the plan involves referrals for caregiver support, staff will identify the specific referrals, which could include
    a. Training opportunities
    b. Respite care
    c. Support groups
3. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Programs for caregivers are ?offered through local or regional AAAs
    a. **Information** ADRC staff will provide any information, such as resource guides or informational pamphlets, as well as answering questions verbally.
    b. **Assistance** ADRC staff will assist any caregiver with issues regarding their caregiving duties, whether that be through referrals, helping fill out Medicaid applications or mailing appropriate information. Assistance means thorough probing of needs and timely follow-through.
    c. **Individual Counseling, Support Groups and Training** ADRC staff will alert the caregiver of area support groups and training as well as agency training opportunities for caregivers. Options counseling will be provided to caregivers, and if the caregiver requires professional counseling for mental health issues, then ADRC staff will refer the caregiver to appropriate agencies and resources.
    d. **Respite** ADRC staff will confirm with the caregiver that the caregiver is caring for an individual age 60 years or older and that their assistance is keeping the individual out of a nursing facility. If it seems that a caregiver would be appropriate for respite services, then reference agency's internal protocol for Caregiver Program referrals.
    e. **Supplemental Services** If a caregiver requires additional services that could be met through area agencies or resources, then proceed to refer caregiver to area resources. If the agency has supplemental service provisions, then reference agency's internal protocol for Caregiver Program Supplemental Services referrals.
4. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
    a. If the individual wishes to make the contact directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual.

b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

5. If the plan involves Medicaid, ADRC staff should determine the individual's Medicaid status:
   a. Medicaid recipient or
   b. Medicaid-eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the individual may be eligible) or
   c. Not Medicaid-eligible
6. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
7. Assess the need for follow-up and carry out the follow-up plan.
8. Document all required information in the tracking database.

Financial Assistance

Procedure

1. Options counseling process suggests that employment support may be a part of a plan for achieving the individual's goals.
2. Determine the nature of the financial need
    a. Medical Bills
    b. Utility Assistance
    c. Housing Assistance
    d. Other Financial Assistance
3. If the plan involves referrals for financial support, staff will identify the specific referrals, which could include
    a. Township Trustees
    b. Energy Assistance Programs
    c. Disease-related Funding Programs (i.e. AIDS fund, Kidney fund)
    d. Community Service Groups
    e. Medicaid
    f. Religious Organizations
    g. Other programs not listed
4. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Agencies may include
    a. Disability Employment services
    b. Veteran Employment services
    c. Senior Employment Programs
    d. Benefits Counseling
5. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
    a. If the individual wishes to make the contact or submit an application for services directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual. ADRC staff will also provide applications for programs, when available.
    b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

6. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
7. Assess the need for follow-up and carry out the follow-up plan.
8. Document all required information in the tracking database.

Home Care Options

Procedure

1. Options counseling process suggests that assistance with home care options may be a part of a plan for achieving the individual's goals.
2. Determine the nature of the home care needs, home care options could include, but are not limited to:
    - Homemaker
    - Home Health Aid
    - Respite Care
    - Home Nursing
    - Emergency Response Units
3. After the determination of the specific service that is needed, proceed to discuss the different payment options for home care. Payment options could include the following:
    - Private Pay
    - Reverse Home Mortgages
    - Long Term Care Insurance
    - Home Equity Loans
    - Medicaid Waivers
    - The Alternative Program (see SOP)
    - Title 3 (Older Americans Act)
4. If the individual is interested in private paying for home care, proceed to discuss the private case management option (see Private Case Management SOP). If the individual is interested in Private Case Management, continue with those procedures.
5. If the individual who wishes to private pay is not interested in Private Case Management, provide information on agencies that could provide the specific service(s) needed. Proceed with assisting the individual with referral information as listed below.
6. If a waiver program is being considered, ADRC staff should determine the individual's Medicaid status:
    - Medicaid recipient
    - Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible)
    - Not Medicaid eligible
    -
7. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Agencies may include
    a. Home health agencies

b. Personal care agencies

c. AAAs

d. CILs

8. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
   a. If the individual wishes to make the contact or submit an application for services directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual. ADRC staff will also provide applications for programs, when available.
   b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.
   c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.
   d. If possible and warranted, staff will assist the individual in completing the application.
9. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
10. Assess the need for follow-up and carry out the follow-up plan.
11. Document all required information in the tracking database.

Home Modifications/Maintenance

Procedure

1. Options counseling process suggests that home modifications may be a part of a plan for achieving the individual's goals.
2. Determine the nature of the home modifications, which could include,
    a. Location of the home
    b. If the individual owns or rents
    c. Ability to purchase home modification, financial status
    d. Specific home modification (ramp, door widening, bathroom safety, etc.)
3. ADRC staff will research programs and information regarding home modifications, based on the specific need determined by probing. Research will be done by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for home modification could include, but are not limited to:
    a. Carpenters Union
    b. Local home supply businesses (lumber yards, home improvement stores, etc.)
    c. Local volunteer groups (summer work camps, colleges, religious organizations, etc.)
    d. Local handyman businesses/individuals
    e. Local Housing Authority
4. If the individual is interested in private paying for home modifications, proceed to discuss the private case management option (see Private Case Management SOP). If the individual is interested in Private Case Management, continue with those procedures.
5. If the individual who wishes to private pay is not interested in Private Case Management, provide information on agencies that could provide the specific service(s) needed. Proceed with assisting the individual with referral information as listed below.
6. If a waiver program is being considered, ADRC staff should determine the individual's Medicaid status:
    a. Medicaid recipient OR
    b. Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible) OR
    c. Not Medicaid eligible
7. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.

a. If the individual wishes to make the contact or submit an application for services directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual. ADRC staff will also provide applications for programs, when available.

b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

8. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
9. Assess the need for follow-up and carry out the follow-up plan.
10. Document all required information in the tracking database.

Hospice

Procedure

1. Options counseling process suggests that hospice may be a part of a plan for achieving the individual's goals.
2. Consider hospice eligibility: individual has been diagnosed with a terminal condition
3. Determine insurance coverage
    a. Medicare
    b. Medicaid
    c. Private health insurance
    d. Other
    e. No insurance
4. Provide information about the nature of hospice care provided in Medicare publications. Inform the individual that not all listed services are provided, only those that are identified as part of the care plan developed by the hospice.
5. If the individual does not have insurance coverage, ADRC staff should determine the individual's Medicaid status:
    a. Medicaid recipient OR
    b. Medicaid eligible (if the individual is receptive, screen for eligibility using the Medicaid Screening SOP and determine if the person may be eligible) OR
    c. Not Medicaid eligible
6. Provide information about questions to ask potential hospices.
7. ADRC staff will identify specific resources that may meet the individual's need. ADRC staff will research programs and information by using 2-1-1 or local resource lists. Consider whether the need is home-based or whether the individual will require facility-based care.
8. When a referral to another agency is part of the plan, ADRC staff will encourage the individual to participate in the process to the greatest degree possible.
    a. If the individual wishes to make the contact or submit an application for services directly, ADRC staff will provide contact details to the individual in writing, via email, or by other means that are effective for the individual. ADRC staff will also provide applications for programs, when available.
    b. If the ADRC staff is assisting in making the initial contact, staff will initiate a three-way or conference call including ADRC staff, the agency, and the individual. The individual will be encouraged to provide background and other information.

c. If the individual requests that ADRC staff make the contact in the absence of the individual, staff will obtain verbal or written consent from the individual or the individual's agent, guardian, or other surrogate, if the individual lacks the capacity to consent. Staff will then contact the agency by telephone, or by sending a written request via email, fax, or US mail.

d. If possible and warranted, staff will assist the individual in completing the application.

9. If the individual is actively working with a case manager or another department within the agency, notify the case manager via email and/or telephone.
10. Assess the need for follow-up and carry out the follow-up plan.
11. Document all required information in the tracking database.

Housing

Procedure

1. Options counseling process suggests that housing may be a part of a plan for achieving the individual's goals

2. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on housing, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts. Some of the information to probe for during a housing inquiry could include, but is not limited to:

- Financial Assistance (subsidized rentals, low income rentals, subsidized home purchasing, etc.)
- Disability Accessible Housing
- Emergency Housing
- Senior Housing Options (senior living communities, senior apartments, assisted living facilities, adult foster care, etc.)

3. ADRC staff will research programs and information regarding housing options, based on the specific need determined by probing. Research will be done by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for housing could include, but is not limited to:

- U.S. Department of Housing and Urban Development
- Utah Housing and Community Development Authority at (800)-872-0371.
- Section 8 Housing
- Local assisted living facilities (See Assisted Living SOP)
- Local senior living communities
- Local senior apartments
- Local Housing Authority
- Local real estate agencies
- Local subsidized housing programs
- Local disability accessible housing options
- Local nursing facilities (See How to Choose a Nursing Home and/or Pre-Admission Screening SOPs)
- Local homeless shelters
- Local emergency shelters

4. ADRC staff will inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the person is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties may communicate. It is best if the resource agency receives information directly from the individual. However, if the person requests that ADRC supply information to the referred agency, then ADRC staff will obtain a verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:
    a. Contact the referred agency for a verbal referral, OR
    b. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
    c. Assist in completing an application, if applicable.

5. Document all information in your tracking database.

6. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

7. Follow-up for housing inquiries may be necessary depending on the situation. If follow-up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Information & Referral

Procedure

1. The ADRC staff will identify the issue(s) leading to the inquiry, establish rapport with the inquirer, determine the nature of the situation, and evaluate the knowledge and capacities of the inquirer, in order to determine how to approach the information-giving service.

a. The ADRC staff will provide information, which is updated at least annually, about services, resources and programs which will assist people to experience daily life with dignity and security, maximizing their opportunities for self-sufficiency and choice.

b. The ADRC staff will identify and respond quickly to emergency situations.

c. Information and assistance can be provided in person, including home visits and walk-ins, over the telephone, via e-mail, or through written correspondence.

Legal/Advocacy

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on legal assistance, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts. Some of the information that may need to be collected prior to referring the individual to an agency or program may include the following:
   - Age of the inquirer
   - Specific legal issue. Issues could include, but are not limited to:
     - Health Care – Medicare, Medicaid, other insurance issues
     - Estate Planning – simple wills, trusts, and simple estate administration
     - Protective Services
     - Tax laws
     - Advance Directives for Health
     - Power of Attorney
       - Banking
       - Bill Paying
       - Real Estate
       - Investments
       - Insurances
       - Public Benefit Applications
     - Guardianship
       - Plenary
       - Limited
     - Consumer rights
     - Grandparents' Rights
     - Advocacy
     - Discrimination
     - Complaints and grievances
     - Spousal Impoverishment

2. ADRC staff will research programs and information regarding Legal advocacy. Such programs for Legal Advocacy could include, but are not limited to:

   - Utah Legal Services:
     a. Salt Lake City 801-328-8891
     b. Cedar City 435-586-2571
     c. St. George 435-628-1604
     d. Provo 801-374-6766

e. Ogden 801-394-9431

- Disability Law Center 801-363-1347, TTY: 800-550-4182
- Legal Aid Society of Salt Lake 801-328-8849 www.lasslc.org
- Local Area Agencies on Aging
- End of Life Partnership www.carefordying.org
- Div. of Aging & Adult Services 877-424-4640, 801-538-4263
- AARP Legal Services Network www.aarp.org
- National Academy of Elder Law Attorneys www.nacla.org
- National Senior Citizens Law Center at (202) 887-5280. www.nsclc.org
- Local Legal Clinics and Pro Bono Services
    a. Salt Lake – Family Law Legal Clinic
        i. Held every 1st and 3rd Wednesday of the month from 6-8pm. Matheson Courthouse, 450 South State, Room W-19A
    b. St. George
        i. Held the 4th Wednesday of the month from 9-11:30am (no appt. necessary) and every Tuesday from 5-7pm (by appt. only) at the Southern Utah Community Legal Center, 229 East St. George Blvd., Suite 103. 435-628-1604
    c. Tooele
        i. Held every 1st, 3rd, and 5th Monday of the month from 10am – 12noon at Third District Courthouse, 47 South Main. 435-843-3210
    d. Vernal – Utah Legal Services Clinic
        i. Held every 2nd Tuesday of the month from either 9am – 12noon, or 1-4pm at the Eighth District Court, 920 East Highway 40. 435-781-9300
    e. Provo – Utah Legal Services Clinic
        i. Spanish speaker emphasis, but everyone welcome. Held every 1st Monday of the month from 5-7pm at Utah Legal Services, Inc., 455 North University Avenue, Suite 100. 801-374-6766
    f. Richfield – Utah Legal Services Clinic
        i. Held every 4th Wednesday of the month from 10am – 1pm at the Sixth District Court, 895 East 300 North. 435-896-2700
    g. Roosevelt – Utah Legal Services Clinic
        i. Held once a month on the Wednesday following the 2nd Tuesday from 9am – 12noon. Located at the Senior Center, 50 East 200 South. 435-722-4296.
- Bar Associations – Utah State Bar www.utahbar.org
- Utah Department of Health
- Partnership for Caring www.caringinfo.org (provides information on advance care planning and all state advance directives
- National Consumer Law Center www.nclc.org

- Private Attorney

3. ADRC staff will inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the person is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties may communicate. It is best if the resource agency receives information directly from the individual. However, if the person requests that ADRC supply information to the referred agency, then ADRC staff will obtain a verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:

   A. Contact the referred agency for a verbal referral, OR
   B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

6. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Long Term Care Insurance

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on long term insurance, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts.

2. ADRC staff will research programs and information regarding long term care insurance by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for long term care insurance could include, but are not limited to:

- SHIP, State Health Insurance Assistance Program
- Utah Department of Insurance
- Local Elder Law Attorneys
- Other local agencies or resources that assist with long term health insurance issues.

3. ADRC staff will inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the person is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties may communicate. It is best if the resource agency receives information directly from the individual. However, if the person requests that ADRC supply information to the referred agency, then ADRC staff will obtain verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:

A. Contact the referred agency for a verbal referral, OR
B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

6. Follow-up for inquiries may be necessary depending on the situation. If follow-up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Medicaid Screening

Procedure

1. To assist individual to apply for Utah Medicaid or to get answers to his/her questions, call a Medicaid worker at 801-236-6762 in the Salt Lake area or 1-800-662-9651 ext. 998 anywhere in Utah.

2. Medicaid waiver coverage is regular Medicaid with additional benefits for special medical groups. The waiver medical groups are:

A. Aging Waiver – for people who are at least 65 and need help to get the services needed to stay in the home or in a community setting instead of a nursing home. Call the local area agency on aging for more information.
B. Utah Community Supports Waiver –for people of all ages with intellectual disabilities and other related conditions who need assistance with activities of daily living. Must meet a disabled, aged, blind, child or family Medicaid category. Call DSPD at 801-538-4200 for more information.
C. Technology Dependent Waiver – for children under age 21 or those who qualify for waiver services by the month turning 21 and rely on medical devices for life support. Call DFHS at 801-584-8505 for more information.
D. Brain Injury Waiver – for people who are 18 years or older and have a brain injury that results in problems with providing self-care and engaging in the regular activities of daily living. Call DSPD at 801-538-4200 for more information.
E. Physical Disabilities Waiver – for people at least 18 years of age that require nursing home level of care and have lost the use of at least two limbs. Call DSPD at 801-538-9864 for more information.
F. New Choices Waiver – for people who are 21 years of age or older who may be able to move out of institutional care to a community care setting. Call the Long-term Care Bureau at 801-538-6400 for more information.

2. Medicaid waiver services require financial and medical eligibility. The individual must submit an application, either in person or by mail. Obtain a written or verbal consent that the release of this information to the ADRC staff meets with his/her approval. If the individual requests your assistance, proceed with the gathering of the following information:

- Proof of citizenship
- Proof of identity
- Health insurance and Medicare cards
- Proof of income received by individual and/or spouse
- Proof of assets owned by individual and/or spouse
- Medical bills individual owes or has just paid
    - o

- Medicaid can only cover past bills for medical services received no earlier than 90 days before the day individual applies. Individual must meet eligibility criteria for the time period in which he/she received medical care.
- If past bills are not covered by Medicaid or other insurance, individual may be able to get an income deduction for past medical bills still owed. Ask Medicaid worker about help with past medical bills.

5. After the conclusion of the contact, document all information in proper location and update database for tracking.

6. If the individual is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified about the action taken (i.e. assisted with applying for Medicaid, etc.).

7. Follow up may be necessary depending on the situation. If follow up is appropriate to make sure that the information given was appropriately handled, then proceed with proper follow up. This may include, but is not limited to, calls to family members, the individual seeking assistance or a Power of Attorney.

Rights and Responsibilities of Applicants for Medicaid

Individual has the right to:

- Apply or reapply anytime for any Medicaid program
- Receive help completing the application forms
- Know the name of the person he/she is working with
- Be treated with courtesy, dignity, and respect
- Be asked for facts and verification clearly and courteously
- Be told in writing why his/her application was approved or denied

- Be told in writing when any changes are made on case
- Have an agency conference to discuss case
- Ask for a hearing anytime there is disagreement with an action taken on individual's case
- Look at any information used to decide eligibility and the amount to be paid by individual
- Look at the policy manuals

Responsibilities of Individual Applying for Medicaid

Individual has the responsibility to:

- Apply for Medicaid by completing and signing an application and verifying eligibility factors with the Bureau of Eligibility Services, Utah Department of Health or the Department of Workforce Services
- Give complete and accurate facts for eligibility determination
- Report any changes immediately. This includes changes to income, income of spouse, bank accounts opening or closing, receipt of new assets. Changes in medical insurance coverage should also be reported
- Apply for other benefits entitled to, such as Medicare Part B, if not already receiving coverage.

Medicare

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on Medicare, then ADRC staff is responsible to disseminate accurate information and refer callers to appropriate resources or contacts.

2. ADRC staff will research programs and information regarding their Medicare need by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for Medicare inquiries could include, but are not limited to:

- State Health Insurance Assistance Program (SHIP)
- The Medicare website: www.Medicare.gov or Toll Free number at (800)-MEDICARE.
- Medicare O mbudsman at (800) 633-4227.
- Social Security Administration
- Other local programs that assist with Medicare issues and questions.

3. ADRC staff will inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the person is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties can communicate. It is best if the referred agency receives information on the concern from the caller. However, if the caller requests that ADRC supply information to the referred agency, then ADRC staff will obtain a verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:

   A. Contact the referred agency for a verbal referral, OR
   B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

7. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

8. Medicare Advamtage Plans - the following Q & A is a result of follow-up from the 2010 Denver National Medicare Training:

MA - Private-Fee-For-Service (PFFS) Plans

Question: **Tell us as much as you can about the 2011 requirement that Medicare Advantage – Private-Fee-For-Service (PFFS) Plans have a network of providers?**

Answer: This question is too open ended, and our Medicare Health Plan area has requested that the person asking be more specific.
The basic rule is any PFFS plan operating in a county with two other plans, must be a network PFFS plan in 2011. The two other plan rule is not two different health plans, just two plans or plan benefit packages.

Question: **Do providers have to actually sign contracts with PFFS Plans?**

Answer: Yes they do. CMS has requirements of what type of wording is required in the contract between the Network MA Network PFFS Organizations and the HealthCare Providers.

Question: **With regard to PFFS plans network requirements, how many primary care providers are required to be in the plans network?**

Answer: Requirements are based upon the Medicare population in a particular geographic area, the number of Primary Care Providers (and also Specialist providers) within the same geographic area, and the normal pattern of healthcare that the Medicare beneficiaries use in everyday life in seeking care.

Question: **What about payment requirements for visits to out of network PFFS providers (if permitted)?**

Answer: Network PFFS plans will be similar to an MA PPO. Out of network care paid to a provider by an HMO, PPO, or PFFS generally needs to be paid the same as original Medicare. The health plan determines the beneficiary's cost sharing for out of network care. Cost sharing will generally be higher for out of network services.

Question**: How will PFFS with a network in 2011 differ from an HMO or PPO (we want to understand this so we can appropriately counsel people)?**

Answer: The rules that Medicare beneficiary members will have to follow in a Network MA PFFS will in many ways resemble the rules of a MA PPO. Having In-Network benefits, and possibly lower cost sharing when getting healthcare within the network, plus the ability to seek care outside the Network, at possibly higher cost sharing. One would have to look at the particular Benefit Plan offered to better understand the difference for in and out-of-network cost sharing.

MA - Annual Out of Pocket Limits
Question: **are MA/Other Medicare Health Plans required to have limits on annual out of pocket costs? If so, what costs count towards these limits? Can CMS generally clarify,**

Answer: In 2011, if a MA Organization has voluntarily included Maximum out-of-pocket maximum (MOOP) to the "voluntary" level of $3,400, they would be allowed to have more flexibility with various "individual" cost sharing items (e.g. Chemotherapy, Dialysis co-pays, when a SNF co-pays start, etc.) within the plan of benefits. If an MA Organization has not included this voluntary Maximum out-of-pocket limit, they have a Mandatory out-of-pocket maximum of $6,700 instilled upon their submitted Plan, and would not be allowed the same flexibilities in individual cost sharing for services, resulting in more scrutiny during the Bid Approval process. This is a very simple explanation and should not be considered a complete explanation with all of the detail of a very large memorandum. Maximum Out of Pocket limits on Medicare beneficiary member spending includes costs for all covered Medicare Part A and B services.

MA - Cost Sharing Requirements

Question: **In 2011, we understand MA plans will be prohibited from imposing higher costs-sharing requirements than Original Medicare for some Medicare covered benefits, e.g., chemotherapy, SNF, dialysis treatments – can you clarify how these new requirements will be applied? We're use to the general requirement that plans benefit packages have to be actuarial equivalent to Original Medicare…**

Answer: The previous answer on Annual Out-of-Pocket limits explains much of this. At the lower voluntary limit of $3,400, there may be situations where an individual cost sharing limit for Chemotherapy services , Dialysis services or SNF co-pays may be higher, or start sooner than Original Medicare. At the higher limit MOOP of $6,700, the cost sharing for these types of services would fall under additional scrutiny, and the chance for any of these individual cost sharing being higher than Original Medicare would most likely not be allowed. Benefit Packages are still required to have "at least" the actuarial equivalence of Original Medicare, but they can be valued higher.

Mental Health Options

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on mental health, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts. ADRC staff will query the individual to determine the specific mental health need, which could include, but is not limited to the following:
   - Counseling services
   - Alcohol and other drug abuse services and supports
   - Psychiatric treatment
   - Hospitalization
   - Semi-independent living assistance

2. ADRC staff will research programs and information regarding their specific need by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for mental health options could include, but are not limited to:
   - Mental Health Association
   - Mental Health Ombudsman
   - Local inpatient & outpatient centers
   - Local hospitals
   - Mental Health Organizations
   - Counseling Centers
   - Local Psychiatrists and/or psychologists

3. ADRC staff will inform the individual to contact the resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the person is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties may communicate. It is best if the referred agency receives information on the concern from the person. If the individual requests that ADRC supply the information, the ADRC staff will obtain verbal or written consent from the individual (or the individual's guardian, agent, or other surrogate) and then proceed to:
   A. Contact the referred agency for a verbal referral, OR
   B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the person is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified (via e-mail and/or telephone) about the contact.

6. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

How to Choose a Nursing Home

Procedure

1. Determine, from the individual , the nature of the need; i.e., health issues, disability, frailty.

2. After the determination has been made, utilizing the hand book, "How to Choose a Nursing Home" recommend the following:

A. **Make a List** (this would include any facility of interest).

B. **Discuss options** with friends, clergy, those you trust who might have information or experience with the facilities listed.

C. **Plan to visit various facilities in person**. During the visit speak with staff and residents about the facility; make the visit unannounced. View the results of the latest survey conducted by the Utah State Department of Health. This report is to be accessible to residents and visitors. Also, use your five senses. How does the facility smell? Are there loud noises? Is the facility clean? Are residents participating in activities? Do the staff members speak to each other and to residents in a kind manner? If the visit is during meal time, does the food smell good? Is the menu easy to follow? Use a checklist to document and note specifics about each facility visited.

D. **Understand Finances** How will you pay for the care? (If the answer indicates the need, Medicaid screening should be completed at this time. Medicaid Packet attached.) Ask for a copy of the facility's admission agreement and read it thoroughly. You may ask the admissions contact or administrator to clarify any question.

E. **Further resources to assist in choosing a nursing home include**: Health Care Financing Administration: "Your Guide to Choosing a Nursing Home", publication No. 02174; Health Care Financing Administration: "Nursing Homes-Basic Information on How to Choose", publication No. 10121 (Order either publication by calling 1-800-633-4227) . Also, contact your local Ombudsman and the Area Agency on Aging.

F. **Making a Decision** When making this decision, it is recommended that the prospective resident be included in this decision since he/she is most affected by this move. Also keep in mind that if a decision is made that is unsatisfactory, you can always look around for a facility that is better suited to the resident.

G. Making the nursing home decision can be difficult and stressful and sometimes seems overwhelming. Understanding options and learning as much as possible will help make the best possible decision.

H. Inform the contact that in the event this decision is made, a screening process (PAS) is mandatory in the state of Utah. Give contact information to inquirer to facilitate the process.

I. Offer to mail a Nursing Home Question and Check List (attached).

J. Offer to mail information about surveys from various web sites.

3. After the conclusion of the contact, document all information in RESOURCE DIRECTORY and mail any requested information.

NURSING HOME QUESTIONS AND CHECKLIST

General
*****How long have the current owner, administrator and director of nursing been with the facility?
*Has there been stability at these levels?
*Is there a written statement of resident's rights clearly posted?
*Are visiting hours convenient for residents and visitors?
*Who owns the nursing home and how does that person or organization get consumer input?

Medical Care
*Is the home reasonably close to a hospital offering emergency services?
*How does the home assure regular medical attention?
*How often do physicians visit?
*Is transportation provided for medical appointments outside the building?
*Is there on-site physical and occupational therapy?
*What is the turnover rate for nurses and nursing assistants?
*What is the staff- to- resident ratio?
*Are residents able to choose their own physician?

Resident Rooms
*In shared rooms, does each resident have private space, room for individual belongings and space for visitors? How many residents share a bathroom?
*How are room changes and roommate concerns addressed?
*Is there locked storage available?
*Are there roommate privacy curtains?
*Are furnishings adequate?
*Do staff knock on the door and wait for an answer before entering rooms?

Environment
*Are there individual room temperature controls?
*Is there air-conditioning?
*Are there designated smoking areas and times?
*Is the home smoke-free?
*Are exits clearly marked?
*Are the grounds well lit?
*Are special considerations taken in the design of outside areas for residents with memory loss or wandering issues?

Dining
*Are there interesting menu choices?
*Are there posted substitutions?
*Can residents choose seating?
*Are guests allowed?
*Are residents permitted to have food/snacks in their room?
*How are the dining rooms staffed?
*What are meal times?
*Do meals look appetizing?
*Is food served at the proper temperature?

Staffing
*How many residents are assigned per nursing assistant?
*Is that different on other shifts?
*How are new staff screened and trained?
*Is there on-going training for all staff?
*Is there a volunteer program?
*Are there adequate social services, activities and therapy staff?
*Do staff members show genuine interest?
*Do they take time to visit with residents?

Residents
*Do residents appear happy and content?
*Is there fellowship among residents?
*Is there a resident council?
*Is there a resident newsletter?
*Is there a family council?
*Are residents involved in the planning of menus and activities?
*How are residents notified and invited to care plan conferences?
*Are residents well-groomed and nicely dressed?
*Do residents speak favorably of the home?

These are just a few of the questions that you should keep in mind and ask yourself when touring or determining which facility you will choose. Consult friends and others in the community for feedback on their experiences. With this information you will be able to make an informed decision on which facility best suits you or your family member's needs.

Nutrition

Procedure

1. Determine, from the inquirer, the nature of the nutritional need:
   - Not complying with a special diet
   - Lack of available food
   - Not able to prepare a meal
   - Other nutritional needs

2. Determine the following information from the inquirer, about the person in need:
   - Demographics (name, address, phone number)
   - Age
   - Mobility (i.e. ability to drive)

3. Research and discuss nutrition options with the inquirer, based on the information received. Use the RESOURCE DIRECTORY database or resource material located in the training manual to find applicable programs and services. Search for specific nutrition programs, such as (in no particular order):
   - Soup Kitchens
   - Food Pantries
   - Food Banks
   - Congregate Meals
   - Home-delivered Meals
   - Nutrition Web Sites
   - Food Vouchers
   - Food Stamps
   - Counseling

4. If the inquirer is interested in any of the programs discussed, continue by offering additional assistance, such as:
   - Assisting the inquirer with applying for a program, or if assistance is not needed, providing the appropriate paperwork to apply for a program, if that paperwork is available.
   - If the paperwork to apply is not readily available, offer to contact the appropriate agency or person. Make sure to obtain a verbal or written consent from the individual seeking assistance or that person's Power of Attorney to share information with any referred agency/program. To contact the agency or person, make a three-way call, if the inquirer is a caller. If the inquirer is a walk-in a call use the speaker phone option so that all parties can communicate. If they do not desire additional assistance, provide them with the appropriate information required to make their own contacts.

6. Make sure that all available nutrition options have been exhausted. Confirm with the inquirer that there is no other need or option to be discussed.

6. After the conclusion of the contact, document all information. All databases must be referred to and, if the individual's (the person in need) information is present, then the database(s) must be updated.

7. If the individual is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified about the action taken (i.e. assisted with applying for food stamps, assisted with getting home-delivered meals started, etc.)

8. Follow up may be necessary depending on the situation. If follow up is appropriate to make sure that the information given was appropriately handled, then proceed with proper follow up. This may include, but is not limited to, calls to family members, the individual seeking assistance, or the referred agency.

Options Counseling

Procedure

1. Determine, from the inquirer, the purpose of the contact. Assess the situation, asking such questions as:
   - What kind of help are you looking for?
   - What is the underlying problem?

2. Determine where options counseling will take place. Schedule options counseling.

3. Explain the nature and goals of options counseling. Query further to find out all the needs of the individual. Ask the inquirer the following about the individual in need; this information can help find specific programs that meet the needs mentioned. Discuss inclusion of individual if call is from a caregiver.

   - Individual's goals and motivations
   - Demographics (name, city, phone number)
   - Location (home, facility, hospital, etc.)
   - Age
   - Physical Disabilities
   - Mental Disabilities
   - Support System (family, friends, neighbors, etc.)

4. After a good understanding of the needs involved, discuss and educate about the pros and cons of the following options, and if that option is applicable for the individual in need, proceed with the following step(s):

   A. In-Home Services
      Including, but not limited to: Home Health Aide, Homemaker, Bath Aide, Attendant Care Aide, Friendly Companion and Home Care Nurse. See the Funding Home Care Options SOP to proceed with any one of these options.

   B. Nutrition
      Including, but not limited to: congregate meal sites, food pantries, food banks, food vouchers, food stamps and home-delivered meals. See the Nutrition SOP to proceed with any one of these options.

   C. Housing/Shelter
      Including, but not limited to: homeless shelters, low rental apartments, disabled apartments, subsidized apartments, Section 8, home repair and weatherization. See the Housing SOP to proceed with any one of these options.

   D. Adult Day Services
      See the Funding Home Care Options SOP to proceed with this option.

   E. Assisted Living
      See the Assisted Living Facilities SOP to proceed with this option.

F. Assistive Technology
   See the Assistive Technology SOP to proceed with this option
G. Financial Assistance
   Including, but not limited to: religious organizations, energy assistance programs, community- service groups and Medicaid. See the Financial Assistance SOP to proceed with this option.
H. Respite Services
   See Funding Home Care Options and Caregivers SOPs to proceed with this option.
I. Transportation
   Including, but not limited to: senior transportation program, transportation expense assistance, medical transportation, wheelchair transportation and mass transportation. See the Transportation SOP to proceed with this option.
J. Legal Services
   Including, but not limited to, senior legal programs, legal clinics, guardianship services and power-of-attorney. See the Legal Advocacy SOP to proceed with this option.
K. Mental Health Services
   Including, but not limited to, counseling services, residential services, in-patient services, out-patient services, mental health associations, support groups and therapies. See the Mental Health Options SOP to proceed with this option.
L. Health/Dental Services
   Including, but not limited to, community clinics, dental programs, physician-referral hotlines and dental clinics. See the Dental/Medical Assistance SOP to proceed with this option.
M. Education
   Including, but not limited to, GED programs, continuing-education programs, caregiver training, senior education programs, language programs and literacy programs. Assist as needed to link the individual with any of the listed options.
N. Recreation
   Including, but not limited to, senior centers, senior programs, developmental disability recreational programs, sports and fitness programs, arts programs. See the Senior Centers SOP and/or assist as needed to link the individual with any of the listed options.
O. Nursing Facility Placement
   See the How to Choose a Nursing Home SOP to proceed with this option.
O. Assess need for assistance with applications for benefits/services.
P. Assess the need for short-term case management.

5. After the conclusion of the contact, document the plan in your tracking database. All databases must be referred to and, if the individual's information is present, then the database(s) must be updated.

6. If the individual is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified about the action taken (i.e. placed on waiting lists, made a referral, made a Pre-Admissions Screening referral).

7. Follow up for options counseling may be necessary depending on the situation. If follow up is appropriate to make sure that the information given was appropriately handled, then proceed with proper follow up. This may include, but is not limited to, calls to the individual, family members, a hospital, the police department or a mental health organization.

The Technical Assistance Exchange (TAE) has worked with states implementing options counseling in their Aging and Disability Resource Center (ADRC) programs to identify six core competencies of options counseling that should underpin the process:

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

State Interpretive Guidelines/Additional Comments: (our own interpretation)

Options Counseling is ***successful*** when:

- The individual defines and is invested in achieving the goals
- The individual feels valued and understood
- The individual is motivated to make changes
- The individual is satisfied with the decisions and the plan
- The options counselor has explained the relevant options

Every person receiving Options Counseling will be:

- Listened to and heard

- Treated with respect, empathy, and dignity, and without judgment

- Assisted in making decisions about long-term care
- Supported in achieving long-term care preferences and choices
- Served in a timely manner

The individual receiving Options Counseling is/has:

- Intelligent
- Unique circumstances
- Unique needs
- Unique personal values

The individual has the ability and right to:

- Make independent choices
- Take risks
- Be responsible and accountable for his/her decisions

Physicians

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on physicians, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts.

2. ADRC staff will research programs and information regarding their specific need by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for physician referrals could include, butare not limited to:

- American Board of Medical Specialists at www.certifieddoctor.org
- Local hospitals, which may have hotlines for physician referrals.
- Utah Family Healthline at (800) 433-0746.
- County Medical Associations

3, If possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. If the individual is a walk-in, then the ADRC staff may attempt a call using the speaker phone option so that all parties may communicate. It is best if the referred agency receives information on the concern from the person. If the individual requests that ADRC supply the information, the ADRC staff will obtain verbal or written consent from the individual (or the individual's guardian, agent, or other surrogate) and then proceed to:

A. Contact the referred agency for a verbal referral, OR
B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the person is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified (via e-mail and/or telephone) about the contact.

6. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.


Utah
Aging & Disability
Resource Connection

Prescription Drugs

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on prescription drugs, then ADRC staff is responsible to disseminate accurate information and refer people to appropriate resources or contacts. Such prescription inquiries could include, but are not limited to:
   - Prescription Payment Assistance Programs
   - Medicare Part D
   - Private Insurance Prescription Coverage
   - Medicaid
   - Prescription Information
   - Pharmaceutical Assistance Programs

2. ADRC staff will research programs and information regarding their specific need by using the RESOURCE DIRECTORY resource management or resource information located in the training manual. Such programs for prescription information and/or assistance could include, but are not limited to:
   - The Medicare website at: www.medicare.gov for Medicare and Medicaid information.
   - SHIP, State Health Insurance Assistance Program, to discuss insurance options.
   - RESOURCE DIRECTORY search for Prescription Payment Assistance Programs through local agencies.
   - Local pharmacies and their programs.
   - Drug manufacturer websites.
   - Prescription information on the following website: www.talkaboutrx.org.

3. If possible or requested, complete a three-way call with the individual, ADRC staff and referred agency, or if the individual is a walk-in place the phone on the speaker option so that all parties can communicate. It is best if the resource agency receives information directly from the individual. However, if the person requests that ADRC supply information to the referred agency, then ADRC staff will obtain a verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:
   A. Contact the referred agency for a verbal referral, OR
   B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the person is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified (via e-mail and/or telephone) about the contact.

6. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Private Case Management

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on private case management, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts.

2. ADRC staff will refer to “in-house” procedures for making referrals for private case management.

3. Document all information in your tracking database.

4. If the person is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified (via e-mail and/or telephone) about the contact.

5. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Senior Centers

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on senior centers, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts. Senior Center resources may include, but are not limited to:
    - Education
    - Recreation
    - Life enhancement
    - Volunteerism

2. ADRC staff will inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. It is best if the resource agency receives information directly from the individual. However, if the caller requests that ADRC supply information to the referred agency, then ADRC staff will obtain verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:
    A. Contact the referred agency for a verbal referral, OR
    B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
    C. Assist in completing an application, if applicable.

3. Document all information in your tracking database.

4. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

5. Follow up for senior center inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Social Security

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on social security, then ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts.

2. If the inquirer seeks information about social security benefits, identity theft or any other basic social security question, ADRC staff will refer to resource information in the training manual and/or the www.socialsecurity.gov website to help answer any basic questions that the inquirer might have. If the inquirer still seeks further assistance, which the ADRC staff can't help with, then the ADRC staff will inform the inquirer to contact one of the following resources:

- Local Social Security Office, or
- www.socialsecurity.gov

3. If possible or requested, complete a three-way call with the individual, ADRC staff and Social Security Office, or if the individual is a walk-in, place the call on speaker phone so that all parties can communicate. It is best if the Social Security Office receives information on the concern from the inquirer. However, if the person requests that ADRC supply information to the referred agency, then ADRC staff will obtain verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:

   A. Contact the Social Security Office for a verbal referral, OR
   B. Send a referral to the Social Security Office by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the person is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified (via e-mail and/or telephone) about the contact.

6. Follow up for inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Support Groups

Procedure

1. Query the individual for accurate and descriptive information about the situation or concern. If the situation or concern involves resources or information on support groups, staff needs to identify the specific type. Such examples could be:
   - Caregiver
   - Alzheimer's
   - AIDS
   - Bereavement.

2. ADRC staff is responsible to disseminate accurate information and refer individuals to appropriate resources or contacts.

3. ADRC staff will either take and process a referral for in-agency support group programs, if applicable, or inform the individual to contact a resource, and, if possible or requested, complete a three-way call with the individual, ADRC staff and referred agency. It is best if the resource agency receives information directly from the individual. However, if the individual requests that ADRC supply information to the referred agency, then ADRC staff will obtain a verbal or written consent from the individual seeking assistance (or the individual's guardian, agent, or other surrogate) and then proceed to:
   A. Contact the referred agency for a verbal referral, OR
   B. Send a referral to the referred agency by fax, e-mail, mail, etc., OR
   C. Assist in completing an application, if applicable.

4. Document all information in your tracking database.

5. If the individual is actively working with a case manager or another department within the agency, notify the case manager (via e-mail and/or telephone) about the contact.

6. Follow up for support group inquiries may be necessary depending on the situation. If follow up is appropriate to make sure that the concern was resolved, ADRC staff needs to pursue proper follow up. This may include, but is not limited to, calls to the initial contact, support persons, such as family, or the resource agencies.

Transportation

Procedure

1. Determine, from the inquirer, the nature of the transportation need.
- Medical Transportation (i.e. doctor, dental, eye care, etc.)
- Errand Transportation (i.e. grocery shopping, medication pick up, banking, etc.)
- Leisure Transportation (i.e. recreational activities, leisure shopping, family or friend visits, etc.)
- Other Transportation (any other transportation need, not listed above)

2. Determine what kind of hands-on assistance, if any, is required for the individual in need to enter a vehicle.
- No assistance needed
- Needs a "steady" arm to assist into and out of the vehicle
- Needs weight bearing assistance into and out of the vehicle
- Needs wheelchair lift

3. Determine the following about the individual in need:
- Demographics (name, address and phone number)
- Age

4. Research and discuss transportation options with the inquirer, based on the information received. Use the RESOURCE DIRECTORY database or the resource information located in the training manual to find applicable programs and services. Search for specific transportation programs, such as (in no particular order):
- Mass Transportation options (i.e. city bus, etc.)
- Private Company transportation options (i.e. taxi, etc.)
- Medical transportation options (i.e. EMS, ambulance, disease-related transportation programs, etc.)
- Senior Program transportation options
- Transportation Expense Assistance Programs

5. If the inquirer is interested in any of the programs discussed, offer additional assistance, such as:
- Assisting the inquirer with applying for a program, or if assistance is not needed, providing the appropriate paperwork to apply for a program, if that paperwork is available.
- If the paperwork to apply is not readily available, offer to contact the appropriate agency or person. This can be done by a three-way call, if the inquirer is a caller. If the inquirer is a walk-in, a call can be made using the speaker phone options so that all parties can communicate. If they do not desire additional assistance, provide them with the appropriate information required to make their own contacts.

6. Make sure that all available transportation options have been exhausted. Confirm with the inquirer that there is no other need or option to be discussed.

7. After the conclusion of the contact, document all information in tracking database.

8. If the individual is actively working with a case manager or another department within the agency, the active case manager and supervisor must be notified about the action taken (i.e. referred them to a transportation agency, signed them up for a transportation program, etc.).

9. Follow up may be necessary depending on the situation. If follow up is appropriate to make sure that the information given was appropriately handled, then proceed with proper follow up. This may include, but is not limited to, calls to family members, the individual seeking assistance or the referred agency.

Veterans' Benefits

Procedure

1. Determine if individual is a Veteran or the spouse of a Veteran.

2. If yes, refer individual to Utah Department of Veterans' Affairs at 801-326-2372. The current hours of this department are Monday-Thursday 7:00am – 6pm. The Department of Veterans' Affairs will help the individual to determine eligibility for a range of VA programs, including Aid and Attendance.

3. Ask the individual if he or she would like you to participate in the call. If the answer is "yes," either place the call in the presence of the individual, or place a 3-way conference call. When the call is placed, identify yourself and your organization, state that you are with an ADRC site, and explain your role in the planning process.

4. Ask if the caller would like a follow-up call from you after evaluating the eligibility for VA benefits.

5. Document all information in tracking database.

VA Facilities

VA **Medical** Center:
Salt Lake City 84148 (500 Foothill Drive, 801-582-1565 or 800-613-4012)

Clinics:
Fountain Green 84632 (300 W. 300 S., 435-623-3129)
Nephi 84648 (48 W. 1500 N., 435-623-3129)
Ogden 84403 (982 Chambers Street, 801-479-4105)
Orem 84057 (740 W. 800 N., Suite 440, 801-235-0953)
Roosevelt 84066 (210 W. 300 N. (75-3), 435-725-2082)
St. George 84770 (1067 East Tabernacle, Suite 7, 435-634-7608, Ext. 6000)

Regional Office:
Salt Lake City 84158 (P.O. Box 581900, 550 Foothill Dr., 1-800-827-1000)

Vet Centers: (outreach and readjustment counseling services – do not require enrollment in the VHA Health Care System)
Provo 84604 (1807 No. 1120 West, 801-377-1117)
Salt Lake City 84106 (1354 East 3300 South, 801-584-1294)


Utah
Aging & Disability
Resource Connection

Veterans' Benefits – Aid and Attendance

Procedure

1. Determine if individual is a Veteran or the spouse of a Veteran. A Veteran may be eligible for A&A when:

- The Veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself/herself from the hazards of his/her daily environment, OR
- The veteran is bedridden, in that his/her disability or disabilities requires that he/she remain in bed apart from any prescribed course of convalescence or treatment, OR
- The veteran is a patient in a nursing home due to mental or physical incapacity, OR
- The veteran is blind, or so nearly blind as to have corrected visual acuity of 5/200 or less, in both eyes, or concentric contraction of the visual field to 5 degrees or less.

2. If yes, refer individual to Utah Department of Veterans' Affairs at 801-326-2372. The current hours of this department are Monday-Thursday 7:00am – 6pm. The Department of Veterans' Affairs will help the individual to determine eligibility for Aid and Attendance.

3. Ask the individual if he or she would like you to participate in the call. If the answer is "yes," either place the call in the presence of the individual, or place a 3-way conference call. When the call is placed, identify yourself and your organization, state that you are with an ADRC site, and explain your role in the planning process.

4. Ask if the caller would like a follow-up call from you after evaluating the eligibility for VA benefits.

5. Document all information in tracking database.