ALZHEIMER'S DAY CARE RESOURCE CENTER

POLICY AND PROCEDURE MANUAL

CALIFORNIA DEPARTMENT OF AGING
LONG-TERM CARE AND AGING SERVICES DIVISION

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OVERVIEW

ADCRCs may operate within several different kinds of licenses: Adult Day Health Care, Adult Day Care, Adult Day Support Centers, Skilled Nursing, or other licensed facilities. ADCRC sites licensed in any category must comply with the conditions of such license and with the provisions of this manual.

The implementation, administration, and operation of Alzheimer's Day Care Resource Centers (ADCRCs) shall take place within the framework of the mission and goals established by the California Department of Aging (CDA) for this Program, as follows:

Mission of the California Department of Aging

With the enactment of Division 8.5, commencing with Section 9542, of the Welfare & Institutions (W&I) Code, CDA's mission shall be: To provide leadership to the Area Agencies on Aging and other providers in developing systems of home and community-based services that maintain individuals in their own homes or least restrictive homelike environments.

In fulfilling its mission, CDA shall develop minimum standards for service delivery to ensure that its programs meet consumer needs, operate in a cost-effective manner, and preserve the independence and dignity of aging Californians. In accomplishing its mission, the CDA shall consider available data and population trends in developing programs and policies, collaborate with Area Agencies on Aging (AAA), the Commission on Aging, and other State and local agencies, and consider the views of advocates, consumers and their families, and service providers.

MISSION STATEMENT FOR ADCRC PROGRAM

To promote the quality of life and dignity of older Californians with dementia by identifying and addressing issues related to dementia and providing leadership to integrate quality dementia day care services into the community-based system of care and to promote local involvement in policy and program development.

ADCRC GOALS AND OBJECTIVES

- Increase availability and accessibility of quality dementia day care for target populations and for underserved areas.
- Improve availability and access to Alzheimer's day care through continued program development that promotes quality of life for participants and their families.
- Collaborate with and provide technical assistance to other State departments that serve persons with dementia in any capacity.
- Integrate quality Alzheimer's day care programs into the statewide community-based system of care with participation of local and other State agencies through policy and program development.
- Provide dementia program therapies to encourage maintenance of daily living skills for participants and avoid premature institutionalization.
- Support caregivers through education, training, and respite.

LEGISLATIVE AUTHORITY

Welfare and Institutions Code, Chapter 7.5 (AB 2800), Mello-Granlund Older Californians Act.

Chapter 7.5, Section 9542(c), W&I Code, "The department shall adopt policies and guidelines to carry out the purposes of this chapter, and the adoption thereof shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code".

I. INTRODUCTION

The Alzheimer's Day Care Resource Center (ADCRC) program is an important component of California's emerging system of community-based and long-term care which includes such services as: Multipurpose Senior Services Program (MSSP), Linkages, Case Management Services, Adult Day Health Care (ADHC) Program, In-Home Supportive Services, Alzheimer's Disease Research and Care Centers, Caregiver Resource Centers, and many services funded by the Area Agencies on Aging (AAA) under authority of the Older Americans Act.

The primary activity of the ADCRC Program is the provision of quality day care for persons with dementia, while giving respite to their caregivers. In addition, the ADCRC program provides education and training for caregivers, professionals, interns, students, and members of the community about Alzheimer's Disease, and referral and support services to persons with dementia and their families and caregivers.

A. Purpose of Manual

The purpose of this manual is to provide AAAs and local ADCRC program staff with current State policies, procedures, and guidelines governing operations of the ADCRC program and to meet the legislated requirement to adopt policies and guidelines for the conduct of this program. (Section 9452(c) of the W&I Code.)

Those ADCRC sites licensed as ADHCs, Adult Day Care, Adult Day Support Centers, or who operate under the jurisdiction of other licenses, or who receive funding through Title III of the Older Americans Act, Medi-Cal, or other government sources, are subject to the provisions of those other licensing agencies or funding sources, in addition to these policies and procedures.

This manual is intended for use by AAAs, and staff of all ADCRCs. It is designed to provide information in a usable, accessible format so that all staff may effectively carry out local ADCRC operations.

B. Manual Use and Revision

This manual is incorporated by reference into the master CDA Community-Based Services Program contract for operation of an ADCRC. As such, its requirements are binding on all entities operating an ADCRC. However, providers must also abide by any applicable written policy that is issued subsequent to the printing of this manual. These are issued by CDA in the form of Program Memos (PM). This manual describes functional components of the ADCRC site and sets the base requirements for facilities, organization, staff, program, activities, fiscal process, and other procedures which affect the composition and quality of the program. This manual serves as a reference for policy and procedures to meet requirements for an approved ADCRC.

This manual was first produced with the origination of the ADCRC program in 1985, revised in 1988, 1992, 1997, and 2000.

C. History of Authorization for ADCRC Program

The ADCRC program was initially established by the Legislature as part of the Governor's Senior Initiative (Chapter 1600, Statutes of 1984) to serve persons with Alzheimer's Disease or other types of dementia and their families. In October of 1985, eight host agencies were funded in selected areas of the State as a three-year pilot project. The sunset date for the program was extended to January 1, 1995, by legislation (SB 1400). Subsequently, the sunset date was repealed by legislation, SB 1904, Statutes of 1994. Over the years, the number of sites has grown due to State budget augmentations:

- To 36 in 1989; and
- 10 sites were added in 1997.

An additional augmentation to the 1998-99 State Budget also funded the operation of 6 additional sites, for a total of 52 ADCRC sites statewide.

D. Purpose of Program

The ADCRC program was initiated to provide a meaningful experience for persons with dementia and to help meet the respite needs of caregivers. It was designed to provide a service for persons who frequently are not accepted by other service programs.

ADCRC primary objectives are to:

1. Prevent premature or inappropriate institutional placement of persons with dementia;

2. Assist dementia patients to function at the highest possible level;

3. Provide respite relief to families and caregivers, enabling them to continue caring for the person with dementia in the community;

4. Provide information, counseling, and care planning;

5. Establish and/or assist family support groups;

6. Provide training opportunities for students, professionals, and other persons providing care and treatment for this population;

7. Increase public awareness and knowledge about Alzheimer's Disease and related disorders through presentations, workshops, and dissemination of information and materials to families, caregivers, professionals, and the public; and

8. Serve as models of the optimum type and level of day care services needed by persons with dementia.

In addition, the ADCRC program provides education and training for caregivers, professionals, interns, students, and members of the community about Alzheimer's Disease and referral and support services to persons with dementia and their families and caregivers.

E. Participant Eligibility

Participants will have Alzheimer's disease or related dementia, with a majority in the moderate to severe stages of dementia. There are no age, financial, or other qualifications for eligibility to participate.

F. Services

Services may vary slightly from center to center, but each center will provide day care for persons with Alzheimer's Disease or related disorders; respite care for caregivers; counseling, support groups, and training for families and caregivers; training for center staff, professionals, students, and the general public; and public information concerning Alzheimer's Disease and other dementia.

G. Fees

Participants are requested to share in the cost of care through fees that are based upon the cost of services, with assistance for individuals who cannot afford the entire cost of the program.

H. Program Models

ADCRC programs utilize a variety of models to achieve the goals outlined in this Program Manual. The service model an ADCRC program chooses may be influenced by a number of factors, such as the physical site and licensure status. Many acceptable models exist, including, but not limited to, stand alone ADCRCs, ADCRCs that are partially or fully integrated with other programs (e.g., Adult Day Health Care), and ADCRCs which operate parallel to other programs. The original legislation, which established the ADCRC program, promoted innovation in services to Alzheimer's Disease patients. Consequently, ADCRC providers developed many effective service models.

II. THE STATE'S ROLE

State authority began in 1984 with the Alzheimer's Day Care Resource Center Pilot Project Act, amended in 1987 and amended again in 1988. At that time, administrative requirements were contained in Chapter 3.1, Section 1568 of the Health and Safety Code. Subsequently, in 1996, previous provisions were repealed and management responsibility of the ADCRC program for oversight of direct service contractors was redirected from the State to the local Area Agencies on Aging (AAA). The law provided that: "The participating AAA shall maintain the existing service arrangements during the 1997-98 and 1998-99 fiscal years. Effective in FY 1999-2000, the participating AAAs will competitively procure contracts according to their assessed need and locally determined priorities for service".

CDA responsibilities shall be to:

- Develop minimum standards for service delivery, considering available data and population trends in developing programs and policies;
- Provide technical assistance and training to AAAs, program managers, staff, and volunteers providing services;
- Maintain a clearinghouse of information related to the interests and needs of older individuals and provide referral services, if appropriate;
- Collect and report on specified data and eliminate redundant and unnecessary reporting requirements;
- Encourage and support the involvement of volunteers;
- Disperse needed information to the AAAs;
- Establish criteria for the designation, sanctioning, and defunding of AAAs;
- Adopt and promulgate regulations, policies, and guidelines to carry out the purposes of Section 9542 and Division 8.5 of the W&I Code;
- Review and approve the Community-Based Services Network component of the Area Plans of participating AAAs;
- Enter into contracts with AAAs to carry out specified requirements;
- Develop respective responsibilities for CDA and participating AAAs;
- Develop model language for AAAs for their procurement and contracts with direct service providers;

- Enforce statewide requirements to ensure compliance with statutes and regulations;

- Ensure the AAA Area Plan is economical and enhances benefits to consumers in areas without adequate supply of services;

- Adopt policies and guidelines to carry out the purposes of the ADCRC program specifications; and

- Monitor ADCRC direct services contract performance and ensure compliance with State and federal laws or regulations and nondiscrimination requirements.

III. AREA AGENCY ON AGING ROLE

A. Participating Area Agencies on Aging Administrative Requirements

AAA responsibilities shall be to:

- Contract with CDA to locally manage the community-based programs, including ADCRCs, in accordance with the requirements of Chapters 7 and 7.5 (commencing with Section 9540) of the W&I Code;

- Integrate the community-based services programs into the local area plan development process;

- Administer the program, including ongoing oversight, monitoring, and service quality evaluation to ensure that service providers are meeting standards of service performance established by CDA;

- Maintain existing ADCRC arrangements unless either a contractor terminates the agreement, CDA and the AAA terminate the agreement for legal cause under the terms and conditions of the existing contract, or if State funds cease to be budgeted for the specified services;

- Ensure, where the AAA proposes to redirect funding, that it has submitted its recommendations to a locally formed advisory committee, that shall include consumers of long-term care services, representatives of local organizations of seniors, functionally-impaired adults, representatives of employees who deliver direct long-term care services, and representatives of organizations that provide long-term care services. At least one-half of the members of the advisory committee shall be consumers of services or their representatives. In the case of redirection of funding, the AAA must submit an administrative action plan for approval by its governing board after considering the input received from the advisory committee, before submitting to CDA for final approval. Specific detailed program policy guidance concerning the redirection of these funds is found in PM 98-37(P).

  In addition, where the AAA proposes to redirect funding, an administrative action plan shall be developed by the AAA and shall receive the approval of the AAA's governing board, before submitting the plan to CDA for final approval.

- Determine, effective in Fiscal Year (FY) 1999-2000, which of the original (FY 1997-1998) community-based services programs, including ADCRC, will continue to be funded and the amount of funding to be allocated for that purpose;

- Provide directly, through contracts with other local governmental entities or through competitively procured contracts, the community-based services, including ADCRC programs;

- Relinquish, when required, funding originally contracted, and associated local management, to the long-term care integration pilot program;

- Appropriately expend and account for all funds and provide access to all program books of account and other records to State auditors;

- Comply with data collection and reporting requirements for the ADCRC as outlined in Program Memo (PM) 98-26(P) and PM 99-10(P). AAAs are required to report this data to CDA by the thirtieth day following each reporting quarter. Detailed transmittal reporting requirements are contained in PM 98-26(P) and PM 99-10(P); and

- Establish grievance procedures for situations in which ADCRC staff cannot resolve a grievance initiated by a participant, conservator, or other person (e.g., caregiver) who has the authority to act on behalf of the client.

IV. ADCRC ELIGIBILITY, GRANT, AND ASSESSMENT

A. Qualifying Criteria

To receive an ADCRC grant award, service providers shall meet the following criteria. Italicized statements that follow in items 1-14 are directly excerpted from the Older Californians Act, found in the W&I Code, Sections 9542, et seq.

1. Program for Special Needs

   Provide a program and services to meet the special care needs of, and address the behavioral problems of participants.

   Service providers shall identify the level and type of services needed by participants and provide an environment necessary to accommodate conditions associated with dementia.

   The standard for minimum operation of day care services is established at the level of at least five hours per day, three days a week.

2. Staffing

   Provide adequate and appropriate staffing to meet the nursing, psychosocial, and recreational needs of participants.

   Service providers shall demonstrate appropriate staffing mix to meet the health, psychosocial, recreational, and supervision needs of each participant and for the administrative agency needs. A minimum ratio of one staff to five participants, or optimally, one staff to three participants, including volunteer staff is recommended.

   Service providers shall develop, organize, and provide training for professionals and other persons caring for participants.

3. Facilities: Safety and Security

   Provide physical facilities that include the safeguards necessary to protect the participants' safety.

   California law prohibits locking doors of any program, unless specifically licensed as a locked facility.

   All ADCRC service providers must take precautions to minimize the consequences of wandering. To maintain a secure environment, ADCRC staff must protect participants from wandering away from the premises and becoming lost. This may be accomplished with the installation of an alarm system, buzzers or bells on doors, individual devices, enclosing outdoor areas, staff surveillance, etc.

becoming lost. This may be accomplished with the installation of an alarm system, buzzers or bells on doors, individual devices, enclosing outdoor areas, staff surveillance, etc.

Any system used to protect participants from wandering must be approved by the local Fire Marshal.

Persons with dementia are generally considered non-ambulatory in regard to safety in exiting a building. Any securities system or safety procedures should be designed to work with non-ambulatory persons, especially in cases of emergency that require rapid evacuation of a building.

4. Fee for Service: Assistance and Match

Provide a program for assisting individuals who cannot afford the entire cost of the program. This may include, but need not be limited to, utilizing additional funding sources to provide supplemental aid and allowing family members to participate as volunteers at the applicant's facility.

Service providers may use a sliding scale fee to charge for program services.

Service providers will use fees to offset the cost of operating the program.

Service providers are required to provide a match of not less than 25 percent of the contract amount consisting of cash or in-kind contributions, identify other potential sources of funding for the facility, and outline plans to seek additional funding to remain solvent. Client fees shall not be used for match. For additional guidance on the treatment of contributions and program income, see PM 99-02(P). The PM identifies "client fees" as the only program income generated by the ADCRC. Service providers are encouraged to earn income to defray program costs. The AAA does not, however, have authority over a contractor's expenditure of funds identified as "non-program" income as defined in PM 99-02(P).

5. Use of Volunteers

Utilize volunteers and volunteer aides and provide adequate training for those volunteers.

Volunteers add an important dimension to the participant's day, extend the effectiveness of the staff, acquire expertise about the disease and patient care/treatment, as well as offer a means of in-kind service for cost of care.

6. Support Groups

Maintain family and caregiver support groups.

Support groups have an important role in giving respite to the caregiver, improving the participant's home care, and extending the length and quality of time they are able to remain in the home. Support groups provide a time to share common problems, their own feelings and needs, exchange knowledge and care practices, and learn successful ways to handle the illness and related participant needs.

Service providers shall provide or assure the availability of support groups for families and caregivers.

7. Transportation

Encourage family members and caregivers to provide transportation to and from the applicant's facility for participants.

The time, expense, and special care required for contracted transportation often restrict the number of participants who can attend Alzheimer's daycare. Arranging for private transportation, when possible, makes it possible for the maximum average daily attendance at the ADCRC.

8. Level of Disability

Concentrate on participants in the moderate to severe ranges of disability, whose care needs and behavioral problems may make it difficult to participate in other existing care programs.

9. Meals and Snacks

Provide or arrange for a noon meal to participants.

The service provider shall provide a noon meal to participants, which includes one-third of the recommended daily allowance for older persons, as adopted by the Food and Nutrition Board of the National Resource Council.

Service providers may arrange to have the meal provided through contract by an organization that provides meals to the elderly or to those who are needy. Local requirements for food handlers and sanitary conditions must be met. Food services must provide for special needs of participants when medically necessary and ordered by a physician. These special diet menus shall be reviewed by a dietician who will ensure that the participant files contain the required physician's order.

10. Participation in Education Programs

Establish contact with local education programs, such as nursing and gerontology programs, to provide onsite training to students.

11. Referral to Other Resources

Provide services to assist family members, including counseling and referral to other resources.

12. Model Centers

Serve as model centers available to other service providers for onsite training in the care of these patients.

13. Outreach Activities

Involve the center in community outreach activities and provide educational and informational materials to the community.

Service providers shall disseminate information such as videotapes, brochures, and fact sheets to the public regarding Alzheimer's disease and other dementing disorders.

14. Data Capture

Maintain a systematic means of capturing and reporting all required community-based services program data.

15. Additional Criteria

In addition to ADCRC criteria identified above, other qualifying factors for an ADCRC program include:

- The quality of programming and care provided;
- Adequacy of space and of the physical plant;
- Safety and sanitary conditions; and
- Administrative capacity of the applicant.

B. Licensure Requirement

1. Exempt ADCRC Sites

Authorized ADCRCs are exempt from licensure requirements. Providers of dementia day care services are exempt from existing licenses generally applied to programs providing care and supervision to older persons, and they shall be subject exclusively to provisions of Chapter 7.5 and Section 9542(e) of the W&I Code.

Nothing shall prevent existing adult day care services, including Adult Day Health Care centers, from developing a specialized program under authorizing legislation. Applicants shall meet all of the requirements for direct service contractors, as described in Section A above in this chapter, and satisfactorily demonstrate that the direct services contract funding shall be used to develop a distinct specialized program for this target population.

Funding shall be used to develop a distinct specialized program for this target population.

a. Other Licenses

ADCRC sites licensed as Adult Day Health Care, Adult Care, Adult Day Support Centers, or who operate under the jurisdiction of other licenses or other government sources are subject to the provisions of those other licensing bodies.

Changes to current licensing status, including capacity, ownership, obtaining or terminating a license, etc., must be reported to the local AAA, no less than 30 days prior to the anticipated change.

C. Grant Award

1. Grant Term

Grant funds for one fiscal year, beginning July 1 of each year and ending June 30 of the next year, are contingent upon legislative authorization of funds through the budget act and satisfactory compliance with the terms and conditions of the grant by the grantee.

2. Selection Process

Distribution of grant funds will be made by each local AAA. The AAA will conduct the selection of ADCRC service providers using a competitive Request for Proposal (RFP) process. Evaluation of applicants is based on their ability to provide required program services.

3. ADCRC Allocation per site

a. Allocation Amount

As specified in PM 99-31(P), the ADCRC allocation per site (provided directly from the State allocation) is to remain "whole" since it represents a "minimum" base amount for an ADCRC site. It is essential that each ADCRC service provider have access to the maximum funding authorized in order to develop its service capacity

and expertise, as well as to ensure that plans to expend the allocation are consistent with the contractor's proposal. It is incumbent on the contractor to propose (through the local RFP process) plans to expend the total allocation. The AAA then evaluates, accepts, or rejects the contractor's proposal.

b. Satellite Sites

Although AAAs cannot mandate that a recipient of an ADCRC grant established a "satellite" site, the AAA may enter into a joint assessment, with the provider, regarding the feasibility of such an arrangement. A satellite configuration is permissible, if both the AAA and service provider agree to the satellite arrangement and assure that all required program service responsibilities and quality criteria will be met.

The satellite must also be an organizational part of the entity that has been awarded the ADCRC service contract, in order to ensure that the necessary authority exists to execute the overall plan. The ADCRC allocation cannot be divided for the purpose of subcontracting with other service providers who have separate organizational identities from the responsible contractor. As stated in preceeding a., the responsible contractor must have full access to the total ADCRC grant.

4. Contract Dispute

Any dispute regarding the procurement of, and the terms and conditions of the direct service contracts procured by the AAA shall be resolved locally, consistent with mandated provisions of the Older Californians Act. Any applicant believing that the AAA did not follow published procedures may request reconsideration of the selections made through the process established by the AAA.

5. Appeals Process

A hearing must be provided upon the request of either provider whose existing direct services contract is terminated prior to its expiration date or reduced in scope outside of the State or federal budget process, or any applicant that is not selected in a direct service contract procurement process due to the alleged presence of a conflict of interest, procedural error or omission in solicitation request, or the lack of substantial evidence to support the award.

6. Contract Terminated by ADCRC Service Provider/Discontinuing Care

If a service provider terminates its subcontract with an AAA, discontinuing services to ADCRC enrolled participants, the service provider shall submit a written plan to the AAA. This plan shall include the following:

a. Documentation that each participant's caregiver, family, legal guardian, or other responsible party was notified, in writing, of the intent to terminate services.

b. A written discharge plan for each participant, which includes the level of care each participant requires, and recommendations for continued care after the ADCRC terminates services.

c. A plan for the disposition of the ADCRC's health-related records.

The preceding (a-c) must be submitted to the AAA at least 30 days prior to the termination of services to ADCRC participants.

7. Grant Cycle

Each grant cycle begins at the time set by the AAA with the submission of a budget showing estimated costs of operation for the upcoming fiscal year. The budget is incorporated into a contract with a scope of work and terms and conditions, which must be signed by authorized personnel, at the grantee agency, and at the AAA, after which funds become available to the ADCRC on a reimbursement basis. The original proposal from the RFP is an element of the terms and conditions by reference.

8. Amendments

A letter requesting approval to amend the existing operating plan must be submitted to the AAA prior to making substantive changes. The AAA will respond to the proposed changes in writing, within 30 days of receipt.

Changes in name of the agency or ADCRC or any address for reimbursement and authorized signatures must be made in writing to the AAA.

Budgeted amendments through the AAA are discussed in Section XIII.

D. ADCRC Site Access

Authorized AAA representatives shall have the right to monitor and evaluate the performance of the grantee and to ensure compliance with the provisions of the

grant agreement. This includes, but is not limited to, audits, inspections of project premises, participant charts and files, inspection of food preparation, physical site as appropriate, and interviews with project staff and participants.

E. ADCRC Monitoring Visits by the Area Agency on Aging

An ADCRC monitoring visit will be conducted at least annually (or more often, as necessary) by the AAA, which has responsibility for the local ADCRC program. Notification of the monitoring visit will be scheduled at least 21 days in advance.

The purpose of the ADCRC monitoring visit is to:

- Assess ADCRC site and program operation and grant compliance as described in Exhibit A;
- Make recommendations that would enhance the performance of the program as described in Exhibit A under "Compliance Indicators";
- Assist in rectifying identified areas of concern;
- Provide technical assistance; and
- Assess physical plant safety

The document entitled "ADCRC Core Service Guidelines" provides standards and quality assurance indicators to be used when monitoring an ADCRC site. (Included as Exhibit A.) The guidelines consist of three categories: 1) Core Service; 2) ADCRC Compliance Indicators; and 3) Quality Indicators. The specified standards under "Compliance Indicators" must be reviewed at the time of monitoring the ADCRC program and activities. These "Compliance Indicators" are considered core program monitoring elements.

An ADCRC Monitoring and Assessment tool containing these Compliance Indicators is also included as Exhibit B. This tool is not a required tool, but all "Compliance Indicators" must be incorporated into a local tool, used to monitor the ADCRC. The last category, "Quality Indicators", provides helpful assistance from which to evaluate how well the local program is achieving a level of quality beyond the minimum compliance indicators. These "Quality Indicators" represent the areas for continuous program improvement.

After completion of the monitoring visit, the AAA shall share the results with the ADCRC in an exit interview. Within 60 days following the monitoring visit, the AAA shall provide results to the ADCRC in written form.

A corrective action plan responding to any identified areas of concern shall be returned to the AAA by the service provider no later than 60 days after receipt of the monitoring visit report. The AAA must monitor the corrective action plan to ensure appropriate follow through by the ADCRC. Additional time to correct areas of concern may be requested.

What follows in the balance of this Manual are the core operating standards for ADCRCs. These operating standards are reflected in Exhibit A, Alzheimer's Day Care Resource Core Services.

V. PHYSICAL PLANT

The ADCRC physical plant shall be maintained in good repair and adaptable to the proposed program, including meeting accessibility standards for persons with physical disabilities.

Attached as Exhibit C is a Physical Plant Evaluation Checklist entitled, "Creating a Supportive Environment in Adult Day Care," that is an excellent resource to guide facility space arrangement, design, and décor.

In addition to space requirements, the ADCRC shall:

- Be clean, in good repair, and free from health and safety hazards at all times;
- Be accessible to persons with physical disabilities, including at least one bathroom, all hallways, door entrances; and be well located;
- Have safe and adequate parking and passenger loading areas; and
- Have adequate heating and cooling systems, suitable furniture and space for program activities, and have a cheerful, pleasant, and attractive décor, creating a suitable setting for the participants.

A. ADCRC Site Location

The ADCRC shall determine the need for dementia day care in the local community and choose an accessible location considering the concentration of older persons, easy access, and suitable physical resources. The AAA shall conduct a site visit as part of the contract process.

B. Relocation

The ADCRC's sponsoring agency or grantee must notify the AAA in writing of its intent to relocate a program at least 60 days prior to actual relocation. The AAA may conduct a pre-evaluation visit to the proposed location prior to rendering final approval. If the ADCRC is licensed, the local licensing district office must also be consulted. The approved move will constitute an amendment to the ADCRC program operation plan. Written notification must include the following:

- Description of selected geographic service area, including census data of the services with age, minority, and poverty level data (if different than existing service area);
- A drawing or sketch of the design of the proposed physical plant with dimensions of all usable space, including a description of the outdoor space designated for use by the ADCRC program;

- Description of the safeguards which will be used to ensure participant safety related to exits, outdoor space, storage areas, glass patio doors, stairs or steps, passenger loading zones, kitchens, and bathrooms;

- Description of emergency and mass casualty plans;

- Description of any anticipated site renovations and costs. Description of any changes to program operating plan. Include increase or decrease in capacity, staff, volunteers, operational hours, etc.; and

- A budget amendment, if appropriate.

C. Fire/Sanitation

At a minimum, ADCRC providers shall maintain a valid fire clearance certification from local fire officials. Fire clearances shall be posted in a conspicuous location within the ADCRC, along with any other required licenses or certificates. Service providers will be responsible for any fees charged by local fire inspectors.

For ADCRC sites exempt from licensure, a fire clearance shall be obtained from the local fire marshal every three years, whenever a change in maximum occupancy is requested, or if an ADCRC is relocated. The AAA may require exempt ADCRCs to have an inspection at any time if there is sufficient reason to believe that a site has become unsafe. In such cases, the AAA will request an inspection directly from local fire officials.

D. Capacity

ADCRC program capacity is determined by the Program Director.

In establishing ADCRC program capacity, the types of daily activities planned, the number of persons who can safely be served based on the number of staff available, and other factors such as need for space for ambulation assistive devices must be considered.

Physical plant capacity is determined by the local fire inspector. ADCRC program capacity may be less than the physical plant capacity, due to program considerations.

E. Space Requirements

All ADCRCs must have space for the following:

1. Activity Space

   A large room that can accommodate more than one activity. ADCRCs that serve persons with both physical and mental impairments need room to conduct parallel programs for different levels of ability.

2. Quiet Space

A separate room or partitioned-off area for "time out", allowing a rest, removal from stimulation, calming down, or individual attention. This space may double as a private interviewing room for family members or caregivers.

3. Kitchen

Space and equipment to prepare or serve snacks and lunches is required. Kitchen space and equipment may be used for cooking activities and family support groups.

4. Bathroom

ADCRC sites shall have at least one handicapped accessible bathroom. If possible, bathrooms should include showers and storage space for personal clothing for participants. Laundry facilities are helpful (although not required) and work well when located close to bathroom facilities.

5. Storage Space

Space for ADCRC supplies, equipment, cleaning materials, games, prostheses, and personal belongings of participants, is essential to assure safety and minimize confusion and physical hazards. Sharp objects such as scissors, letter openers, knives, knitting needles, and crochet hooks should be placed out of the reach of participants.

Disinfectants, cleaning solutions, poisons, and other toxic substances, which could pose a danger to participants, shall be stored in a separate area and locked if necessary, and not accessible to participants. In addition, these items shall not be stored in food storage areas used by or for clients.

Medications should be stored in a locked area and shall be tracked for expiration date and for administration to participants.

6. Outside Space

The center should provide adequate outdoor space to accommodate walking, exploring, and exercising. Closures on gates should be approved by the local fire inspector.

7. Office and Staff Space

It is important for office space to be separated from group activities and for staff to have space available for paper work, breaks, etc.

F. Renovations

ADCRC funds can be used for site renovations. If additional changes are undertaken after program start up, the service provider should request approval from the AAA describing the proposed changes, the reasons for them, cost estimates, and the plan for ADCRC operations during renovation, at least 60 days prior to commencing renovations. The AAA shall respond within 30 days.

G. Maintenance

The site shall be maintained in a clean, safe, and sanitary condition at all times. Maintenance services and procedures for repairs should be established to ensure the safety and well being of participants, employees, and visitors.

H. Supplies

The program shall maintain, at all times, sufficient supplies for program activities, building maintenance, food handling, and participant care.

I. Equipment Purchased With Grant Funds

1. Reportable Property

   The acquisition of property purchased all, or in part, with grant funds must be reported to the AAA.

   Examples of reportable property include, but are not limited to, computers, refrigerators, medical equipment, video equipment, and furniture.

   The State reserves title to all State-purchased or financed property not fully consumed, unless otherwise required by federal law or regulations. Prior to disposal of any State-owned property, the service provider must obtain approval from the State, via the AAA, regardless of the acquisition value.

2. Property Reporting Procedures

   If purchase of equipment is a reimbursable item, the equipment will be specified in the ADCRC budget.

   Annually, with the closeout, the service provider will submit an inventory of property purchased fully or partially with funds awarded by ADCRC grant funds, using the Report of Property Furnished/Purchased with Agreement Funds (CDA 32).

3. Care and Use of Property

The ADCRC shall use the property for the purpose for which it was intended and exercise due care in the use, maintenance, protection, and preservation of property purchased with grant funds, and assume responsibility for its replacement or repair until final disposition of all property, as required by the State, via the AAA.

The service provider shall immediately investigate, and within five days, fully document the loss, destruction, or theft of such personal property.

The contractor may share use of the property and equipment or allow use by other projects with written approval of CDA, via the AAA. As a condition of the approval, CDA, via the AAA, may require reimbursement for its use.

Equipment or supplies acquired with grant funds shall not be used for personal gain or to usurp the competitive advantage of a privately owned business entity.

4. Disposal of Grant Purchased Equipment

The ADCRC service provider shall notify the AAA of the intent to dispose of equipment purchased with grant funds. The AAA shall obtain written authorization from CDA to sell or otherwise dispose of any grant purchased equipment, regardless of its acquisition value.

When no longer needed for its intended purpose, the contractor may, with written approval of CDA, via the AAA, use the property in the order listed:

- Another State program providing the same or similar service; or
- Another State-funded program.

Upon dissolution or completion of the project, the service provider shall provide a final inventory (CDA 32) to CDA, via the AAA. Within 120 days after termination or notification of dissolution or completion of the project, CDA, via the AAA, will issue written disposition instructions to the service provider.

VI. ADCRC SITE ADMINISTRATION

A. Governing Body

The governing body is responsible for signing the grant agreement and accompanying forms from the AAA and is required to provide a resolution approving the receipt of ADCRC funds for each fiscal year.

Nonprofit organizations formed for the purpose of operating ADCRCs should include persons on their board of directors who are knowledgeable about adult day care, social services, Alzheimer's disease and related dementia, ADCRC operations, associated legal issues, health care, and other relevant areas.

Multipurpose agencies may have boards with broader interests and expertise. Larger agencies may wish to develop an advisory body for their ADCRC program to help focus special knowledge on internal policies specific to the ADCRC program.

B. Confidentiality

ADCRC program staff have access to information about participants and caregivers, both written and verbal, from the participants, their caregivers, service provider agencies, and physicians. It is essential that participant/caregiver information be protected locally from inappropriate access by persons/organizations not directly involved in serving the participant or caregiver, and at the AAA or State level from individuals or persons not otherwise authorized. ADCRC staff must become familiar with the laws and regulations that protect confidentiality in licensed facilities.

Participants or their authorized representatives must sign and date an "Authorization to Release Records" form before the ADCRC may obtain medical or other necessary information. A signed release is valid for one year from the date of signature, at which time, a new release should be obtained or the existing one renewed by signing and dating. Participants and caregivers should be informed that although their signed consent is voluntary, it might be difficult to carry out the basic ADCRC services if necessary medical information cannot be obtained. These rules for obtaining signed releases also apply to providing information to others and/or to using photographs or names in news or other publications.

ADCRCs may not request or receive a blanket authorization or a blank release. Participants or their responsible representative must authorize the release of information to specific entities. Participant signatures may be accepted only if the participant can understand what he or she is signing.

Participants and/or their authorized representatives are entitled to access the participant's case records. While ADCRC staff are not obligated to provide free copies of participant information to the participant, it is suggested that information be provided to the participant or authorized representative to the maximum extent possible, when requested. However, the following exclusions apply:

- Information received from third party sources, such as psychological reports or reports of physical examinations, shall not be released without the knowledge and approval of the originating source;

- To help protect participant/caregiver privacy, the ADCRC shall:

  Not use any identifiable information concerning a participant/caregiver for any purpose other than carrying out their program responsibilities or statutory obligations. The participant's name and other identifying information (identifying numbers or symbols or other identifying characteristics such as fingerprints, voiceprints, or photographs) must be deleted from documents made available to the public; and

- Store confidential information in a locked or secured area.

C. Nondiscrimination

1. Service Provision

   ADCRCs shall accept persons on a nondiscriminatory basis. They shall provide equal treatment and services without regard to race, color, sex, sexual orientation, religion, national origin, or ancestry.

   Programs receiving federal funds through Medi-Cal or other resources must adhere to federal nondiscrimination requirements (Title VI of the Civil Rights Act).

   ADCRC service providers shall establish a nondiscrimination statement and post the statement in a prominent location.

2. Hiring Practices

   A Statement of Compliance (STD. 19) shall be signed each year as part of the grant renewal process, certifying that the ADCRC service provider will not discriminate against any employee, or applicant for employment, on the basis of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, sex, age, or sexual orientation.

D. Drug-Free Workplace

The grantee shall certify at each annual grant renewal that it shall comply with Section 8355 of the Government Code to provide a drug-free workplace.

E. Notification of Changes and Signature Authorizations

The ADCRC service provider must report to the AAA when the following changes occur:

- Host or site relocation;
- Appointment or designation of the executive director or site director;
- Change in the persons authorized to sign grants and invoices;
- Days and hours of site operation; and
- Licensing status.

F. Program Development and Operations

Although these program development activities will be ongoing throughout the duration of the program, activities 1, 2, 3, and 4 listed below, must be developed prior to provision of ADCRC services:

1. Long-Term Care Resource File

   ADCRCs must develop and maintain long-term care resource files in the most useful and economical form suited to their operations.

   Some form of general service directory can be found in virtually every community in California. Many of these directories contain fairly complete information about community-based long-term care services. The data in such directories can form the basis for, or supplement the data contained in the ADCRC resource files.

2. Plan of Operation

   It is the administrator's responsibility to develop, review, and maintain a current written plan of operation following the criteria outlined in the initial request for proposal.

3. Marketing and Outreach

   In order that ADCRC services are clearly understood and accepted by their communities, service providers are required to develop and maintain marketing plans that outline how they "sell" their product to the public. The plans shall include:

   - A description of how the ADCRC will make its services known to persons with dementia and their families, to referral agencies, and to members of the community;

   - ADCRCs may choose to conduct orientation sessions to introduce the ADCRC program to the community. Several different types of orientations have been utilized in the past, from focus group

discussions with senior citizens or Alzheimer's disease support groups to community-wide orientations;

- Public relations and outreach materials shall focus on describing what the ADCRC program has to offer to potential participants, providers, and the community that is unique and different from traditional adult day care programs; and

- Brochures that are developed must include reference to the ADCRC program. Brochures shall be submitted to the AAA following publication.

Marketing and outreach are complementary activities. Marketing educates, informs, and sensitizes the community and other service providers to the purpose, value, and availability of Alzheimer's Day Care. Outreach focuses on contacts with targeted populations such as existing dementia support groups, minority families, family caregivers, and other potential users of Alzheimer's Day Care. Outreach should also be targeted to referral sources such as doctors, case managers, discharge planners, and senior centers.

4. Volunteers/Student Interns

Section 9542 of the W&I Code requires ADCRCs to use volunteers. Service providers shall develop a volunteer plan, which addresses the following areas:

- Methods of recruitment and source of volunteers;
- Duties of ADCRC volunteers;
- Orientation of the volunteers;
- Supervision (by site and/or volunteer agency);
- Training (by whom and how often);
- Legal issues, if any (liability insurance, etc.);
- Method of reimbursement, if any (stipends, etc.); and
- Plan for implementation.

In addition, the ADCRC program is required to provide on-site training to student interns from local universities and community colleges.

5. Emergency Plans

a. Disaster and Mass Casualty Plan

Each ADCRC must have a written plan for emergency preparedness, including evacuation in the event of fire, earthquake, or other potentially life threatening disaster, taking into consideration that many participants would be too confused to follow verbal orders, necessitating their being led to safety. This may require

some innovative approaches, such as use of volunteers or neighbors to assist. Planned use of outside persons should be prearranged.

The plan should include provisions to care for mass casualties, which ideally would include collaboration with local hospitals. Fire and evacuation drills should be conducted and documented periodically with staff and participants. Local fire departments are willing to assist local ADCRCs in making evacuation plans and providing related information. Service providers shall determine their relationship to any civil defense or disaster plan in place for their geographic area.

An evacuation plan must be posted in each room in addition to visual signs such as directional arrows.

b. Planning for Individual Participant Emergencies

Any participant may choke, suffer a fall, experience a seizure, or develop any number of symptoms requiring emergency assistance. The ADCRC program director must have a formal system for the provision of emergency care for individual participants.

Changes to the emergency plans must be submitted to the AAA, for review and approval, 60 days prior to the proposed date of change.

c. Staff Preparedness

At a minimum, one staff person who is trained in cardiopulmonary resuscitation (CPR) and basic first aid should be present when there are participants on the premises. Program staff members shall receive basic first aid training and CPR training. Staff shall be taught to observe unusual behaviors that might indicate the development of a potentially serious problem.

d. Participant Emergency Information

The ADCRC site director must have in place an easily located emergency file of information on each program participant. This file should include exact data on:

- Height;
- Weight;
- Sex;
- Color of hair and eyes;
- Noticeable identifying feature(s) or characteristic(s);
- Use of eyeglasses or prostheses;

- Emergency contact person (it may be someone other than the primary caregiver);
- A recent photograph;
- Allergy history;
- Pertinent medical information;
- Physician's name and telephone number; and
- Regularly taken prescriptions or over-the-counter medications.

This file shall also note if the participant wears a Medi-alert or other identification bracelet.

e. Lost Participant

Each ADCRC shall have in place a written plan of action that can be implemented immediately should a participant wander away from the ADCRC site and become lost. The AAA shall be notified within 24 hours of the lost participant, which can be done by telephone or in writing. This notification shall contain the information required for the "Unusual Incident Report."

f. First Aid Kit

A complete first aid kit shall be maintained and be readily available in a specified location in the facility (ADCRC site). The kit shall be a general type approved by the American Red Cross and include a current edition of a first aid manual approved by the American Red Cross, the American Medical Association, or a State or federal health agency.

g. Insurance Requirements

Insurance requirements that apply to all Community-Based Services Programs, including the ADCRC, are contained in the terms and conditions of the CDA/AAA Master Contract for governing the provision of all these Programs.

h. Budget and Closeout

An annual budget and a closeout report are also required for each year of operation. These fiscal requirements are discussed further in Section XIII.

i. Personnel

(1) Personnel Policies

Each employee must be informed of and receive a current copy of the local ADCRC's personnel policies, and receive a current duty

statement at the time of employment. Personnel policies should include the following:

- Philosophy of the organization;
- Recruitment, hiring, evaluation, and dismissal procedures;
- Pay practices, including deductions;
- Sick leave, vacation policies, and other benefits;
- Hours of work and duty statements; and
- Drug-free workplace adherence.

(2) Personnel Records

Personnel records shall demonstrate adequate staff coverage necessary for ADCRC operation by documenting the staff hours actually worked. A file for each staff member of an ADCRC should be maintained in a secured location containing information related to the following:

- Employee's full name;
- Social Security number;
- Date of employment;
- Written verification that employee is at least 18 years of age, including, but not limited to, a copy of his/her birth certificate or driver's license;
- Current home address and telephone number;
- Educational background;
- Past experience, including types of employment and former employers;
- Type of position for which employed at the ADCRC and current duty statement;
- Worker's Compensation information (kept in a separate file);
- Verification of training completed;
- Periodic evaluations by supervisor;
- Emergency contacts;
- Termination date, if no longer employed by the facility;

- Reason for leaving; and
- Evidence of acceptable TB test within 7 days of appointment.

j. Participant Records

ADCRC programs shall securely maintain a record for each program participant. The participant record shall include, but is not limited to:

- Admission agreement;
- Application forms;
- Intake/Screen and Functional Assessment Information;
- Care plan;
- Medical history, including physician's diagnosis;
- Evidence of tuberculosis screening which has been completed within one year prior to admission;
- Fee determination sheet;
- Service contract;
- Current photograph of client;
- Complete signed authorizations for release of medical information and photos, as appropriate;
- Participant-related correspondence;
- Where appropriate, medical information sheet, documentation of physician's orders, treatment, therapy, and medical notes;
- Daily progress notes;
- Emergency contacts; and
- Personal rights.

k. Management Information System (MIS)

Information pertaining to the data layouts required of all Community-Based Services Programs is included in PM 98-26(P) and PM 99-10(P).

l. Records Retention

The retention of ADCRC records is governed by:

- good business practice;
- policies of the host agency;
- contract provisions; and
- policies of licensing and funding sources (e.g., federal, State, or AAA policies or specific program policies).

Participant Records

Original copies of documents used for client specific information, including the Folstein Mini-Mental Status Examination (Exhibit D), must be retained for a maximum of 7 years by the service provider.

m. Records Disposal

(1) Confidential

Confidential forms that need disposal must be shredded or otherwise disposed of in a way to protect all confidential information.

(2) Non-confidential

Fiscal and other non-confidential forms may be disposed of in accordance with each agency's standard practice.

VII. STAFFING

A. Ratio of Staff to Participant

ADCRCs shall operate at a minimum ratio of one staff to five participants, or optimally, one staff to three participants, including volunteer staff, depending on the severity level of participants. To ensure a safe and therapeutic program and to care for those participants who may need one-on-one attention to intervene or divert problem behaviors, two staff persons should always be in the room with participants. There shall also be sufficient staffing to prevent staff exhaustion and turnover. As the number of participants and level of severity and functional impairments increase, the staff/participant ratio should be adjusted accordingly.

B. Personnel Qualifications, Job Descriptions, and Duties

Adequate and appropriate ADCRC staff shall be hired to meet the health, psychosocial, and recreational needs of the participants of the program. Each service provider must maintain current job descriptions of all staff. Job descriptions must include time-base and employment categories.

Staff may be employed full-time, part-time, or through a contract. In the event that other program staff or facility services are used to augment the services at the ADCRC, the staffing plan should describe this arrangement and include a copy of the memorandum of agreement authorizing the arrangement.

There must be at least two responsible persons at the ADCRC during all times that participants are present. One shall be a paid staff member. The ADCRC Site Director must designate qualified staff to assume supervision of the site in his or her absence.

While individual ADCRCs have discretion in determining the appropriate mixture and level of staffing, the following minimum is recommended:

1. Executive/Site Director

    a. Qualifications

        The Executive/Site Director must be, at a minimum, able to supervise paid personnel and volunteers; be knowledgeable about basic office procedures, administration, and personnel activities; have fiscal and budgeting experience; have experience with grants and fund raising; be proficient in community relations and coordination; have experience with outreach and marketing techniques; have demonstrated aptitude for working with caregivers, seniors, disabled, and/or demented persons. Experience in adult day care, or working specifically with persons with dementia, is preferred. A person with a master's degree in a human service field, or equivalent, is desirable.

The Director must be knowledgeable about participant transfer and have a valid driver's license.

b. Executive/Site Director--Job Description

The Executive/Site Director will be responsible for daily operation of the ADCRC. The Executive/Site Director reports to the ADCRC's Board of Directors. Responsibilities appropriate to this position shall be assigned to the Executive/Site Director in accordance with the organizational structure of the ADCRC and the host agency for the ADCRC Site.

c. Duties

The Executive/Site Director will maintain responsibility to carry out or delegate to staff responsibility for the following:

(1) Administrative and Personnel Responsibilities include:

- Supervising program staff;
- Hiring of staff other than the Executive/Site Director;
- Conducting written annual evaluations of staff and administration of probationary reviews for newly hired employees;
- Overseeing the administration of fringe benefits;
- Developing and maintaining site and personnel manuals;
- Attending Board of Directors' meetings and maintaining board membership roster;
- Conducting orientation and training for newly hired staff;
- Overseeing the recruitment, training, and supervision of volunteers; and
- Termination of staff, when necessary.

(2) Record Keeping Responsibilities include:

- Overseeing all data and reports required by the Board of Directors;
- All funding sources including foundations, State and federal government agencies, and other funding sources;
- Attendance records for participants;

- Employee records;
- Supportive records (schedules, training hours for volunteers, interns, students, etc.);
- Approving and signing staff time cards;
- Overseeing telephone log;
- Overseeing client behavior/problem log;
- Completing outreach reports; and
- Ensuring timely completion and transmission of program activity reports.

(3) Program Management Responsibilities include:

- ADCRC client intake;
- All required program activities including transferring participants;
- Client assessment or reevaluation, as required;
- Maintaining client records, care plans, and emergency records;
- Terminating inappropriate clients from program participation;
- Administering required measurement instruments;
- Establishing and maintaining program schedule; and
- Overseeing the meal program, transportation services, if provided, planning for terminating and discharging program participants.

(4) Budgeting and Fiscal Responsibilities include oversight of:

- Maintenance of all accounting records for money received;
- Individualized records of client fees and implementation of fee schedule;
- Reconciliation of expenditures, receipts, and deposits at the close of each month;
- Submission of accurate and timely end-of-month reports;

- Regular submission of bank deposits;

- Acts in compliance with contents of contracts and program budgets and has overall responsibility for carrying-out terms and conditions of AAA/ADCRC contracts; and

- Accountability for all purchases, including supplies and equipment.

(5) Community Relations, Coordination, Outreach, and Marketing Responsibilities include:

- Maintaining a liaison with all dementia, long-term care, and agency providers;

- Maintaining a liaison with adult education entities, such as community colleges and universities and meal program providers;

- Overseeing the site transportation program and liaison with law enforcement agencies;

- Coordinating, marketing, and conducting outreach efforts in support of program referrals;

- Developing an ADCRC center brochure; and

- Developing and maintaining an ADCRC center mailing list.

(6) Fund Raising and Grant Responsibilities include:

- Identifying funding sources;

- Submitting fund raising proposals; and

- Overseeing fund-raising activities.

(7) ADCRC Responsibilities for Executive/Site Director include:

- Serving as liaison to the host agency;

- Building (site) security oversight;

- Overseeing physical appearance of program location;

- Overseeing physical plant maintenance; and

- Other duties as assigned.

(8) Professional Staff requirements

Sufficient professional staff shall be available to properly conduct activities such as participant assessments, care plan development, family counseling and support groups, the specified physical exercise program, and dementia activity program. These professionals may include health professionals, social workers, and miscellaneous therapists as needed.

2. Activity Coordinator

a. Qualifications

The Activity Director shall have a working knowledge of Alzheimer's Disease and related dementia, be experienced in organizing activities and supervising other staff, obtain and maintain current CPR and First Aid certificates, and have a demonstrable aptitude for working with older individuals, persons with disabilities, or dementia.

b. Activity Coordinator--Job Description

The Activity Coordinator has primary responsibility for developing and implementing a structured daily activity program and planning and organizing events. This person may assist in ensuring on-going care and personal hygiene of participants, the coordination of program leaders and volunteers, and may also serve as an assistant to or substitute for the Director.

c. Activity Coordinator--Duties

Appropriate duties for the Activity Coordinator include the following;

- Working with the Director to complete daily paperwork;
- Ordering lunches and snacks;
- Collecting and recording fees;
- Preparing daily schedules;
- Maintaining telephone log;
- Maintaining client behavior/problem log;
- Supervising overall program to ensure that all participants remain inside designated areas;

- Helping to set up and serve lunches and snacks;
- Supervising mealtime activities and assisting with feeding/clean up;
- Providing program administration on behalf of the Site Director when absent;
- Opening and closing premises, when necessary;
- Monitoring behavior of participants - wandering, disposition, etc.;
- Planning, organizing, and conducting follow up of special events and parties;
- Assisting in bathing, showering, toileting, and basic personal care and hygiene of participants; and
- Performing other duties as assigned.

Nursing Staff

A nurse or comparable health professional should be on staff, on call, or available for consultation, to assist with medication and health needs of ADCRC site participants. The health professional shall prepare and conduct in-service training for other staff concerning useful health and medical information. Development of a policy for handling of medications shall be the responsibility of the Site Director in consultation with a qualified health professional.

3. Program Aide/Specialist

a. Qualifications

A Program Aide/Specialist should demonstrate aptitude in working with persons suffering from Alzheimer's Disease and other related disorders. A Program Aide/Specialist must obtain and keep current CPR and First Aid certificates and attend training and in-service sessions. A Program Aide/Specialist must be responsible and work well with other staff and site participants.

Experience in working with older individuals, persons with disabilities, or those with dementia, is preferred.

b. Program Aide/Specialist--Job Description

The Program Aide/Specialist will provide personal care for participants in the program and assist other staff with daily activities and meals.

c. Program Aide/Specialist Duties

Appropriate duties for a Program Aide/Specialist include:

- Setting up room for the daily program;
- Maintaining neatness and order in rooms;
- Assisting participants to and from their cars;
- Assisting participants with personal care, toileting, and transfer;
- Organizing and distributing lunches and snacks;
- Assisting participants with eating and clean up;
- Helping program leaders and staff with daily activities;
- Assisting Activity Coordinator with special events/parties;
- Taking participants for outside walks;
- Keeping Director and Activity Coordinator informed of needed supplies;
- Socializing with participants;
- Monitoring behaviors of participants - disposition, wandering, etc.;
- Helping maintain behavior/problem log and client files;
- Supervising overall activities to ensure that participants remain inside designated areas;
- Opening and closing premises, when necessary; and
- Performing other duties as assigned.

4. Volunteers

Volunteers with special skills may be of great assistance and support to ADCRC site participants. These skills may include musical talent, specialties in gardening, art, crafts, cosmetology, massage, or other skills.

a. Volunteer Qualifications

Volunteers should show concern for and interest in older people and have the ability to work cooperatively with the program staff and other volunteers.

b. Volunteer Job Description

Volunteers may be of great service in all aspects of the ADCRC program. Volunteers in the day care setting will work under the supervision of the Volunteer Coordinator, the Activity Coordinator, or other designated staff.

Volunteers should be individuals or groups who desire to work with Alzheimer's participants. Volunteers can supplement the program in many ways, including clerical or reception support, one-on-one interaction with participants, assistance with activities, outreach, telephone reassurance, entertainment, and professional services. Individual volunteer duties, to be performed under the supervision of a staff member, should either supplement staff in established activities or provide additional services for which the volunteer has special skills or knowledge. Volunteers should take part in program orientation and training.

VIII. ADMISSION AND PARTICIPATION

A. Eligibility

The ADCRC program is primarily designed to serve persons in the moderate to severe stages of Alzheimer's disease or related disorders, whose care needs and behavioral problems make it difficult for them to participate in other care programs.

Each ADCRC should develop a written policy describing participants who are appropriate and those who may not be appropriate for enrollment in their particular ADCRC. This policy should be consistent with statewide policy and discussed with the applicant, and family or caregiver, at the time of admission.

Eligibility for participation in the ADCRC should be established based on:

- Medical diagnosis of dementia; and
- Functional and cognitive assessments completed as part of the screening and intake process.

B. Participant Rights

The personal rights of all participants shall be protected by the service provider, including, but not limited to:

- Being accorded dignity in personal relationships with staff, residents, and other persons;
- Being accorded safe, healthful, and comfortable accommodations, furnishings, and equipment;
- Being free from any type of punishment, humiliation, intimidation, mental abuse, or other actions of a punitive nature;
- Visiting the ADCRC prior to admission, along with family or other responsible persons; and
- Wearing his/her own clothes and using his/her own personal possessions as appropriate.

The ADCRC should develop a personal rights statement, advise all participants and caregivers of the personal rights, and provide a copy to the caregiver at the time of admission. The statement should be signed by the participant, if he/she is able, or by the participant's authorized representative. A copy should be kept in the participant's file at the ADCRC.

C. Fees

The ADCRC shall establish the cost of services provided for participants. The ADCRC shall inform the applicant and family member, caregiver, or authorized representative of the cost of services, and charge the applicant a fee to pay for all or part of the cost of services, as established by the ADCRC.

The applicant's fee shall be based upon the applicant's ability to pay. No applicant shall be denied admission to the program because the applicant is unable to pay the entire cost of services.

ADCRCs located in ADHC licensed centers may bill Medi-Cal for those participants who meet all Medi-Cal eligibility requirements.

ADCRCs shall develop a written subsidy plan to assist individuals who cannot afford the entire program cost.

ADCRCs shall establish a mechanism (e.g., sliding scale, scholarship program, etc.) to reduce fees for those individuals who are unable to pay the full cost of services.

ADCRCs shall establish a method for fee determination that takes into consideration available participant resources only. ADCRCs shall develop a written subsidy plan to assist individuals who cannot afford the entire cost of services. As part of the subsidy plan, the ADCRC may allow a family member, caregiver, or authorized representative to participate as a volunteer in lieu of fee payment.

Families, caregivers, or authorized representatives may be asked to sign a statement or agreement indicating they will contribute to the participant's share of cost of day care services. Method and time of payment shall be negotiated with each family, caregiver, or authorized representative.

If payment of the agreed fee is not forthcoming, the ADCRC should make every attempt to discuss the matter with the family, caregiver, or authorized representative to determine the reason. Staff may also attempt to negotiate for a different payment schedule or reduced fee. Participants may be terminated due to failure to pay the agreed upon fee, after all negotiating and collection attempts have failed.

D. Admissions Process

At the time of enrollment, ADCRCs may wish to have a specific enrollment or admissions agreement with families to assure understanding of ADCRC operations, fees, and other provisions. Such agreements are the responsibility of each ADCRC and, at a minimum, should include participants' rights, grievance procedures, and termination/disenrollment information.

ADCRCs shall establish policies consistent with their licensure status regarding "Do Not Resuscitate" (DNR) or "No Code" orders. ADCRCs that are licensed by the Department of Social Services or operate under the ADCRC licensure exemption are considered non-medical facilities and, therefore, cannot comply with DNR or "No Code" orders.

Participants must be informed that the ADCRC cannot participate in or recognize "DNR" or "No Code" orders. For such orders to become effective, caregivers must directly contact the Emergency Medical Services and local medical facilities, informing them of the existing "DNR" or "No Code" directives.

Applicable laws and regulations do, however, allow ADCRCs that are integrated with ADHCs to establish policies that respect "DNR" or "No Code" orders.

ADCRCs shall review their policies regarding "DNR" or "No Code" orders with participants and/or their caregivers at the time of admission.

1. Inquiry/Intake Screening

   Inquiry or intake is the point-of-entry into the ADCRC program. This is the introduction to the program for potential participants as well as referral agents.

   ADCRC staff carrying-out the inquiry/intake function will be responding to inquiries from a variety of sources, each one unique in terms of purpose and need. For example, a family may require more patience, explanation, and interviewing skills than a service provider who is referring a potential client to the program. In addition, certain other inquiries will be from people who are simply interested in receiving information.

   Although no minimum requirements are imposed in terms of level of education or academic discipline for staff responsible for the inquiry/intake function, staff members performing these functions shall be able to respond to all inquiries in a patient, friendly, and informative manner. Staff conducting the screening for this program needs basic interviewing skills, training, and experience in working with persons with dementia. Screening staff should understand common characteristics and behaviors associated with Alzheimer's Disease and related disorders and be familiar with caregiver issues.

   If the screening process indicates that a potential participant may be eligible for other needed community programs, he or she should also be referred to the appropriate resource.

2. Home Visit

   A visit to the applicant's home is optional, but recommended. ADCRCs may wish to make a home visit to better understand how the applicant

functions at home, together with the needs of the family and the environment in which they live. Home visits may also be used as an opportunity to train caregivers on behavior management techniques, safety, and environmental modifications. If home visits are made, they should be recorded in each participant's file and the information gained should be used to enhance care planning.

3. Functional and Cognitive Capacity

a. Functional Assessment

The ADCRC program requires that an assessment be made of each participant's functional ability. Functional assessments are essential in order to provide individualized, effective and high-quality care, and to measure individual functional capacity.

b. Cognitive Assessment

The Folstein Mini-Mental Status Exam (FMMSE) (Exhibit D) is an examination nationally recognized and most commonly used to evaluate cognitive function. The results of this test are retained at the ADCRC, with the participant records, only as sensitive and confidential information. Administration of the Mini-Mental Status Exam is required:

- To enhance the information available to ADCRCs to determine the severity of each participant's cognitive impairment and care needs; and

- To provide ADCRCs with a consistent method of evaluating the cognitive impairment of participants and to provide a means of evaluating changes in functioning. This gives a better basis for exchanging information between ADCRCs when needed, it is consistent with the Alzheimer's Research Care Centers (ARCCs) as they refer persons for day care, and it will provide baseline information for the potential use of researchers who may evaluate outcomes within the day centers.

The FMMSE shall be completed as follows:

- At intake;

- At reassessment; and

- Whenever deemed necessary to help evaluate marked changes in participants' capacity or behavior.

Behavioral symptoms (e.g., agitation, anger) or increasing cognitive impairment may interfere with administration of the FMMSE. When it is not possible to administer the FMMSE, this should be noted in the participant's file.

E. Reassessment

Formal reassessment occurs six months after the initial assessment or whenever the participant's situation changes markedly. If a reassessment occurs prior to the sixth-month reassessment date, a new reassessment date should be established six months from the latest assessment.

Utilization of the Intake Screen (CDA 100) and the Functional Assessment (CDA 200) forms is optional. If other assessment forms are used, they shall contain all required elements indicated on the intake and functional assessment forms.

F. Termination and Disenrollment

The ADCRC shall develop a written policy that outlines the conditions and circumstances that would result in the termination of a participant from the program. A termination is an act initiated by the ADCRC to discharge a participant from the program. A disenrollment is the discharge of a participant from the program that is initiated by the participant or by the participant's conservator or person who has the authority to act on behalf of the participant. Persons who have the authority to act may include the participant's spouse, relative, or designated caregiver or caregivers.

1. Termination

Participants who may be considered appropriate for termination from the ADCRC program include persons whom:

- Become bedridden or require care and/or services not offered by the center;
- Are unduly disruptive and threaten the safety and well-being of themselves or others;
- Have no established diagnosis of Alzheimer's Disease or related dementia after three months of enrollment ;
- After three months of enrollment a functional assessment indicates no further need for the program; or
- Require nursing home or other institutional placement.

The ADCRC service provider policy should include a reasonable period between notice of termination and the actual discharge date, and provide for a work plan to work with caregivers to plan for alternative care arrangements. Every effort should be made to discuss the nature of the termination with the caregiver and provide referrals or help to develop alternative plans for care of the participant.

If an ADCRC determines it necessary for the participant to be terminated within two weeks or less, the participant, family member, caregiver, and/or authorized representative will be provided the reasons and date of termination in writing, and a copy shall be retained in the participant's file.

If extreme situations make it necessary for the participant to be discharged as soon as possible, the participant is entitled to a formal Notice of Action (NOA), which must be mailed before the date of discharge. This NOA should contain a two-week advance notice, when possible, sent to the authorized representative or caregiver. Exceptions to a two-week notice include instances of health and safety for participant and others. The ADCRC is responsible for preparing this NOA in writing and retaining a copy in the participant's file. The notice should specify why termination is occurring.

2. Disenrollment

Reasons for disenrollment include a person moving away from the ADCRC catchment area, choosing to leave the program, or dying. For participants who choose to be disenrolled from the program or are disenrolled by their authorized representative or caregivers, discharge may take place any time after the ADCRC has been notified. No formal written notice or waiting time is required. However, reason(s) for the disenrollment may be requested.

G. Grievance Procedures

ADCRC participants or their caregivers have a right to file a notice of grievance if they believe they have been wrongfully discharged or if they are dissatisfied with services received at the center.

Each contractor shall establish procedures for the resolution of complaints from participants or the participant's authorized representative. The complaint resolution procedures shall be consistent with the procedures required of the AAA in CDA's regulations, Title XXII, Section 7400 et. seq., of the California Code of Regulations. The procedures shall be posted in a conspicuous location for review and the contractor shall ensure that the participant or the participant's authorized representative is aware of the procedures.

1. ADCRC Site Grievance Procedures

Each ADCRC shall establish its own grievance policies and procedures. Such procedures shall be posted in a conspicuous location available for review by the family, caregivers, and participants.

Procedures must include resolution and notification of response to participants and their caregivers within 30 days. In addition to local grievance procedure notification, ADCRCs are responsible for informing participants and their caregivers regarding the recourse on an ADCRC decision by use of the AAA Grievance Procedure. The first step in the grievance process is attempting to resolve the problem at the ADCRC level. The AAA will become involved in the grievance process only after all remedies have been tried and the local ADCRC grievance procedure has failed to resolve the issue. For those issues that cannot be settled at the ADCRC level, the grievant should be referred to the local AAA.

The ADCRC shall make private space available for an Ombudsman to visit a participant, if needed.

IX. PROVISION OF SERVICES

The Statute (W&I Code, Chapter 7.5), requires all ADCRCs to:

- Concentrate on serving participants in the moderate to severe ranges of Alzheimer's Disease or related dementia;
- Provide services and programming to meet the health, psychosocial, and recreational needs of these participants;
- Provide a noon meal to participants. ADCRCs may arrange to have the meal provided by an organization which supplies the elderly with meals;
- Provide services, including counseling and referral to other resources, to family members and/or caregivers of dementia participants;
- Establish family and caregiver support groups;
- Train professionals involved in nursing, gerontology, and other related fields;
- Serve as model centers available to other service providers for on-site training in the care of patients suffering from dementia; and
- Engage in community outreach activities and disseminate educational and informational materials to the community.

A. Participant Care Plan

For each participant there shall be a written individual plan of care developed, based upon functional capacity and services needed, and available within the context of the day care program and its resources. Care plans shall be developed by the staff person conducting the participant assessment, or by an ADCRC team composed of several persons who work with the participant, such as a social worker, health professional, therapist, activity coordinator, and program aides.

Care planning should include multidisciplinary input. The participant, family/caregiver, and other service providers (when appropriate) should be given an opportunity to contribute to the care plan development, implementation, and evaluation to the extent possible, considering:

- Participant demographics of age, sex, marital status, living environment;
- Functional abilities of physical and mental Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL), mental status, emotional state, behavior patterns, and capacity for cooperation;

- Status of health problems, medications, physical disabilities;
- Social factors of relationships with family; and
- Capabilities of participant strengths, interests, skills, knowledge, capacity to respond, and interact.

The goal of the care plan is to sustain optimum functioning of the participant as the disease progresses. The written care plan shall reflect the participant's strengths, needs, and problems.

Each care plan should include:

- Identified service needs;
- Time-limited, measurable goals and objectives of care for the participants;
- Services to be provided by the center or other sources to achieve those goals and objectives and schedule for delivery to the participant;
- The staff responsible for implementing elements of the plan;
- Regularly recorded activities and outcomes observed in participant performance every six months;
- Documented observation should be discussed at reassessment or when participant needs change; and
- A record of actions taken to implement the plan.

Activity planning should be an integral part of the total care plan for the participant and should reflect professional understanding of the needs and abilities of that participant. Activities should emphasize strengths and abilities of each participant rather than impairments and should contribute to the participant's feelings of dignity, competence, and accomplishment. The individual care plan should be reviewed and updated every six months along with the reassessment. A care plan can be revised at any time it is deemed necessary due to changes in the participant's performance and capability. Such changes should be noted on the plan and in the narrative.

As part of development of care planning activities, it is important for the Program Director to review the care planning process to determine both its usefulness and effectiveness. Changes may be desired in the procedures followed, expectations, and assignment of activities to the participant or monitoring of outcomes. The following criteria will help evaluate the care plan:

- Are the problem areas clearly identified and easily understood by anyone reviewing the care plan?
- Are the proposed activities responsive to more than one problem area?
- Are the proposed activities balanced in relationship to the participant's physical, cognitive, social, recreational, and emotional needs?
- Are all problem areas addressed in the proposed activities?
- Are expected outcomes realistic?
- Does the plan require the cooperation of the caregiver?
- Does the service provider have the capacity to carry out the care plan?

B. Planned Activities

ADCRCs must conduct dementia appropriate, specifically designed activities related to social, cognitive, and physical functioning, as well as ADLs/IADLs that maintain the dignity of each individual and use available skills and knowledge.

Activity coordinators shall identify ways in which to enhance activity programs in a variety of settings. The program should encompass both multi-level activities and parallel programming in order to address the varying mental and functioning levels of the participants.

The daily program shall include activities that are matched to the person's impairments, strengths, and interests and that provide opportunities for successful participation. These activities should include sensory, cognitive, and perceptual stimulation. Music for singing, dancing, and enjoyment should be an integral part of the activity plan and is an important element of many different activities.

Service providers should ensure that the individual's care plan for activities is followed. Activities should be designed to include the following components:

- IADLs – personal care as well as work type activities such as folding napkins, setting the table, cooking, and other simple household/office type jobs.
- Cognitive/Intellectual – activities of a perceptual nature, which act to stimulate the senses, maintain reality orientation, and evoke memories and emotions. Activities should include word games, creative writing, poetry, arts and crafts, etc.
- Physical – activities designed to maintain physical well being, motor skills, mobility, and body senses, such as walking, dancing, light exercise, etc.

- Social and recreational – activities that emphasize fun and enjoyment, creativity, and self-expression. They offer opportunities for social intervention, group participation, common goals, and enhancement of group pride and cohesion.

- Sensory – activities designed to stimulate memory, evoke interactions, encourage discussion, and maintain functions. Music is especially effective in evoking memories and participation.

ADCRCs shall post notices of their planned activities in a central location.

C. Observation of Participants

It is the responsibility of ADCRC staff to observe participants daily for any obvious signs of illness, marked changes in behavior, or other conditions, which would require further attention, such as bruises or other new conditions. The service provider shall establish policies and procedures in response to observed changes that include the following actions:

- Note change in participant record;
- Reassess participant's physical, mental, and cognitive functioning;
- Refer to an appropriate health care provider for further examination;
- Notify (discuss with) caregiver;
- Develop a plan for other appropriate follow-up care or action;
- Report suspected abuse or neglect;
- Document follow-up care and observation; and
- Note conclusions or resolution in the narrative.

D. Personal Assistance and Care

Recognizing the possible inability of a person with dementia to notice such things as grooming, food spills on clothing, disarray of clothing, minor injuries, nail care, or other personal maintenance activities, it is the responsibility of the ADCRC staff to observe and provide assistance when appropriate. Just as the primary caregiver would attend to these matters at home, staff assumes that role at the day center.

Principles that should underlie this care include:

- Participant privacy and dignity should always be maintained;

- Care should be taken to tell the person what you are doing, and why, so the person will not be offended by unexpected touching or attention to personal needs, e.g., washing face or hands;

- If possible, remind the person to manage the activity and give clear instructions, e.g., brushing hair or tying shoe laces; and

- The service provider should talk with the primary caregiver to assure that patterns of behavior and personal preference are observed. The ADCRC may want to instruct the caregiver on ways to handle new areas of dysfunction.

Any of the following ADLs may fall into this category of assistance and care: eating, transfer, walking (inside or outside), dressing, grooming, bathing, toileting, or continence care.

E. Toileting

The ADCRC should establish, as part of the daily schedule, plans for providing toileting assistance to participants whom do not initiate their own toilet breaks. A one to two hour schedule will create a reminder for some participants who do not need help. The schedule shall accomplish the following:

- Provide a break in programming so that participants are not disturbed by leaving an activity; and

- Permit staff to take time to help those participants who need assistance.

The privacy and dignity of each participant should be carefully maintained when providing this assistance.

In addition to a general schedule that accommodates all participants, some individuals may require more frequent toileting. Specific staff should be assigned to these participants with a method to chart the number and times toileting is needed to help avoid accidents.

Where health professionals are available and appropriately trained, participants may be trained in reducing episodes of incontinence. Such efforts should be made in cooperation with the caregiver with plans to help the caregiver follow a similar scheduling or training activity at home with the participant.

F. Food Service

1. Nutrition

   Legislation requires service providers to provide or arrange for a nutritious noon meal for participants. The noon meal should provide one-third of the Recommended Dietary Allowance (RDA) for older persons, as established by the Food and Nutrition Board at the National Research Council of the National

Academy of Sciences. Morning and afternoon snacks should be available and served as appropriate in the ADCRC and participant's schedule.

a. Meals

Meals may be obtained from a caterer or provider for meals authorized through the Older Americans Act. These nutrition providers are required to ensure that meals served meet one-third of the RDA for each meal. Hospitals usually have the capacity to provide an equally nutritious meal and may be able to provide special diets.

b. Snacks

Snacks should be low in fat, sugar, and salt and should be easy to eat and swallow. Occasionally, cakes or cookies are appropriate, especially when part of a cooking activity or celebration. Fruits and vegetables are good snacks if they are texturally appropriate for easy chewing and swallowing. Snacks are not to be counted as part of the luncheon RDA requirement.

2. Hydration

Visible access to water and reminders to drink water shall be provided.

An established toileting schedule may provide a good time to remind participants to get a drink.

3. Food Handling

Service providers need to practice sanitary and safe food handling for both preparing and serving food. This includes a sanitary place for food preparation with safe dishwashing and storage methods; hot and cold controls for foods during serving and storage; and the use of hairnets, plastic gloves, and appropriate utensils for serving food. ADCRCs that prepare food need to follow local sanitation policies or hire a dietitian to assure safe practices.

G. Transportation

Transportation is critical for successful ADCRC participation, and most often, public transportation cannot accommodate the needs of a caregiver and a person with dementia. Paratransit services and various "Dial-a-Ride" programs may be willing to enter an agreement to provide regular transportation for an ADCRC.

There is some advantage to having family members transport the participant. This gives ADCRC staff and the caregiver an opportunity to exchange current information about the participant's needs, mood, or behavior and gives the ADCRC staff an opportunity to offer support to the caregivers. However, the respite value of ADCRC is reduced for the caregiver if he/she must spend the time and effort to transport the participant.

If the ADCRC does provide transportation, all laws and regulations pertaining to vehicle maintenance, the qualifications of drivers, and all insurance requirements shall be followed to assure safety.

ADCRCs with their own transportation program shall ensure that drivers receive appropriate training in providing escort assistance and handling persons with dementia.

H. Medications

The decision to manage medication in the ADCRC program should be made before the program admits participants. This decision carries with it certain responsibilities and requires the availability of qualified staff persons to manage medication and monitor the correct medication dosages.

Before making the decision, the ADCRC service provider should investigate the applicable laws and regulations for the type of license held, regarding proper storage, management, and disposal of medications, plus requirements for documentation. Adult Day Health Care and other licensed health facilities have regulatory language regarding medications that must be followed.

If the decision is made to assist with the management of medications, the ADCRC must develop a policy and procedures for medications, considering the following requirements:

- Medication shall be stored in containers with prescription labels;
- The medications and times to be taken shall be documented in the participant's record;
- Responsibility for dispensing medications should be centralized with a nurse, the ADCRC site director, or the program director;
- Medication-related information should be maintained in a daily log;
- If a participant refuses to take medications, the family and/or caregiver must be notified immediately. Additionally, refusal to take medications shall be documented in the participant file, including circumstances, and the ADCRC's attempts to assure the proper management of the medications;
- Unused portions of the medications shall be returned to the family; and
- A written notice, verifying receipt of the unused portion of the medication, should be signed by the family, or the client's authorized representative. Verification notices should be maintained in the participant's file.

A clear record of all medication managed during program hours shall be made by the individual responsible for medication management. A chart or index card can

be used to list all medication that the participant is presently receiving. Caregivers shall be asked to provide information concerning prescribed medications.

I. Infection Control and Prevention of HIV

Recommendations for infection control and the prevention of HIV transmission in health care settings should be obtained from the local county health department. Although ADCRCs are not routinely involved in bodily invasive procedures, they may be involved with body emissions such as feces and urine.

Universal precautions to assure infection control should be consistently used for all participants, because the infection status of an individual is not always known or available.

Hand washing and wearing gloves are especially relevant in appropriate circumstances for adult day care staff. The portion of these precautions most applicable to adult day care staff are placed at the front of the guidelines to emphasize their importance and to provide for their easy access. These infection control guidelines must be incorporated into site policies and procedures.

X. TRAINING

An important part of the ADCRC program includes training provided by the service providers to the following: staff and volunteers working at the site; professionals; and the community, lay public, and caregivers. ADCRCs are required to serve as model sites and offer on-site training and outreach presentations to educate others about dementia.

A. Staff In-Service

A minimum of six in-service training sessions per year to staff and volunteers are to be conducted by each ADCRC. Training programs should be designed that include emphasis on understanding dementia and on the usefulness of the day care program for participants, family members, and the community. Training should develop and enhance teamwork and group problem solving skills, as well as provide staff with the knowledge and skills needed to maintain the highest possible functioning level of each participant, using behavior management strategies and other appropriate interventions.

In-service training should include on-the-job training, which is perhaps the most effective way for staff to learn how to deal with dementia and particularly with the center's participants. Centers should strive to conduct one in-service training event each month.

There are three distinct components of staff in-service training:

1. Orientation of new staff to the ADCRC, the program, and the participants.

2. Training by experienced staff or outside trainers and professionals regarding the disease, behavior management, and other client, caregiver, or program-related issue.

3. Training devoted to team building and problem solving.

In-service training may include presentations by staff members or guest speakers, films, videotapes, and experiential activities.

B. Volunteers

The designated volunteer coordinator is responsible for working with volunteers to select appropriate schedules and assignments based on the volunteer's skills, interest, and program needs. Training shall be provided by the center. A volunteer manual shall be reviewed by all volunteers. Volunteers shall be provided with orientation and training sessions, as appropriate. Volunteers providing direct care shall be included in staff meetings, in-service training, and follow-up training sessions.

The volunteer coordinator shall be available to talk with volunteers on an individual basis, as needed, and provide training in specific duties and areas of service.

C. Families/Caregivers

Support and training for caregivers is to be conducted through caregiver support groups and other caregiver activities, no less than 12 times per year, by staff associated with the ADCRC or by arrangement with other support group providers in the local community.

Staff should be trained in methods to identify the specific needs of caregivers. Once the caregiver's needs have been identified, the service provider should provide the needed training or give instructions to caregivers regarding how to access required information. Staff should be trained to assist the caregiver in areas such as respite, participant care, and emotional reactions. Families/caregivers should be provided with appropriate literature and brochures to meet their informational needs. Families/caregivers should also receive information and instruction regarding participant care during home visits and support group sessions.

D. Professionals/Interns

At least four times per year, training for professionals is to be conducted through student intern programs, presentations to specific professional groups, and general presentations (alone or jointly) to professional service providers in the community.

ADCRCs are encouraged to coordinate with local educational institutions to arrange nursing, social work, gerontology, or other professionally related interns to participate in the ADCRC program to receive hands-on training in the provision of care to dementia participants. The ADCRC would benefit from the volunteer time donated by the interns, in addition to providing students with a direct experience with dementia.

In addition to on-site training, the program director, training officer, or other staff may provide presentations at workshops, conferences, or other events. Day care staff are especially well prepared to train other professionals on issues pertaining to hands-on care, behavior management, communication methods, and enhancing participants' functioning.

E. Public/Community

At least one annual presentation to the community lay public and caregivers will be conducted alone or jointly with other community providers.

Service providers should identify and arrange to train the general public, organizations that are available to professionals in dementia day care programs, and related service providers that work with persons with dementia and their caregivers. The range of available supportive services varies considerably from community to community.

There is a wide array of services about which professionals working with a person with Alzheimer's disease or related dementia should be aware. ADCRC personnel should provide needed information to professionals and service providers in the community through presentations, brochures, and other literature.

In some instances, these providers need to be better informed about the nature of Alzheimer's disease and persons with dementia. Training can focus on ways to include persons with dementia in existing programs, how to work with caregivers, what symptoms to look for, etc.

XI. SUPPORT GROUPS

A. Support for Family/Caregivers

Service providers are responsible for meeting respite needs by caring for the person with dementia, and for making counseling and support groups available to family members. Overall, caregiver support includes providing useful information about available resources; giving individualized or group training as described in Section XI of this Manual; being sensitive to the psychosocial, emotional, physical, and financial stress experienced by caregivers and responding with understanding and respect; and providing or making available counseling and support group sessions.

A main thrust of the ADCRC sites is to assist caregivers whenever possible, and when appropriate, refer them to specific resources to address issues in-depth. ADCRC staff are not expected to act as case managers or psychotherapists. ADCRCs with trained social workers or other professionals on staff can provide counseling. However, counseling should be provided in that context only if required by the job description and ADCRC objectives. Otherwise, referral to other resources is appropriate.

B. Operating Support Groups

All service providers are responsible for assuring that support groups are available to their participants' caregivers, as specified by statute.

Support Group Elements include:

1. Facilitator

   A qualified facilitator is essential. This facilitator can be a regular staff person for the group or an outside professional. Qualifications include training and/or experience and extensive knowledge and understanding of dementia and caregiver needs.

2. Timing

   ADCRCs shall hold, or arrange to hold, support groups or refer caregivers to existing community support groups. Collaboration with other groups creates important partnerships for shared activities and referrals.

3. Types and Frequency

   The frequency or length of a support group will depend largely on the type of group being considered. Group meetings may be time-limited or open-ended.

Time-limited groups may be most useful when a specific subject has been selected and the resource material or leader presents a certain body of information. Sometimes new participants feel easier committing to a time-limited group, so there is an established end of the activity. Time limitations may be appropriate for families of newly diagnosed persons, because they may want to shift focus after the initial issues have been addressed.

Open-ended groups may be established to accommodate a flow of persons who come in new and leave when their need is met. Facilitators need to be sensitive to the group's need for ongoing subjects, variety, or reorganization. Each group develops its own character in response to individual need, unless it is established with specific curricula by the facilitator.

4. ADCRC Resources

To the extent possible, ADCRCs should facilitate groups that fit the needs of the caregivers associated with their centers. If resources (staff, space, etc.) are not available in the site, other community support groups may be used. In order to inform caregivers, the service provider shall collaborate with other agencies to assure that caregivers are welcome, that space is available, and to obtain specific information on time, place, type, etc. In some cases, ADCRC staff may help facilitate groups sponsored by other agencies and help promote support groups in the local community.

XII. ELDER AND DEPENDENT ADULT ABUSE REPORTING

ADCRC staff are legally mandated elder and dependent adult abuse reporters.

1. Each ADCRC employee must sign a statement confirming knowledge and understanding of Section 15630 of the W&I Code, agreeing to comply with its provisions.

2. ADCRCs must maintain the signed statements on file at the service site.

Sections 15610 through 15659 of the W&I Code contain elder abuse definitions, reporting requirements, and penalties. Sections 15630 and 15631 of the W&I Code contain mandated reporters, mandated and non-mandated reports, and voluntary reporters information.

When elder abuse is suspected, a mandated reporter is required to:

1. Report by telephone to the county adult protective services agency or the local law enforcement agency. [15630(e)]

2. Report by telephone to the local long-term care ombudsman or law enforcement agency if the suspected abuse occurred in a twenty-four hour residential care facility. [15630(b)(1)(A)]

3. Forward the following written report, within two working days, to the contacted agency: California Health and Human Services Agency "Report of Suspected Dependent Adult/Elder Abuse", SOC 341 (4/90), which is herein incorporated by reference.

4. Forward the written report to the local AAA within two working days.

Exhibit G contains current reporting requirements and forms.

XIII. FISCAL ACCOUNTABILITY

Administration of the ADCRC program requires fiscal accountability that includes accurate and timely fiscal reporting, adherence to State/AAA fiscal policies, and compliance with all provisions of the Grant Agreement authorizing the award of funds. In addition, ADCRC sites licensed by other State departments or those in receipt of State and/or federal funds from other programs must also adhere to requirements established by these entities.

An ADCRC program budget requires inclusion of an itemized match amount that is equal to at least 25 percent of the total grant funds awarded. This match may be fulfilled by cash or in-kind contributions provided by volunteers or other resources contributed in support of the program. Client fees or Medi-Cal reimbursement for services may not be used as program match.

A. Annual Budgets

All ADCRC service providers shall annually complete a budget for all planned expenditures for the ADCRC program.

ADCRCs that operate within an ADHC setting must take special care to ensure that ADCRC contract funds are not applied to those services covered or required by Medi-Cal in the ADHC program. Staff positions required by ADHC include those that provide nursing services, therapy services, and program oversight. Positions funded by the ADCRC must cover those services otherwise required to meet the special dementia-programming needs of the ADCRC, e.g., additional program aides to serve program participants with moderate to severe dementia or for a dementia activity director.

1. Budget Summary to be used by AAAs providing direct ADCRC services.

All AAAs that oversee the State-Funded ADCRC programs are required to complete a Budget Summary annually. The Budget Summary is provided for as part of the Community-Based Services Program Contract between the CDA and the participating AAA.

The Budget Summary consists of the following five pages:

Page 1. Budget Summary - Community-Based Services Programs
Page 2. AAA Administrative Budget Narrative
Page 3. Direct Services Budget Narrative
Page 4. Contracted Service Schedule
Page 5. Performance Estimates

The Budget Summary shall be submitted to CDA annually for review and approval.

2. **Program Budget Summary to be used by ADCRC programs contracting with the AAAs.**

All service providers that contract with a AAA to provide an ADCRC Program are required to submit annually to the AAA a budget in accordance with timeframes and procedures established by the AAA.

B. Budget Revisions

All revisions to the Budget Summary shall be submitted to CDA by the AAA. Revisions must be in accordance with the process and procedures established by the Department.

All budget revisions from ADCRC service providers shall be submitted to the AAA for review and approval, and be in accordance with the process and procedures established by the AAA.

C. ADCRC Program Year End Financial Closeout Report

At the end of each fiscal year, CDA shall transmit to each AAA instructions for completing the ADCRC Program Year-End Financial Closeout Report. The AAA will then provide each ADCRC service provider with instructions on completing its closeout procedures. Each AAA will then submit the ADCRC Program Year-End Financial Closeout Report to CDA by the established deadlines.

D. ADCRC Grant Payments

At the beginning of each fiscal year, one advance payment of 25 percent of the contract amount may be requested by the AAA to meet funding needs of the ADCRC program and in accordance with AAA procedures.

Thereafter, all monthly payments will be made to AAAs as a reimbursement for actual program expenditures reported to the CDA.

E. Audits

Refer to the Audit Section of the Master Contract Terms and Conditions.

EXHIBITS

Alzheimer's Day Care Resource Center
Core Services

Core Service	Compliance Indicators	Quality of Care Indicators
Day Care Services: Clientele	Number of persons served with a documented diagnosis of Alzheimer's disease or other dementia. Number of participants that have moderate-to-severe dementia. Number of discharges initiated by the center. Charts are maintained for all participants. Intake includes the ADCRC 100 Intake Form. At admission, and every six months thereafter, cognitive status and functional abilities are evaluated with approved assessment tools. At admission, staff develop an individual plan of care, which is updated every six months.	Staff exhibit understanding of ADCRC philosophy of care. Staff admit participants who demand a high level of care and exhibit behavioral problems. Staff can provide examples of cases in which discharge due to behavioral problems was avoided or delayed. Staff demonstrate knowledge of procedures and polices, including confidentiality. Staff demonstrate knowledge of test administration procedures for cognitive and functional screening tools. Staff demonstrate knowledge and skills needed to develop and write individual plans of care which address participants' social, emotional, cognitive, physical, and functional needs. Staff exhibit the ability to use assessment information (i.e., from the cognitive, functional, and behavioral screening) in developing the individual plan of care. Staff address the special needs of participants and caregivers related to dementia in the individual plan of care and exhibit the ability to respond to those needs.

Core Service	Compliance Indicators	Quality of Care Indicators
Day Care Services: Staffing	Center maintains a 1:5 paid staff to participant ratio. Center supplements paid staff with volunteers and maintains records of volunteer hours. Employees and volunteers receive an orientation that includes an introduction to dementia care, as recorded in the personnel files. Center provides a minimum of 6 inservice training sessions per year for staff and volunteers. At least 3 of the 6 trainings are dementia-specific, on topics such as types of dementia, behavior management, and activity programming.	Staff demonstrate expertise in interacting with and managing persons with dementia. Staff exhibit their knowledge and skills by: - Using a calm, nonconfrontive approach. - Maintaining a positive attitude toward participants. - Using a combination of eye contact, verbal cues, and physical prompts to engage participants. - Using dementia-sensitive communication strategies. - Interacting with participants in an adult manner, emphasizing dignity and respect. - Successfully redirecting participants who become agitated or exhibit behavioral symptoms. - Using creative problem-solving approaches; - Responding to the needs of participants and environmental demands in a flexible way. - Knowing the participants' interests and and backgrounds. - Attending promptly to the safety and basic needs of participants. Staff demonstrate the requisite skills to provide family support, including knowledge about dementia, family caregiving, and community resources. Supervisory staff exhibit the knowledge and skills necessary to orient employees and volunteers to dementia care. Center provides an employee/volunteer orientation manual which addresses dementia care and includes current, accurate information. Records of dementia-specific inservice training sessions indicate that current, accurate information was provided to employees/ volunteers.

Core Service	Compliance Indicators	Quality of Care Indicators
Day Care Services: Activity Programming	Center provides caregivers with a monthly schedule of activities. A schedule of activities for the day is posted in a prominent place. The schedule of activities for the day is written in letters large enough participants to read.	Center provides a variety of activities which: - Emphasize abilities known to be preserved in Alzheimer's disease. - Tap participants' interests and skills. - Match the cognitive and physical abilities of participants. - Offer varying levels of participation (*i.e.*, from observation to active involvement). - Use a variety of formats (*i.e.*, large group, small group, individual). - Take into account the cultural diversity participants. - Are age-appropriate and presented in an adult manner. Staff maximize the success of activities by: - Engaging in activities with participants. - Using an expressive, enthusiastic approach. - Drawing participants who are isolated or exhibiting problem behaviors into activities. - Being observant of and promptly attending to participants' needs. - Offering parallel activities at various levels of functioning. - Providing participants with choices. - Maintaining the structure within the activity program, but exhibiting enough flexibility to change activities when participants aren't responding. Staff adequately document personal care needs of each participant in his/her individual care plan.

Core Service	Compliance Indicators	Quality of Care Indicators
Day Care Services: Personal Care/ Medications	Inservice records indicate that staff Receive periodic training on topics related to personal care (e.g., managing incontinence, meeting dietary needs, and use of medications. Center posts and provides to caregivers a monthly menu meals and snacks.	Staff can explain methods for reducing incidents of incontinence (*e.g.*, toileting schedules, checkoffs) used by the center. Staff are sensitive to nonverbal behaviors and and cues which suggests that a participant has a personal care need he/she is unable to verbally request help with. Staff use a respectful approach when attending to personal care needs such as toileting and feeding. Staff have knowledge of how much and what types of assistance (e.g., verbal cues, physical prompts, full assist) participants need. Staff allow sufficient time for toileting, nutrition intake, and other personal care needs. Staff responsible for giving medications: - Demonstrate a working knowledge of medication use in dementia. - Can describe side effects of commonly used medications in dementia. - Are skilled in getting moderately to severely impaired dementia patients to accept/take medications. - Can describe when use of PRN medication to reduce behavioral symptoms is appropriate. Staff review participant medications on a periodic basis with caregivers and chart any medication changes.

Core Service	Compliance Indicators	Quality of Care Indicators
Day Care Services: Behavioral Interventions	Records indicate that at least one of the six inservice trainings per year is specifically on the management of behavioral symptoms in dementia. The number of discharges due directly to behavioral symptoms such as wandering or combativeness that exceed the ability of staff to provide a safe and therapeutic environment.	Staff adhere to a philosophy of care that emphasizes the use of behavioral interventions over medications to manage behavioral symptoms. Supervisory staff provide on-line staff with a mechanism (*e.g.*, morning team meetings, staff meetings) for discussing participant behaviors/needs and generating solutions. Staff demonstrate a working knowledge of behavioral interventions in dementia, including, but not limited to: - Identifying behavior patterns in order to anticipate and reduce behavioral symptoms. - Problem-solving approaches such as the A-B-C (Antecedent-Behavior-Consequence) model. - Recognition of underlying needs (e.g., personal care needs) in the occurrence of behavioral symptoms. - The effects of medication changes, health problems, task difficulty, and similar factors on the behavior of participants with dementia. - How to communicate with and redirect participants in ways that reduce behavioral symptoms. - An awareness that staff behavior can precipitate and/or exacerbate behavioral symptoms of participants. - Specific techniques commonly used to address behaviors such as wandering, combativeness, and agitation. - Ways to manipulate one's own behavior or the environment to reduce behavioral problems. Staff exhibit the skills needed to support families in the use of behavioral interventions.

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Monitoring and Assessment Tool

Date:_____ Site:_____

Assessment performed by:_____ Title:_____

Compliance Indicators	Identified Areas of Concern	Plan of Corrections
Day Care Services: **Clientele**		
Number of persons served with a documented diagnosis of Alzheimer's disease or other dementia.		
Number of participants that have moderate-to-severe dementia.		
Number of discharges initiated by the center.		
Charts are maintained for all participants.		
Intake includes the ADCRC 100 Intake Form.		
At admission, and every six months thereafter, cognitive status and functional abilities are evaluated with approved assessment tools.		
At admission, staff develop an individual plan of care, which is updated every six months.		

Core Service	Compliance Indicators	Quality of Care Indicators
Training for Families	Number of group trainings. Number of persons attending group trainings. Topics of group trainings. Number of individual family trainings. Number of individuals trained.	Trainer is knowledgeable about dementia, including, symptoms, behavior management, physical care, environmental assessment, security measures, communication strategies, legal issues, and caregiver stress. Trainer is knowledgeable about current research in dementia. Trainer is knowledgeable about medication use in dementia. Trainer has knowledgeable about diagnostic diagnostic procedures for dementia. On-site resource materials are current and contain accurate information.
Support Groups	Number of groups offered, which Shall be a minimum of 12 per year. Average number of persons attending groups.	Support group facilitator is experienced. Facilitator has demonstrated knowledge of of community resources. Facilitator is knowledgeable about dementia, including symptoms, behavior management, physical care, environmental assessment, security measures, communication strategies, legal issues, and caregiver stress. Facilitator is knowledgeable about current research in dementia. Facilitator is knowledgeable about medication use in dementia. Facilitator is knowledgeable about diagnostic procedures for dementia.

Core Service	Compliance Indicators	Quality of Care Indicators
Counseling	Number of persons counseled. Number of hours of counseling.	Counselor is qualified by experience or education to assess participant and family psychosocial needs. Counselor exhibits ability to develop individual plan of care that includes appropriate interventions. Counselor demonstrates thoughtful, objective documentation of counseling. Counselor is knowledgeable about dementia, Including, symptoms, behavior management, physical care, environmental assessment, security measures, communication strategies, legal issues, and caregiver stress.
Community Education	Number of community education sessions presented to the lay public, caregivers, and general community (minimum one annually). Number of persons attending educational session(s). Purpose/topic of the educational session.	Trainer is knowledgeable about dementia, including symptoms, behavior management, physical care, environmental assessment, security measures, communication strategies, legal issues, and caregiver stress. Trainer is knowledgeable about current research in dementia. Trainer is knowledgeable about medication use in dementia. Trainer has knowledgeable about diagnostic procedures for dementia. On-site resource materials are current and contain accurate information. Outreach for community education is conducted in an appropriate manner that presents clientele with dignity and respect.

Core Service	Compliance Indicators	Quality of Care Indicators
Professional Training	Training sessions are offered specifically for professionals, including service providers and interns (minimum of 4 times per year). Number of professionals trained.	Trainer is knowledgeable about dementia, including symptoms, behavior management, physical care, environmental assessment, security measures, communication strategies, legal issues, and caregiver stress. Trainer is knowledgeable about current research in dementia.. Trainer is knowledgeable about medication use in dementia. Trainer is knowledgeable about diagnostic procedures for dementia. Training sessions are adapted to meet the specific educational needs of the audience. Presentation materials contain current and accurate information.
Inservice Training	Number of inservice trainings (minimum of 6 per year). Number of staff and volunteers trained.	Training topics increase staff knowledge and skills needed to maintain the highest possible functioning level of each participant. Trainer is knowledgeable about dementia, including symptoms, behavior management, physical care, environmental assessment, communication strategies, security measures, legal issues, and caregiver stress. Trainer is knowledgeable about current research in dementia. Trainer is knowledgeable about medication use in dementia. Trainer is knowledgeable about diagnostic procedures for dementia. Training promotes teamwork and group problem-solving skills. Presentation materials contain current and accurate information.

Core Services	Compliance Indicators	Quality Indicators
Dementia-Friendly Environment	The ADCRC site includes sufficient activity space to offer two or more activities simultaneously.	Space used by participants is free of clutter, has clear pathways, and is decorated in a familiar, homelike manner.
	The ADCRC site includes a quiet space where an individual participant can be separated from the larger group.	Décor is free of disorienting patterns (*e.g.*, geometric or busy); lighting system provides sufficient illumination and eliminates glare.
	The ADCRC site includes space and equipment to prepare and/ or serve meals and snacks.	Signs, pictures, clocks, and calendars are used to help orient participants.
	The ADCRC site includes two or more bathrooms, with at least one handicapped accessible.	Areas used by participants are free of distracting noise.
	The ADCRC site includes sufficient private space for interviewing family members, counseling, and support groups.	Use of mirrors is limited to restroom areas.
	The ADCRC site includes storage space for supplies, equipment, medication, and participants' personal items.	Site is handicapped accessible, and includes handrails and ramps.
	The ADCRC site has a fenced or secured outdoor area with shade, seating, and space for activities and/or walking.	An emergency communication system is incorporated into the site, enabling staff to easily access each other.
	The ADCRC site has sufficient office space separate from program space.	All items which could pose a danger (*e.g.*, cleaning solutions, tools) are kept Inaccessible to participants.
		Medication is stored in a locked area.
		The ADCRC site is designed in a manner that maximizes participant security (*e.g*, alarms, secured perimeters).
		Outside space is free of hazards (*e.g.*, low walls, potholes, uneven pavement).
		Walkways provide a continuous circular walking pattern.

For more information about creating a dementia-friendly environment, see:

Brawley, Elizabeth C. (1997). Designing for Alzheimer's disease: Strategies for creating better care environments. New York: John Wiley & Sons, Inc.

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concern	Plan of Corrections
Day Care Services: **Staffing**		
Center maintains a 1:5 paid staff to participant ratio.		
Center supplements paid staff with volunteers and maintains records of volunteer hours.		
Employees and volunteers receive an orientation that includes an introduction to dementia care, as recorded in the personnel files.		
Center provides a minimum of 6 inservice training sessions per year for staff and volunteers.		
At least 3 of the 6 trainings are dementia-specific, on topics such as types of dementia, behavior management, and activity programming.		

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Day Care Services: **Activity Programming**		
Center provides caregivers with a monthly schedule of activities.		
A schedule of activities for the day is posted in a prominent place.		
The schedule of activities for the day is written in letters large enough participants to read.		

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Day Care Services: **Personal Care/Medications**		
Inservice records indicate that staff receive periodic training on topics related to personal care (e.g., managing incontinence, meeting dietary needs, and use of medications).		
Center posts and provides to caregivers a monthly menu of meals and snacks.		

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Day Care Services: **Behavioral Interventions**		
Records indicate that at least one of the six inservice trainings per year is specifically on the management of behavioral symptoms in dementia.		
The number of discharges due directly to behavioral symptoms, such as wandering or combativeness, that exceed the ability of staff to provide a safe and therapeutic environment.		

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Training for Families		
Number of group trainings..		
Number of persons attending group trainings..		
Topics of group trainings.		
Number of individual family training.		
Number of individuals trained.		
Support Groups		
Number of groups offered, which shall be a minimum of 12 per year.		
Average number of persons attending groups.		

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Counseling		
Number of persons counseled.		
Number of hours of counseling.		
Community Education		
Number of community education sessions presented to the lay public, caregivers, and general community (minimum, one annually).		
Number of persons attending educational session(s).		
Purpose/topic of the educational session.		

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Professional Training		
Training sessions are offered specifically for professionals, including service providers and interns (minimum of 4 times per year).		
Number of professionals trained.		
Inservice Training		
Number of inservice trainings (minimum of 6 per year).		
Number of staff and volunteers trained.		

EXHIBIT B

Alzheimer's Day Care Resource Center
Core Services Guidelines

Compliance Indicators	Identified Areas of Concerns	Plan of Corrections
Dementia-Friendly Environment		
The ADCRC site includes sufficient activity space to offer two or more activities simultaneously		
The ADCRC site includes a quiet space where an individual participant can be separated from the larger group		
The ADCRC site includes space and equipment to prepare and/or serve meals and snacks		
The ADCRC site includes two or more bathrooms, with at least one handicapped accessible		
The ADCRC site includes sufficient private space for interviewing family members, counseling, and support groups		
The ADCRC site includes storage space for supplies, equipment, medication, and participants' personal items		
The ADCRC site has a fenced or secured outdoor area with shade, seating, and space for activities and/or walking		
The ADCRC site has sufficient office space separate from program space		

PHYSICAL PLANT EVALUATION CHECKLIST A. ACCESSIBILITY/ENTRANCE	YES	NO	NOTES
1. Is the entrance to the center identified (e.g. signage) and easy to locate?			
2. Is drop off and/or parking area adequate and convenient for Center users?			
3. Are there stairs to the entrance? If yes, answer the following: 3a. Do they have railings on both sides? 3b. Do the stairs have non-skid contrasting colored strips on each stair edge? 3c. Are the stairs in good repair?			
4. Is there a ramp to the entrance? If yes, answer the following: 4a. Is incline of ramp steep and difficult to maneuver? 4b. Is ramp surface non-slip or does it have non-skid strips? 4c. Are there handrails on both sides of the ramp?			
5. Is there an overhang or other overhead protection at main entrance?			
6. Are exterior surfaces (walkway) in good condition? (no holes, cracks or raised changes in level)			
7. Is front door easy for participants to open? (e.g. not too heavy, level handles)			
8. If front door is glass, are there cues to indicate a barrier or to reduce distortion? (e.g. decals or other markers)			
9. If there is outside seating at the front entrance, is there comfortable furniture with overhead protection?			

	YES	NO	NOTES
3. Are there a variety of tactile and sensory cues used within the Center? (e.g. color, photographs, client-centered art, cooking smells animals, music, wall hangings, plants)			
4. Are cultural or traditional objects used within the Center that are simple, in contrasting colors on the background, uncluttered and meaningful to the participants?			
5. Are the decorations, bulletin boards and other materials large enough for participants to read and hung at a height that is easy to see whether one is ambulatory or non-ambulatory?			
6. Have textures been used in Center to provide orientation cues as well as tactile stimulation for participants? (e.g. wallcovering, fabric art)			
D. ORIENTATION/WAYFINDING			
1. Are there permanent cues (e.g. signs, pictures, architectural features) in the Center that are consistently pointed out to help them find their way?			
2. Are orientation cues such as calendars, clocks, and schedules used that are large, easy to read and well located?			
3. Are large print activity schedules available for each day as well as for the week or month?			
4. Are large bathrooms visible and easy to locate from main activity area?			
5. Is bathroom location/entrance highlighted with multiple cues to help participant find it independently? (e.g. colored strips on floor, colored doors, awnings, large easy to read signage)			

	YES	NO	NOTES
6. If there is an outdoor enclosed area, is it visible and easy to locate from the main activity area? 6a. Is outdoor area exit highlighted with multiple cues to help find it independently?			
7. Are there multiple corridors or hallways in Center? 7a. If so, are they distinct from one another in decor? (e.g. color, materials)			
8. Have corridors been used to provide visual and sensory cues as well as for circulation? (e.g. art walk, tactile wall hanging, Center artwork)			
9. Where color coding has been used, can participants distinguish the different colors for orientation purposes? (e.g. color contrasts)			
10. Are there large print directional signs pointing the way to such places as the elevator, outdoor area or bathrooms?			
11. Are the large print signs naming special rooms and areas that are easy to read or reinforce with pictures? (e.g. toilet/picture of toilet)			
E. FURNISHINGS 1. Are furnishings in good condition and easy to for staff to maintain?			
2. Are there a variety of styles of chairs/ furniture used that are easy for an older user to get in and out of? (e.g. firm seat, not too deep, high back with arms that extend forward)			
3. Is furniture that is difficult to get out of used purposefully to restrain clients from wandering?			

	YES	NO	NOTES
4. Are there a variety of seating arrangements that encourage both large and small group interaction? (e.g. round tables, chairs at right angles rather than "gang" type seating, circular arrangements)			
5. Have furniture arrangements been used to create separate and distinct activity areas?			
6. Are chairs used that provide movement? (e.g. platform rockers or swivel chairs)			
7. Is furniture stable and without sharp edges?			
8. Have a variety of materials been used on furniture or accessories? (e.g. both vinyl as well as fabric or fabric pillows)			
9. Are patterns and colors used that are home-like and attractive?			
F. ACOUSTICAL CONDITIONS/HEATING/AIR CONDTIONING			
1. Is there background noise from appliances, air conditioning or traffic that may be disturbing to participants, staff or program activity?			
2. Has there been an effort to limit background noise in activity areas? (e.g. regulating use of phone, appliances, use of acoustical materials)			
3. Has the meaningless background noise of a radio, muzak or tv that no one is listening to been eliminated?			
4. Are heating and air conditioning systems in good condition and operating efficiently?			
G. LIGHTING CONDITIONS/WINDOWS			
1. Is lighting throughout the Center even and free from glare, particularly in the hallways and stairwells?			

	YES	NO	NOTES
2. Are there window shades or draperies that can be adjusted to maintain even lighting or modify views outside if necessary?			
3. Has lighting been adjusted so that there is little or no glare from exposed light bulbs, open windows, floors, table tops or other surfaces?			
4. Is there a combination of both fluorescent and incandescent fixtures within the Center?			
5. Are fluorescent fixtures in good repair and free from flicker?			
H. SAFETY FEATURES 1. If the Center has a kitchen area is it part of the activity program in which the participant participates?			
2. Are dangerous products and objects locked away or removed?			
3. Does stove have burners that can be covered or can knobs be taken off when not in use?			
4. Are hallways and doors wide enough to allow for safe and easy movement?			
5. Are floor coverings throughout Center in good repair, non-skid and free from glare? (e.g. corridors, stairwells, bathrooms)			
6. Have patterns or designs that can be ambiguous or confusing been avoided on walls and floors? (e.g. dark/light contrasting tiles that may look like holes to cognitively/visually impaired)			
7. Are there stairs within the Center that are used by participants? (e.g. exercise, gait training, circulation) 7a. If so, are there railings on both sides of wall? 7b. Are stair edges identified with non-skid strips or nosings?			

	YES	NO	NOTES
7c. Can stairs be secured if use by participants is not desirable? (e.g. safety gate)			
8. Are rooms and corridors uncluttered and easy to circulate in? (e.g. not too much furniture, clearly defined circulation paths)			
9. Are items stored in activity areas or hallways that provide obstacles to participants or staff?			
10. Are water faucets well marked for temperature identification?			
11. Are water fountains wheel chair accessible?			
12. Are all changes of level marked clearly with contrasting color?			
13. Are thresholds to rooms no higher than 1/2" and well marked?			
14. Are doors that are used by participants equipped with lever type handles?			
15. Are all large expanses of glass marked to indicate a potential barrier?			
I. BATHROOMS/PERSONAL CARE			
1. If bathrooms are used for multiple purposes (e.g. smoking area, cleaning up dishes) does it compete with participant use or staff convenience?			
2. Are bathroom doors easy for participant to open/close?			
2a. If no doors, have alternative coverings been considered for privacy or ease in use? (e.g. shower curtain)			
3. Are lever handles used on doorknobs and faucet handles?			
4. Is there adequate participant privacy for toileting and washing up?			

	YES	NO	NOTES
5. Is there adequate room for staff to aid participant in toileting/transferring? 5a. If no, can stalls be removed for more space?			
6. Are there adequate grab bars/railings for support?			
7. Is there any form of emergency call system by toilet?			
8. Are there showers available? 8a If yes, do they have grab bars and non-skid strips on floor?			
9. Have assistive aides been introduced where needed? (e.g. hand-held shower, bathbench, adaptable lever handles.			
10. Is there storage space for extra clothes located near clean-up/dressing area?			
11. Are clothes, storage bins and supplies coded for ease in identification and enclosed to protect participants property? (e.g. theft, borrowing, destroying)			
J. STAFF NEEDS 1. Is there adequate office space for staff?			
2. Does sharing of offices create a problem for staff?			
3. Is there adequate storage, both locked and unlocked, available for staff and participants needs?			
4. Is clean-up/storage area for activities well situated for programs?			
5. Is furniture easy for staff to arrange or set up and take down when necessary?			

	YES	NO	NOTES
6. Is there adequate visual and auditory privacy in staff offices?			
7. Does staff have separate bathrooms? 7a. If no, can they use participant bathroom and obtain needed privacy? (e.g. use of sign on door saying "occupied")			
8. Does staff have separate areas for breaks?			
K. SECURITY/SURVEILLANCE 1. Are there security devices at entrance and exit of Center?			
2. Is there surveillance at front entry at all times?			
3. Have unobtrusive design modifications (other than security devices) been used in Center to promote security if too many exits or if there is a need to restrict an area? (e.g. camouflaging area, simple barriers)			
4. Is staff able to view main activity room corridors from their offices (e.g. use of vision panels)			
5. Is there an enclosed, secured outdoor area for participants to use safely?			
6. Is there a view of the outdoor area from the main activity room(s) so that participants and staff can see out?			
7. Does outdoor area have overhead protection and comfortable seating for participants?			
8. Are there outdoor activities for participants to participate in if they wish? (e.g. gardening, raking, picking fruit)			
9. Are the outdoor surfaces in good repair and free from changes of level?			
10. Is the area wheelchair accessible?			

	YES	NO	NOTES
11. If there is a view of street activity (e.g. people being picked up and dropped off) from this area, is it disturbing to participants?			
12. If so, can it be blocked off through design or through landscape (e.g. large trees in pots)			
EMERGENCY/MASS CASUALTY			
1. Is the emergency, mass casualty and evacuation plan posted, and is it adequate to ensure the safety of staff and participants?			
2. Is a current non-ambulatory fire clearance posted?			
3. Did the last fire drill occur without incident?			
4. Is participant emergency information maintained in an easily accessible location?			
5. Does site emergency planning include report to notify AAA of the incident?			
6. Is there a first aid kit maintained and is staff trained to use it?			

FOLSTEIN MINI-MENTAL STATUS EXAM

PATIENT IDENTIFIER: _____ DATE: _____

INTERVIEWER: _____ SCORE: _____ (30 possible)

	MAX	Score
"I would like to ask you some questions to check your memory and concentration. Some of them may be easy and some of them may be hard."		
"What is the year?"	1	_____
"What is the season of the year?"	1	_____
"What is the date or day of the month?" (± 1 day)	1	_____
"What is the day of the week?"	1	_____
"What is the month?"	1	_____
"Can you tell me where we are? For instance:"		
"What is the name of this place?"	1	_____
"What city/town are we in?" If interview is occurring in a rural setting ask **"What is the name of the nearest city?"**	1	_____
"What county are we in?"	1	_____
"What state are we in?"	1	_____
"What floor of this building are we on?"	1	_____

"I am going to name three objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to say them again in a few minutes.
The objects are APPLE, TABLE, and PENNY.
Please repeat these words for me."
The words should be read at a rate of one per second, speaking clearly and audibly. You are allowed to read the words only once.

Apple _____ Table _____ Penny _____ 3 _____

Repeat the three words until 1) the subject correctly repeats all three or 2) three trials (including the initial presentation) have been presented.

Number of Trials _____

"Now I am going to give you a word and ask you to spell it forwards and backwards. The word is 'world'. Spell 'world' forwards."
If the subject is unable to spell the word, spell it out loud, and ask the subject to repeat the spelling. Continue until it has been spelled successfully or until you have spelled it for the subject three times.

"Now spell the word 'world' backwards."

_____ _____ _____ _____ _____ 5 _____
D L R O W

B. SPATIAL ORGANIZATION/FURNITURE:	YES	NO	NOTES
1. Is there a separate lobby/reception area where participants can sit?			
2. If there is one main activity room, are separate activity areas defined within the room? (e.g. furniture arrangements, color, flooring, materials, panels)			
3. If there are multiple rooms, are they distinguished from one another? (e.g. materials, color, furnishings)			
4. Are separate activity areas and/or multiple rooms referred to by specific functions? (e.g. living room. dining room)			
5. Can parallel activities be carried out in Center if staff desires?			
6. Is there a separate quiet room/area for participants to rest or be private when necessary?			
7. Is there a separate area/room for participants to smoke if they wish?			
8. Is there a separate and convenient area near entrance for coats and hats to be hung? 8a. If so, is it unobtrusive and not noticed by participants during the day?			
9. Is there separate storage for wheelchairs or assistive aids?			
10. If there are water fountains in the Center are they wheelchair accessible?			
C. OVERALL AMBIANCE 1. Does the Center project a "home-like" feeling?			
2. Does the Center feel uncluttered and calm?			

"What were the three objects I asked you to remember?"
This should be administered as soon as the "world backwards" item is completed.

Apple _____ Table _____ Penny _____ 3 _____

Hold up a wrist watch and ask **"What is this called?"** Repeat with a pencil.

Watch _____ 1 _____

Pencil _____ 1 _____

"I would like you to repeat a phrase after me exactly as I say it. The phrase is: No ifs, ands, or buts." 1 _____
It is very important to speak loudly and enunciate clearly as you read this phrase. One repetition of the phrase is permissible if it is clear that the phrase was not adequately heard. Otherwise, repetition is not allowed.

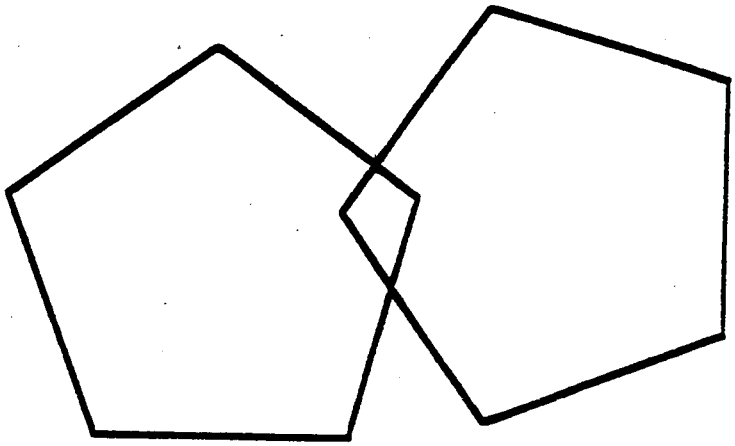
A blank sheet of paper is required for this test. Hold it out and say: 3 _____
"Listen carefully, I am going to give you a piece of paper. When I do, take the paper in your right hand, fold the paper in half, and put the paper on the floor."
It is permissible to repeat these instructions one time if it is clear that the subject has not adequately heard the instructions. Otherwise, repetition or coaching is not allowed. The paper should be handed to the midline of the subject at a sufficient distance that (s)he has to reach out for it.

Show the subject the stimulus page with "Close Your Eyes" at the top and say:
"Read the words on this page, then do as it says." 1 _____

Give the subject a blank piece of paper and pencil and say:
"Write any complete sentence on this piece of paper for me." 1 _____

Give the subject the stimulus page with the design on it and say:
"Here is a drawing. Please copy the drawing on the sheet of paper." 1 _____
If the subject is not sure where to copy the design, point to the blank part of the page below the design and instruct to place the copy there.

CLOSE YOUR EYES



MINI-MENTAL STATUS EXAM

INSTRUCTIONS FOR ADMINISTRATION AND SCORING

"I am going to ask you some questions to test your memory and other mental abilities. Some of the questions I ask you will be easy, some may be difficult. I would like you to do the best you can."

I. Orientation (10 points)

"What is today's date?" If the subject does not respond with the current year, month, date of the month, day of the week, prompt with:

"What year is it?"
"What month is it?"
"What date or day of the month is it?"
"What day of the week is it?"

Scoring - 1 point is given for each correct response. Responses must be exact.

"What season of the year is it?"

Scoring - 1 point is given for the correct season. During the month of March credit is given for either winter or spring, during June credit is given for spring or summer, during September credit is given for summer or fall, and during December credit is given for fall or winter.

"What is the name of this place?"

Scoring - 1 point is given for a correct response. If in a hospital or office or clinic setting responses such as "doctor's office", "hospital", "medical clinic", etc., are acceptable. If at home responses such as "my house", "my home", "my daughter's house" (if accurate), or "my apartment" are acceptable.

"What is the name of this city?" If interview is occurring in a rural setting ask **"What is the name of the nearest city?"**

"What is the name of this county?"
"What is the name of this state?"
"What floor of this building are we on?"

Scoring - 1 point is given for each correct response.

II. Immediate Recall of Three words (3 points)

"I am going to say three words. I would like you to listen very carefully and say these words out loud after I finish. the words are apple, table, and penny. Please repeat the three words I just said." The words should be read at a rate of one per second, speaking clearly and audibly. You are allowed to read the words only once.

Scoring - 1 point is given for each word spontaneously repeated. Credit is not given for recall of words after subsequent presentations.

After immediate recall of the three words has been tested it is necessary to continue presenting the three words until the subject is able to recall all three, two times in a row. This is done to make sure that the subject has registered the words, for which recall will be tested later in this test. Continue repeating words until they have been presented five times if the above criteria is not met. If the criteria has not been met after five presentations, continue with the remainder of the test.

"I am going to ask you to recall these three words in a few minutes. I would like you to repeat them again to make sure that you remember them. The words were apple, table, and penny. Please say them out loud again." Continue according to the above guidelines with: **"Once more, the words were apple, table, and penny. Please say them out loud again."** After the last repetition of the words say: **"Try to remember these three words, because I will ask you to recall them in a few minutes."**

III. Spell "World" Backwards (5 points)

"Spell the word 'world' out loud." If the subject is unable to spell the word, spell it out loud, and ask the subject to repeat the spelling. Continue until it has been spelled successfully two times in a row or until you have spelled it for the subject five times.

"Now spell the word 'world' backwards".

Scoring - 1 point is given for each letter in the correct position. That is, "d" is first, "l" is second, "r" third, "o" fourth, and "w" fifth.

IV. Recall of Three Words (3 points)

"Do you remember the three words you repeated a few minutes ago? What are they?"

Scoring - 1 point for each word spontaneously repeated. If the subject is not able to recall words cuing is allowed, but credit is not given for any word recalled after a cue.

V. Name Simple Objects (2 points)

Hold up a wrist watch and ask, **"What is this called?"** Repeat with a pencil.

Scoring - 1 point for each object correctly named.

VI. Repeat Phrase (1 point)

"Please repeat the following phrase: No ifs, ands, or buts." It is very important to speak loudly and enunciate clearly as you read this phrase.

Scoring - 1 point if "No ifs, ands, or buts" is correctly repeated. Credit is given if one "s" is left off, but response must otherwise be exactly in order for credit to be given.

VII. Three Stage Command (3 points)

A blank sheet of paper is required for this test. Hold it out and say: **"Listen carefully, I want you to take this paper in your right hand, fold it in half, and put it on the floor."** It is permissible to repeat these instructions one time if subject has not yet started to carry out any of the commands.

Scoring - 1 point is given for each instruction correctly carried out. The paper can be folded in half in either direction. The fold does not have to be in the exact middle - any fold near the center line of the paper is acceptable. Credit is not given if the paper is folded more than once - i.e. must be folded in two parts (and not three or four, etc.) in order for credit to be given.

VIII. Read and Comprehend simple sentence (1 point)

Show the subject the page with "Close Your Eyes" at the top and say: **"Read this out loud and do what it says."** If the subject reads it but does not close eyes, prompt once by saying: **"Now do what it says to do".**

Scoring - 1 point if subject closes eyes. Reading the words out loud does not enter into scoring.

IX. Write Simple Sentence (1 point)

Give the subject a blank piece of paper and pencil and say: **"Please write a complete sentence on this piece of paper. The only requirement is that it be a complete sentence."**

Scoring - 1 point for any complete sentence. It must have a subject, a predicate, and express a complete thought. Spelling or punctuation errors or illegible handwriting are allowed if the subject can say the sentence out loud and the writing resembles the sentence that was said.

X Copy Design

Give the subject the page with the design on it and say: **"Copy this design on this sheet of paper."** If the subject is not sure where to copy the design point to the blank part of the page below the design and instruct to place the copy there.

Scoring - In order to receive credit, the subject's copy must meet two criteria: 1) there must be two five-sided polygons, and 2) the intersection of the five-sided figures must be at a four-sided polygon. Any figure that meets these two criteria is acceptable.

It is possible to evaluate the type of impairment by reviewing sections for exact responses. Maximum score possible is 30 points. Levels of impairment are shown below:

Score	25 - 30	=	normal
	20 - 24	=	mild cognitive impairment
	12 - 19	=	moderate impairment
	5 - 11	=	severe cognitive loss
	0 - 4	=	very severe

Aphasia or other handicaps (i.e. hearing loss) may skew the score.

MINI-MENTAL STATUS EXAMINATION

GENERAL INSTRUCTIONS

1. The test should be administered in a setting that is as free from distractions as possible. Adequate lighting should be available.

2. Whenever possible, the subject should be alone with the examiner while the test is being administered. Allowing a family member or caregiver to be present can be distracting and can interfere with test administration.

3. It is important to speak loudly and enunciate clearly when giving directions. Give directions slowly and make sure that the subject understands what he/she is being asked to do.

4. It is best to use the instructions provided verbatim, but if the subject does not understand it is permissible to paraphrase instructions to clarify what is being asked. It is not permissible to either directly give answers or to directly or indirectly give hints that would yield the correct answer.

5. It is important to maintain a comfortable relationship with the subject. Instructions should be presented in a friendly, conversational manner. If the subject is having difficulty with test items encouragement should be offered, such as "you're doing fine" or "this is a difficult item, just do the best you can". It is permissible to give non-contingent feedback, for example, saying "good" after the subject responded to an item. This should be non-contingent, that is, it should be done after both correct and incorrect responses. Direct feedback about whether a response is correct or incorrect should be avoided.

EXHIBIT E

INTAKE/SCREEN

California Department of Aging
FORM 100
Revised 10/91

1. Form# (Circle one) In 1 Re 2 Dis 3 Read 4

COUNTY # | PROGRAM OR PROJECT # | SITE # | 2. PARTICIPANT # ____ – ____ (Site No. – Social Security No.)

3. DATE ____ MM/DD/YY TIME: ____ : ____ a.m. p.m. MODE Letter Drop In Telephone RESPONSE Emergency Normal

APPLICANT NAME: Last First Mi | SYSTEM # (SN)

RESIDENT ADDRESS: Street City State | 4. ZIP | *Tel. # ( )

MAILING ADDRESS:

5. DOB ____ MM/DD/YY	AGE	6. SEX 1 M 2 F	7. MARITAL STATUS 1 Mr 2 Wd 3 Sp 4 Sg 5 Dv	8. RACE/ORIGIN 1 W 2 B 3 A/PI 4 AI/NA 5 Oth 6 F 7 Hisp

TRANS. LANG. Y N	9. LIVES ALONE 1 Y 2 3 4 N	10. PHYS IMP 1 Y 2 N	11. RESIDENCE 1 Hse 2 Apt 3 MH 4 Htl 5 B&R 6 RCF 7 SNF 8 Hmls 9 Oth	PROPERTY Rent Own Oth

SOCIAL SECURITY #	MEDICARE/RRB #	HEALTH INSURANCE NAME AND #

MEDI-CAL # Y N	VETERAN # Y N	12. SSI/SSP 1 Y 2 N	13. LOW INCOME 1 Y 2 N

REGULAR PHYSICIAN: Name Address Tel. # ( )

EMERGENCY CONTACT: Name Relationship Address Tel. # ( )

14. REFERRAL SOURCE: Type: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Name

Address: Street City – State ZIP Tel. # ( )

15. REASON FOR REFERRAL: (Circle one) 1 2 3 4 5 6 7 8 9 10

*PRESENTING PROBLEM/SERVICES REQUESTED/COMMENTS/FOLLOWUP

16. DIAGNOSIS: (Circle one) 1 2 3 4 5 6 7 8 9 10 11 12 13 14

17. DISENROLLMENT - Out of home placement: (Circle one) 1 2 3 4 5 6 7

18. DATE OF DISENROLLMENT ____ MM/DD/YY

COMPLETED BY: Program/Name

Staff Code # 19. Date and Signature ____ MM/DD/YY ▶ ____ Tel. # ( )

INTAKE SCREEN

Instructions

The Intake/Screen Form covers all of the formerly required demographics and should be utilized for several data collection functions. Information required by the Intake/Screen Form is being collected for utilization by the site and by several Department of Aging programs including Linkages, Multipurpose Senior Services Program, SEED, and Alzheimer's Day Care Resource Centers. The form is designed to be used during the intake and screening process of new participants. The Intake/Screen Form is also to be used for updating and revising participant related information, and for collection of required disenrollment and discharge information.

This form is to be completed by program staff and not by a family member.

1. Form #: Circle the appropriate number that indicates the purpose for completing the form. Complete one form for each reported action. 1=Intake/Screen; 2=Revisions (only enter reported changes); 3=Disenrollment/Discharge (only complete participant's identifiers and sections 17, 18, and 19); 4=Readmission (complete entire form).

2. Participant No.: Enter an eleven digit number. The first two digits shall be the site number. The next nine digits are the participant's social security number. This eleven digit number shall serve as the participant's identification number on all forms, and this number must be entered for all participants. If the participant does not have a Social Security number, the site must create a log to establish a nine digit number.

3. Date: Enter MM/DD/YY. Date of enrollment begins after completion of the participant's assessment. This date should remain the same unless the participant is re-admitted into the program. If participant is not enrolled, do not enter a date of enrollment.

4. Zip: Enter the zip code of the participant's resident address.

5. DOB: Enter participant's date of birth (MM/DD/YY).

6. Sex: Circle "M" (Male); "F" (Female).

7. Marital Status: Circle current status: Mr-Married; Wd-Widowed; Sp-Separated; Sg-Single; Dv-Divorced.

8. Race/Origin: Circle one: W-white; B-Black; A/PI-Asian/Pacific Islander; AI/NA-Alaskan Indian/Native American; Oth-Other (Any unnamed group); F-Filipino; Hisp-Hispanic.

9. Lives Alone: Circle "Y" (yes) if participant lives alone. If participant does not live alone, indicate living arrangements by circling one of the following: 2-Spouse; 3-Family; 4-Other.

10. Phys Imp: Circle one: "Y" (yes) or "N" (no). Indicate yes if participant has a visible or reported physical impairment.

11. Residence: Circle one to describe participant's current residence: Hse-House; Apt-apartment; MH-Mobil Home; Htl-Hotel; B&R-Board and Room; RCF-Residential Care Facility; SNF-Skilled Nursing Facility; Hmls-Homeless; Oth-Other, which includes the residence of the caregiver.

12. SSI/SSP: Circle one: "Y" (yes); "N" (no).

13. Low Income: Circle one: "Y" (yes); "N" (no). Low income is determined if monthly income is less than or equal to the monthly SSI/SSP benefit level for a single older person.

14. Referral Source: Circle appropriate number to indicate the source for referral to ADCRC.

1. Self
2. Family
3. Friends
4. Physician
5. Social Worker
6. Hospital Provider
7. Nursing Home (SNF/ICF)
8. Residential Care Facility
9. Home Health Care Agency
10. ADC/ASDC/ADHC
11. Other Community Health Providers
12. Adult Protective Services (APS)
13. Community Support Group
14. Regional Resource Center
15. Alzheimer's Disease and Treatment Center
16. Other

15. Reason for Referral: Circle appropriate number to indicate the reason for referral to ADCRC.

1. Family and/or Caregiver Needing Respite Care
2. Patient Becoming Unmanageable at Home
3. Memory/Cognition Problem
4. Physical Problem
5. Wandering
6. Agitated, Angry, Combative
7. Incontinent
8. Unsafe Left Alone
9. To Participate in Activities
10. Other

16. Diagnosis: Circle appropriate number to indicate the participant's primary diagnosis.

1. Alzheimer's Disease
2. Vascular Dementia
3. Parkinson's Dementia
4. Pseudodemenetia
5. Metabolic Dementia
6. Alcoholic Dementia
7. Space Occupying Lesions
8. Traumatic Dementia
9. Amnestic Syndrome
10. Pick's Disease
11. Infectious Dementia
12. Normal Pressure Hy Drocephalic (NPH)
13. Dementia Type Syndrome (non specified)
14. Other

17. Disenrollment: Circle the corresponding number that provides the reason for the participant's disenrollment from the program.

1-Acute Hospital; 2-SNF/ICF; 3-RCF; 4-Participant/Family Request; 5-Moved Out of the Area; 6-Death; 7-Other.

18. Date of Disenrollment: Enter MM/DD/YY.

19. Date and Signature: Enter the date the form was completed. Enter MM/DD/YY.

FUNCTIONAL ASSESSMENT

1. Form # (circle one): IN 1 RE 2 DIS 3 READ 4

CDA/ALZ FORM 200.1 Revised 10/91

COUNTY NO. PROGRAM OR PROJECT NO. 2. Participant #: ____ ____-____-____ (Site # / Social Security #)

Participant Name (Last) (First) (MI)

3. Assessment Date	☐ No Change	Assessment Seq. # (1=First)	Enrollment Date

4. ADL*/IADL FUNCTIONING	INDEPENDENT	VERBAL ASSISTANCE	SOME HUMAN HELP	A LOT OF HUMAN HELP	DEPENDENT	PARAMEDICAL	DEVICE	HAS FORMAL HELP	HAS INFORMAL HELP	HAS NO HELP	NEEDS (MORE) HELP	COMMENTS
A. HOUSEWORK	1	2	3	4	5							
B. LAUNDRY	1			4	5							
C. SHOPPING & ERRANDS	1		3		5							
D. MEAL PREP & CLEAN UP	1	2	3	4	5	6						
E. MOBILITY INSIDE *	1	2	3	4	5							
F. BATHING *	1	2	3	4	5							
G. GROOMING/	1	2	3	4	5							
H. DRESSING *	1	2	3	4	5							
I. BOWEL, BLADDER, & MENST.*	1	2	3	4	5							
J. TRANSFER *	1	2	3	4	5							
K. EATING *	1	2	3	4	5	6						
L. RESPIRATION	1				5	6						
M. MEDICATIONS	1	2	3		5							
N. STAIRCLIMBING *	1	2	3	4	5							
O. MOBILITY OUTSIDE *	1	2	3	4	5							
P. TRANSPORTATION	1	2	3	4	5							
Q. TELEPHONE	1	2	3		5							
R. MONEY MANAGEMENT	1	2	3		5							
S. CONTINENCE: BOWEL *		1	2	3	4							
T. CONTINENCE: BLADDER *		1	2	3	4							

5. MENTAL FUNCTIONING	No Problem	Mild	Moderate	Severe		No Problem	Mild	Moderate	Severe
A. MEMORY	1	2	3	5	E. Anxiety	1	2	3	5
B. ORIENTATION	1	2	3	5	F. Combativeness	1	2	3	5
C. JUDGEMENT	1	2	3	5	G. Wandering	1	2	3	5
D. COMMUNICATION	1	2	3	5	H. Personality Changes	1	2	3	5

6. LEVEL OF SEVERITY OF CARE NEEDS (circle one) Mild 1 Moderate 2 Severe 3

MM Score 15

COMPLETED BY: Tel. # ( )

Staff Code No. Date and Signature (If applicable)

FUNCTIONAL ASSESSMENT FORM
INSTRUCTIONS (Revised 7/91)

PLEASE NOTE FOR ADCRCs:
This form is used by other programs in addition to the ADCRCs. Answers are required for each of the numbered questions, 1-6, with their subsections as indicated. Question four provides answers numbered 1.1, 1.2, and 1.3 for each function. ADCRC does not require use of these subsets. Space under device, and four "HELP" columns are optional for ADCRC. This program does not tally this information. The site may elect to use this space if desired.

This form is to be completed by a staff person and not a family member.

1. FORM NUMBER: Circle the appropriate number that indicates the purpose for completing the form: 1 = Initial Intake/Screen; 2 = Re-assessment; 3 = Disenrollment/Discharge; 4 = Re-admission.

COUNTY NUMBER: To be assigned.

PROGRAM OR PROJECT NUMBER: To be assigned.

2. PARTICIPANT NUMBER: Enter an eleven digit number. The first two digits shall be the site number. The next nine digit number is the participant's social security number. This eleven digit number shall serve as the participant's identification number on all forms. This number must be entered for all participants.

PARTICIPANT NAME: Enter participant's last name, first name, middle initial.

3. DATE OF ASSESSMENT: Enter MM/DD/YY. Enter the date the assessment was completed.

NO CHANGE: Check this box if there has been no change in the participant's functioning levels. Do not use this box if any new or changed inforamtion, including the Mini Mental (MM) Score, needs to be entered for items 1 - 6.

ASSESSMENT SEQUENCE NUMBER: Enter the number which indicates the sequential order of the participant's functional assessment as completed (i.e., 1=initial assessment; 2=second assessment or reassessment; 3=third assessment; etc.).

ENROLLMENT DATE: Enter MM/DD/YY. Date of enrollment begins after completion of the participant's assessment. This date should remain the same unless the participant is re-admitted to the program. If participant is not enrolled do not enter a date of enrollment.

4. ADL/IADL FUNCTIONING: Completion of this section is required in order to determine the ADL functioning level and the level of severity of care needs. Circle the appropriate number to indicate the level at which the person can perform the function with safety. The following are general standards which apply to all ADL/IADL functions excluding continence. The higher the number the greater the dependency.

1. Independent: Able to perform function without human assistance though participant may have difficulty but completion of the task with or without a device poses no risk to his/her safety. It is unnecessary to use the sub-categories .1, .2, or .3, they will not be collected for data processing.

2. Verbal Assistance: Able to perform but needs verbal assistance as reminding, guidance, or encouragement.

3. Some Human Help: Can perform with some human help; i.e., direct physical assistance from the provider.

4. A Lot of Human Help: Can perform with a lot of human help.

5. Dependent: Cannot perform function at all without human help.

6. Paramedical: Cannot be performed by persons who are not trained or authorized by a certificate, license or special authorization to carry out.

DEVICE: Enter an "X" to indicate that the functional level rated is based on the person's use of a device to perform at that level. Explain device in Comments Section.

HAS FORMAL HELP: Enter an "X" to indicate the person currently has formal help to perform the function being rated. Formal Help refers to services from a provider for which the applicant qualified (e.g., IHSS) or from a provider who received pay for the service (e.g., home delivered meals, even though the fee or contribution may be reduced). Explain in Comments Section.

HAS INFORMAL HELP: Enter an "X" to indicate the person currently has informal help to perform the function being rated. Informal Help refers to assistance from a relative or friend who received no compensation for the service. Explain in Comments Section.

HAS NO HELP: Enter an "X" to indicate the person currently has no help in performing the function being rated.

NEEDS (MORE) HELP: Enter an "X" to indicate if the person has no help and needs help. This could include the occasion when the current helper is exhausted or for other reasons no longer able to continue the level of help now being provided. Explain in Comments Section.

A. HOUSEWORK:
Sweeping, vacuuming, and washing floors; washing kitchen counters and sinks, cleaning the bathroom; storing food and

supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen.

RANK 1: Independent: Able to perform all domestic chores without a risk to health and safety.

RANK 2: Able to perform tasks but needs direction or encouragement from another person.

RANK 3: Requires physical assistance from another person for some chores; e.g., has limited endurance or limitations in bending, stooping, reaching, etc.

RANK 4: Although able to perform a few chores (e.g., dust furniture or wipe counters) help from another person is needed for most chores.

RANK 5: Totally dependent upon others for all domestic chores.

B. LAUNDRY:
Gaining access to machines, sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry, folding and storing. Ability to iron non-wash-and-wear garments is ranked as part of this function only if this is required because of the individual's condition; e.g., to prevent pressure sores or for employed recipients who do not own a wash-and-wear wardrobe.

RANK 1: Independent: Able to perform all chores.

RANK 4: Requires assistance with most tasks. May be able to do some laundry tasks; e.g., hand wash underwear, fold and/or store clothing by self or under supervision.

RANK 5: Cannot perform any task. Is totally dependent on assistance from another person.

C. SHOPPING AND ERRANDS:
Compile list, bending, reaching, and lifting, managing cart or basket, identifying items needed, transferring items to home, putting items away, phoning in and picking up prescriptions, and buying clothing.

RANK 1: Independent: Can perform all tasks without assistance.

RANK 3: Requires the assistance of another person for some tasks; e.g., help with major shopping needed, but client can go to nearby store for small items or needs direction or guidance.

RANK 5: Unable to perform any tasks for self.

D. MEAL PREPARATION AND CLEANUP:
Planning menus. Washing, peeling, slicing vegetables, opening packages, cans and bags, mixing ingredients, lifting pots and pans, reheating food, cooking, safely operating stove, setting the table, serving the meal, cutting food into bite-sized pieces. Washing, drying, and putting away the dishes.

RANK 1: Independent: Can plan, prepare, serve and clean up meals.

RANK 2: Needs only reminding or guidance in menu planning, meal preparation, and/or cleanup.

RANK 3: Requires another person to prepare and clean up main meals on less than a daily basis; e.g., can reheat food prepared by someone else, can prepare simple meals and/or needs help with cleanup on a less than daily basis.

RANK 4: Requires another person to prepare and clean up main meal(s) on a daily basis.

RANK 5: Totally dependent on another person to prepare and clean up all meals.

RANK 6: Is tube-fed. All aspects of tube feeding are evaluated as a Paramedical Service.

E. MOBILITY INSIDE: Walking or moving inside, moving from one area of indoor space to another without necessity of handrails. Can respond adequately to the presence of obstacles that must be stepped around. Includes ability to go from inside to outside and back (exclusive of stair climbing, see separate function).

RANK 1: Independent: Requires no physical assistance from others although person may be slow or experience some difficulty or discomfort. Getting to and from where she/he wants to go can be accomplished safely.

RANK 2: Can move about inside with encouragement, or reminders to watch for steps, or to use a cane or walker.

RANK 3: Requires physical assistance from another person to negotiate a wheelchair, or to steady the person or guide them in the desired direction.

RANK 4: Requires constant attention from another person, at risk of being lost or unsafe if not accompanied.

RANK 5: Unable to move about, must be carried, lifted, or pushed in a wheelchair or on a gurney at all times.

F. BATHING: See definition and scale under "Grooming".

G. GROOMING:
Bathing means cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of a tub, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toe nail care (unless toe nail care is medically contraindicated and therefore is evaluated as a Paramedical Service).

RANK 1: Independent: Able to bathe and groom self safely without help from another person.

RANK 2: Able to bathe and groom self with direction or intermittent monitoring. May need reminding to maintain personal hygiene.

RANK 3: Generally able to bathe and groom self, but needs assistance.

RANK 4: Requires direct assistance with most aspects of bathing and grooming. Would be at risk if left alone.

RANK 5: Totally dependent on others for bathing and grooming

H. DRESSING:
Putting on and taking off, fastening and unfastening garments and undergarments, special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

RANK 1: Independent: Able to put on, fasten and remove all clothing and devices without assistance. Clothes self appropriately for health and safety.

RANK 2: Able to dress self, but requires reminding or directions with clothing selection.

RANK 3: Unable to dress self completely, without the help of another person, e.g., tying shoes, buttoning, zipping, putting on hose or brace, etc.

RANK 4: Unable to put on most clothing items by self. Without assistance would be inappropriately or inadequately clothed.

RANK 5: Unable to dress self at all. Requires complete assistance from another.

I. BOWEL, BLADDER AND MENSTRUAL:
Able to move to and from, on and off toilet or commode, empty commode, manage clothing and wipe and clean body after toileting, use and empty bed pans, ostomy and/or catheter receptacles and urinals, apply diapers and disposable barrier pads. Menstrual care: able to apply external sanitary napkin and clean body. (Note: catheter insertion, ostomy irrigation and bowel program are evaluated as Paramedical Services).

RANK 1: Independent: Able to manage bowel, bladder and menstrual care with no assistance from another person.

RANK 2: Requires reminding and direction only.

RANK 3: Requires minimal assistance with some activities but the constant presence of the provider is not necessary.

RANK 4: Unable to carry out most activities without assistance.

RANK 5: Requires physical assistance in all areas of care.

J. TRANSFER:
Moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to prevent skin breakdown. (Note: If pressure sores have developed, the need for care of them is evaluated as a Paramedical Service.)

RANK 1: Independent: Able to do all transfers safely without assistance from another person.

RANK 2: Able to transfer but needs encouragement or direction.

RANK 3: Requires some help from another person; e.g., routinely requires a boost or assistance with positioning.

RANK 4: Unable to complete most transfers without physical assistance. Would be at risk if unassisted.

RANK 5: Totally dependent upon another person for all transfers. Must be lifted or mechanically transferred.

K EATING:

Reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, chewing, swallowing food and liquids, manipulating food on plate. Cleaning face and hands as necessary following a meal.

RANK 1: Independent: Able to feed self.

RANK 2: Able to feed self, but needs verbal assistance such as reminding or encouragement to eat.

RANK 3: Assistance needed during the meal, e.g., to apply assistive device, fetch beverage or push more food to within reach, etc., but constant presence of another person not required.

RANK 4: Able to feed self certain foods, but cannot hold utensils, cups, glasses, etc., and requires constant presence of another person.

RANK 5: Unable to feed self at all and is totally dependent upon assistance from another person.

RANK 6: Is tube-fed. All aspects to tube feeding are evaluated as a Paramedical Service.

L. RESPIRATION:

Respiration limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and IPPB machines.

RANK 1: Respiration limited to non-respirator or other oxygen equipment. Able to use and clean respirator independently if used.

RANK 5: Needs help with self-administration and/or cleaning.

RANK 6: Needs Paramedical Services such as suctioning.

M. MEDICATION:
Physically and mentally able to identify, handle, and consume (or inject) the correct amount of the prescribed medication at the specified time according to a doctor's prescription.

RANK 1: Independent: Can identify, measure, and self-administer prescribed medication.

RANK 2: Able to perform tasks but needs verbal direction, guidance or reminder to do it, without risk to safety.

RANK 3: Requires some human help such as opening the container or measuring the amount of medication. May or may not need reminder.

RANK 5: Cannot perform any part of this function. May require all liquid or injected medication due to swallowing problems or noncooperative behaviors.

N. STAIR CLIMBING:
Lifting feet, holding hand rail and negotiating stairs from outside to inside from one interior level to another (from 2 or 3 to as many as 12 to 15 steps).

RANK 1: Independent: Physically and mentally able to negotiate stairs from ground level to first floor or from first to second floor without assistance or risk to safety.

RANK 2: Able to negotiate steps but may need reminder to watch steps or hold hand rail.

RANK 3: Able to negotiate steps with use of hand rail and the personal assistance of someone helping to balance or steady the person.

RANK 4: Able to negotiate only a small number of steps, i.e., ground-level to first floor or two to three steps between levels, only with considerable help from another person to lift foot and lift body to next step.

RANK 5: Unable to negotiate any stairs inside or outside, must be carried in chair or on gurney (or stretcher) to go from one level to another.

Q. MOBILITY OUTSIDE:
Walking or moving around outside, moving from one area of outdoor space to another or walking on the sidewalk or path without necessity of handrails. Can respond adequately to uneven sidewalk, or the presence of obstacles that must be stepped around. Includes ability to go from inside to outside and back (exclusive of stair climbing, see separate function).

RANK 1: Independent: Requires no physical assistance from others although person may be slow or experience some difficulty or discomfort. Getting to and from where she/he wants to go can be accomplished safely.

RANK 2: Can move about outside with encouragement, or reminders to watch for steps, or to use a cane or walker.

RANK 3: Requires physical assistance from another person to negotiate a wheelchair, or to steady the person or guide them in the desired direction.

RANK 4: Requires constant attention from another person, at risk of being lost or unsafe if not accompanied.

RANK 5: Unable to move about, must be carried, lifted or pushed in a wheelchair or on a gurney at all times.

P. TRANSPORTATION
Using private or public vehicles, cars, buses, trains, or other forms of transportation to get to medical appointments, purchase food, shop, pay bills or arrange for services, to socialize and participate in entertainment or religious activities. Can arrange for getting and using public transportation or get to, enter and operate a private vehicle.

RANK 1: Independent: Can arrange, get to, enter and travel in public or private vehicles; upon arrival can exit and arrange return travel with the same capability. Does not place the person at risk.

RANK 2: Can use public transportation or ride in a private vehicle when reminded to make arrangements or to enter the vehicle.

RANK 3: Requires physical assistance to make transportation arrangements, i.e., calling, writing instructions about time and place, can ride with others if assisted into and out of the vehicle.

RANK 4: Needs to be assisted to get in and out and accompanied to ride in the vehicle to assure that the person does not try to move around or exit inappropriately, or to assure travel without risk.

RANK 5: Unable to travel at all by self. Has to be carried into and out of vehicle in arms or on a gurney. Requires transportation by others. Cannot use any form of public transit - travels by ambulance, paratransit with no self assist, or private car with full assistance.

Q. TELEPHONE

Obtains number, dials, handles receiver, can speak and hear response, and terminates call, may include use of instrument with loud speaker or hearing devices. Can be expected to use telephone during emergency situations to call 911 or other help.

RANK 1: Independent: Can obtain and dial number, handle receiver, terminate call and replace receiver without assistance.

RANK 2: Needs only reminder on how to use the phone, or how to get the number. May need to be encouraged to use the phone.

RANK 3: Needs human assistance to obtain number or dial, but can carry on conversation once the other party is reached and terminate call.

RANK 5: Unable to use phone at all. Unable to conduct conversation on phone for either physical or mental reasons.

R. MONEY MANAGEMENT

Physically and mentally handles the receipt of monies, expenditures and receipt and payment of bills in a timely and primarily correct manner.

RANK 1: Independent: Handles all financial matters without

RANK 1: Independent: Handles all financial matters without risk of eviction, turn-offs and other "failure to pay" related problems.

RANK 2: Is able to perform all financial transactions but may need to be reminded to pay bills or obtain cash from bank.

RANK 3: For either physical or mental reasons may need assistance in doing banking, writing checks or other isolated elements of financial transactions.

RANK 5: Unable to attend to any part of the necessary financial transactions to receive and disburse funds to meet daily needs.

S. CONTINENCE BOWEL
The physical and mental state of having complete control over elimination of bodily wastes.

RANK 1: Independence: Responds promptly to physical cues for the need to eliminate and responds to the cues promptly and effectively.

RANK 2: Can control physical elimination, but may need to be reminded to do so periodically.

RANK 3: May require assistance due to occasional accidents. Assistance would be in the form of scheduling and implementing toileting.

RANK 4: No control over bowels, requires full time diapering. (Colostomy addressed under Bowel and Bladder.)

T. CONTINENCE BLADDER
Physical and mental capacity to have complete control over urination.

RANK 1: Independent: Responds to physical cues for the need to urinate promptly and effectively.

RANK 2: May need to be reminded to use the toilet but can control urination.

RANK 3: May experience "stress" incontinence, or inability to control urine in certain circumstances--May be responsive to scheduling, training, fluid control with assistance from others.

RANK 4: Unable to control, must rely on diapering or catheter (see also Bowel and Bladder).

5. MENTAL/ BEHAVIORAL FUNCTIONING: Circle the appropriate number to indicate mental functional status.

A. MEMORY:
Recalling learned behaviors and information from distant and recent past.

RANK 1: NO PROBLEM: Able to give correct recent medical history; able to refer appropriately to comments given earlier in the conversation.

RANK 2: MILD: Experiences occasional memory loss.

RANK 3: MODERATE OR INTERMITTENT PROBLEM: Experiences memory loss, but not to a degree which causes risk; client needs occasional reminding.

RANK 5: SEVERE MEMORY DEFICIT: Forgets to start or finish activities thus posing risk to self.

B. ORIENTATION:
Awareness of time, place and other individuals in one's environment.

RANK 1: NO PROBLEM: Participant aware of where he/she is and can give information related to living arrangement, family, etc.; aware of passage of time during the course of the day.

RANK 2: OCCASIONAL DISORIENTATION AND CONFUSION APPARENT BUT DOES NOT PUT SELF AT RISK: Has general awareness of time of day; able to provide limited information about family, age, etc.

RANK 3: MODERATE DISORIENTATION: Frequent disorientation and confusion, requires advice and guidance.

RANK 5: SEVERE DISORIENTATION WHICH PUTS CLIENT AT RISK: Wanders off; lacks awareness or concern for safety or wellbeing; unable to identify significant others or relate to environment or situation; no sense of time of day.

C. JUDGEMENT:

RANK 1: NO PROBLEM with judgement.

RANK 2: JUDGEMENT MILDLY IMPAIRED: Able to evaluate environmental cues and respond appropriately most of the time, occasionally makes poor judgements.

RANK 3: JUDGEMENT MODERATELY IMPAIRED: Shows lack of ability to plan for self; has difficulty deciding between alternatives but is amenable to advice; social judgement is poor.

RANK 5: JUDGEMENT SEVERELY IMPAIRED: Fails to make decisions or makes decisions without regard to safety or well-being.

D. COMMUNICATION:

RANK 1: No problems with communication.

RANK 2: Mild - minimal problems with word-finding or sentences. Able to verbally communicate.

RANK 3: Moderate - more difficulty with finding words and incomplete or confusing sentence structure.

RANK 5: Severe - able to speak words but phrases and words usually do not communicate.

E. ANXIETY:

RANK 1: No problems.

RANK 2: Mild restlessness.

RANK 3: Moderate - restless behavior but able to participate with proper and continuing cues. Occasional verbal/physical aggression one to two times a week.

RANK 5: Severe - very restless, cannot sit for more than a few minutes, constantly moving, agitated. May strike out, may be combative verbally or physically. Without proper assistance, would be very restless.

F. COMBATIVENESS (VERBAL AND PHYSICAL)

RANK 1: Not combative.

RANK 2: Mild. Occasional/rare verbal and physical aggressiveness.

RANK 3: Moderate - more frequent aggression, but usually controlled with case management techniques.

RANK 5: Severe - daily verbal and physical aggressiveness.

G. WANDERING
(Defined by wanting to leave their environment for another location on a consistent basis. Not to be confused with pacing).

RANK 1: No wandering at home or at center.

RANK 2: Mild - tends to want to leave and would likely be lost if outside safety of center or home. Able to take short routine walks with some success.

RANK 3: Moderate - frequently wanders away from safe environment if not secure or accompanied.

RANK 5: Severe - needs constant monitoring if no security is provided. At high risk of being lost. No apparent comprehension of distance or direction.

H. PERSONALITY CHANGES
The client's perception of and actions in normal situations is altered either in a positive or negative manner; e.g., more restless or withdrawn or accepting of situation.

RANK 1: No change from base line.

RANK 2: Able to independently provide own opinions, thoughts and interacts on a social level even if incorrect. Client could cover up mild attitude changes of dementia if others were not aware a problem existed. Mild changes in emotional responsiveness - slightly more irritable or more passive, diminished sense of humor, mild depression, may dwell in past.

RANK 3: Able to interact on a social level and be personal with moderate cuing and assistance. Moderate change in emotional responsiveness - growing apathy, despondent, angry outbursts, cries easily, lack of regard for feelings of others, quarrelsome, irritable.

RANK 5: Unable to initiate responses by their own energy, or unable to initiate a task on their own. Dependent solely on interaction and energy of others. Impaired emotional control - unstable, rapid mood swings, crying or laughing in inappropriate situations - violent outbursts, antisocial behavior.

6. LEVEL OF SEVERITY OF CARE NEEDS: Circle the appropriate category. This is a measure of functional/ behavioral characteristics and not necessarily consistent with the degree of cognitive impairment. 1=Mild; 2=Moderate; 3=Severe. The level will be determined by the summary of all the functioning elements and the judgement of the professional completing the form.

MM SCORE: Enter the score from the Folstein Mini-Mental Status Exam.

COMPLETED BY: Print the staff person's name and title completing this form.

DATE AND SIGNATURE: The form must always be signed by the person completing the Functional Assessment Form.

TELEPHONE NUMBER: Enter the telephone number of the person completing the form.

STAFF CODE NO: To be assigned.

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

Exhibit G

December 23, 1999

TO: CALIFORNIA DEPARTMENT OF AGING
DEPARTMENT OF DEVELOPMENTAL SERVICES
DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE ATTORNEY GENERAL, BUREAU OF MEDI-CAL FRAUD
COUNTY WELFARE DIRECTORS ASSOCIATION
LAW ENFORCEMENT AGENCIES (see attached list)
PROFESSIONAL MEDICAL AND NURSING AGENCIES (see attached list)
HOSPITAL ASSOCIATIONS (see attached list)

SUBJECT: REVISED DRAFT REPORT FORM FOR SUSPECTED DEPENDENT ADULT/ELDER ABUSE (SOC 341)

The California Department of Social Services in consultation with members of the County Welfare Directors Association has revised the Report of Suspected Dependent Adult/Elder Abuse form (SOC 341), dated 12/99 and the reporting instructions. The draft form is being sent to you for review and comments in accordance with Welfare and Institutions Code, Section 15658 (a) (1), which requires consultation with representatives of the above listed departments, agencies, and organizations.

The SOC 341 is a written report which must be used by mandated reporters (and may be used by non-mandated reporters) to report suspected abuse of an elder or dependent adult. Receiving agencies may also use the reporting form to record information received through a telephone report of elder or dependent adult abuse by completing the asterisk (*) sections on the form.

The provisions of Senate Bill (SB) 2199 (Chapter 946, Statutes of 1998) necessitate the changes to the SOC 341. The two significant proposed revisions to the form are due to the changes required by law, which has expanded the definition of a mandated reporter and the definition of abuse. The definition of a mandated reporter has been extended to include any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency. The reporting mandate now includes not only physical (including sexual) abuse, but also abandonment, isolation, abduction, financial abuse and neglect (including self-neglect).

Enclosed are the draft SOC 341 and reporting instructions for your review and comments. Please send your comments to Jennifer Campbell, Chief, Adult Protective Services Bureau, by January 24, 2000 at the following address:

California Department of Social Services
Adult Programs Branch
744 P Street, MS 19-96
Sacramento, California 95814

This information can also be faxed to (916) 229-0337. If the comments that are received are substantial, we will schedule a meeting and provide all interested individuals an opportunity to discuss their concerns. If you have any questions concerning the revised reporting form SOC 341 and instructions, please contact Karen Hobson at (916) 229-3291.

Sincerely,

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Enclosure

c: Calvin Hirsch, M.D.

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS)
ADULT PROGRAMS BRANCH
ADULT PROTECTIVE SERVICES

List of Departments, Agencies, Associations which will review and provide comment on Revised draft form for Reporting Suspected Dependent Adult/Elder Abuse (SOC 341).

State Departments, Various Law Enforcement Agencies, Professional Medical and Nursing Agencies, Hospital Associations, County Welfare Departments:

California Department of Aging
Office of the Ombudsman
1600 K Street
Sacramento, CA 95814

Department of Developmental Services
1600 9th Street
Sacramento, CA 95814
Attention: Suzanne Joy-Livingston

Department of Mental Health
1600 9th Street
Sacramento, CA 95814
Attention: Marita McElvain, L.C.S.W.

Department of Health Services
Licensing and Certification
714 P Street
Sacramento, CA 95814
Attention: Ed Long, Special Projects

California Department of Rehabilitation
830 K Street Mall
Sacramento, CA 95814
Attention: Lana Fraser, Field Operations

California Department of Social Services
Community Care Licensing
Policy Development Unit
744 P Street, MS19-50
Sacramento, CA 95814
Attention: Carole Jacobi

California Welfare Directors Association
925 L Street, Suite 1405
Sacramento, CA 95814

Department of Justice
Office of the Attorney General
Bureau of Medi-Cal Fraud
1300 I Street, 11th Floor
Sacramento, CA 95814

California State Sheriffs Association
2125 19th Street
Sacramento, CA 95814

California Correctional Peace Officers Association
755 River Point Drive
Suite 200
West Sacramento, CA 95605

Commission on Peace Officers Standards Training Academy (POST)
1601 Alhambra Boulevard
Sacramento, CA 95816-7083
Attention: Tom Hood

California District Attorneys' Association
731 K Street, 3rd Floor
Sacramento, CA 95814
Attention: David Le Bahn

Lee Baca, Sheriff
Los Angeles County
4700 Ramona Boulevard
Monterey Park, CA 91754-2169

Charles Plummer, Sheriff
Alameda County
1401 Lakeside Drive
12th Floor
Oakland, CA 94612

California Health Care Association
1201 K Street
Suite 800
Sacramento. CA 95814
Attention: Legal Department

California Medical Association
Government Relations Division
1201 K Street
Sacramento. CA 95814

California Dental Association
1201 K Street
Sacramento. CA 95814

California Dermatology Society
1127 11th Street
Sacramento. CA 95814

California Nurses Association
1100 11th Street
Suite 200
Sacramento. CA 95814

California Licensed Vocational Nurses Association, Inc.
620 Sunbeam Avenue
Sacramento. CA 95814

California Association of Public Health Nurses
P. O. Box 11447
Berkeley. CA 94701

California Association of Psychiatric Technicians
2000 O Street
Suite 250
Sacramento. CA 95814

California Association of Nurse Anesthetists
237 East Katella Avenue
Orange. CA 92867

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY | CONFIDENTIAL | DEPARTMENT OF SOCIAL SERVICES

EXHIBIT G

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS ON REVERSE SIDE.

RECEIVING AGENCY USE ONLY

County APS/Ombudsman Case Number _____ SSN _____

Law Enforcement Case/File Number _____

A. VICTIM

NAME (LAST NAME FIRST):	AGE:	DATE OF BIRTH:	SEX: ☐ M ☐ F	RACE:	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)
ADDRESS (IF FACILITY, INCLUDE NAME):			CITY		TELEPHONE ( )
PRESENT LOCATION (IF DIFFERENT FROM ABOVE):			CITY		TELEPHONE ( )

☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY DISABLED ☐ PHYSICALLY HANDICAPPED ☐ BRAIN IMPAIRED ☐ FRAIL/ELDERLY (Functionally Impaired) ☐ HOSPITALIZED ADULT ☐ UNKNOWN

B. REPORTING PARTY

NAME (print)	SIGNATURE	OCCUPATION	DATE OF THIS WRITTEN REPORT
RELATION TO VICTIM	WHERE TO CONTACT: (STREET) (CITY) (ZIP CODE)		TELEPHONE ( )

C. INCIDENT INFORMATION

DATE/TIME OF INCIDENT(S):

PLACE OF INCIDENT (✓ CHECK ONE) ADDRESS _____
☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL
☐ HOME OF ANOTHER ☐ NURSING FACILITY ☐ OTHER

LEARNED OF INCIDENT BY (✓ CHECK ONE)
☐ VERBAL REPORT ☐ OBSERVATION

D. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS

a. PHYSICAL
☐ ASSAULT/BATTERY
☐ CONSTRAINT OR DEPRIVATION
☐ SEXUAL
☐ PHYSICAL AND/OR CHEMICAL RESTRAINT, MEDICATION, ISOLATION (CIRCLE ONE OR MORE)
☐ OTHER (SPECIFY) _____

b. ☐ NEGLECT
c. ☐ ABANDONMENT
d. ☐ MENTAL SUFFERING
e. ☐ FIDUCIARY
f. ☐ OTHER (SPECIFY) _____

2. SELF-INFLICTED

a. PHYSICAL
☐ NEGLECT
☐ SUBSTANCE ABUSE
☐ OTHER PHYSICAL ABUSE

b. ☐ SUICIDAL
c. ☐ FIDUCIARY
d. ☐ OTHER (SPECIFY) _____

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY)
☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ OTHER (SPECIFY) _____ ☐ UNKNOWN

E. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. (LIST ANY POTENTIAL DANGER FOR INVESTIGATOR.) (ATTACH ADDITIONAL INFORMATION.)

F. COLLATERAL CONTACTS (INCLUDE PERSONS BELIEVED TO HAVE KNOWLEDGE OF VICTIM OR ABUSE, IF AVAILABLE)

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP

G. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM. (IF UNKNOWN, LIST CONTACT PERSON).

NAME	IF CONTACT PERSON ONLY ✓ CHECK ☐	RELATIONSHIP
ADDRESS		TELEPHONE ( )

H. RELATIONSHIP OF SUSPECTED ABUSER TO THE VICTIM

NAME OF SUSPECTED ABUSER
☐ CARE CUSTODIAN (type) _____ ☐ PARENT ☐ OFFSPRING ☐ OTHER
☐ HEALTH PRACTITIONER (type) _____ ☐ SPOUSE ☐ OTHER RELATION (Specify) _____

ADDRESS	TELEPHONE ( )	SEX ☐ M ☐ F	RACE	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

I. VERBAL REPORT MADE (Check one ☐ Reported to Agency (See No. 1-5 on reverse side) ☐ Received by Agency (See No. 6 on reverse side).)

AGENCY:	OFFICIAL CONTACTED:	TELEPHONE ( )	DATE:	TIME:

J. AGENCY USE ONLY

1. ☐ Evaluated/Investigation not warranted By:

2. Assigned ☐ ER ☐ Non-ER To:

3. Cross-Reported to: ☐ Ombudsman ☐ Law Enforcement ☐ CCL or Health Lic. ☐ Professional Board ☐ BMF & PA ☐ APS ☐ Other [Specify] _____

SOC 341 (4/90) 90 89920