Service Standards

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Supportive Services Category Service Standards

Service Name: Home Chore

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	Non-continuous household maintenance tasks intended to increase the safety and independence of the individual(s) living at the residence. Chore Services are needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows, and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the proprietor, pursuant to the lease agreement, will be examined prior to any authorization of service.
UNIT OF SERVICE	• One hour spent performing allowable chore tasks. • 15 minutes spent performing allowable chore tasks • per diem

1. Minimum Standards:

    a. Funds awarded for chore service program may be used to purchase materials and disposable supplies used to complete the chores tasks to increase the safety of the individual. No more than $200 may be spent on materials for any one household per year. Equipment or tools used to perform chore tasks may be purchased or rented with funds awarded up to an amount equal to 10% of total grant funds.

    b. Pest control services may be provided only by appropriately licensed suppliers.

    c. Each program must develop working relationships with the Home Repair and Weatherization service providers, as available, in the project area to ensure effective coordination of efforts.

2. Allowable Tasks

   a. Reimbursement is given for time spent on these allowable tasks:
      i. replacing fuses, light bulbs, electric plugs, frayed cords,
      ii. replacing door locks, window catches,
      iii. replacing/repairing pipes,
      iv. replacing faucet washers or faucets
      v. installing smoke detectors & carbon monoxide detectors,
      vi. installing screens and storm windows,
      vii. caulking windows,
      viii. repairing furniture,
      ix. installing window shades, curtain rods and blinds,
      x. securing carpets and rugs,
      xi. cleaning attics and basements to remove fire and health hazards,
      xii. pest control,
      xiii. grass cutting and leaf raking,
      xiv. cleaning walkways of ice, snow and leaves,
      xv. trimming small overhanging tree branches.

Service Name: Home Modification Assessment

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	Assessment of the home and environment to identify barriers to independent living. The service will assess and set up a plan to make the home environment accessible through modifications and/or equipment
UNIT OF SERVICE	One hour of home evaluation, equipment training or follow up services

Minimum Standards:

a. The home evaluation will be provided by a Michigan licensed Occupational Therapist using appropriate professional assessment measures.

b. Evaluation includes assessment of the client's ability to function independently including activities of daily living and accessibility of the home.

c. An individualized service plan will be developed by the client and the Occupational Therapist.

d. Collaborate and make recommendations for modifications to Home Repair Services.

e. Implementation of the service plan including equipment set up and training will be Provided by a Certified Occupational Therapy Assistant (COTA).

f. Clients will be prioritized for home modifications and equipment needs.

g. Follow up contact will be provided after modifications are completed to ensure that outcomes are met including increased independence with activities of daily living and accessibility.

h. Muskegon County Senior Millage cost share policy will be implemented if no cost share is being paid to Home Repair Services.

i. The program will maintain client records that include assessment, service plan and case notes.

j. A minimum $10 copay (or a minimum as determined by Service Provider) is requested which covers both assessment and equipment services. The copay is good for one year and is waived if there is inability to pay or financial hardship. Additionally, the Senior Millage cost share policy, based on one's income, liquid assets, and the cost of the service provided, is applied to individuals. If a participant cannot afford the cost share because of necessary excessive and additional expenses (medical, health care, etc.), a more thorough financial evaluation is completed.

Service Name: Home Repair Consultation

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	The provision of critical home repairs for seniors who are otherwise not eligible for the Major or Minor Home Repair Programs. To qualify for this program, the estimated cost of the repair job must be less than $7,000. Only critical repairs related to health and safety will be provided. Nonessential repairs (e.g. garages), cosmetic repairs (e.g. painting) and improvements (e.g. attic insulation) will not be provided, except the improvements to enhance access for people with disabilities will be allowed (e.g. bathroom grab bars). Staff can consult with individuals/organizations that will be performing the critical repairs to an eligible person's home.
UNIT OF SERVICE	One completed job (or one consultation).

Minimum Standards:

a. Only homeowners who are eligible will be served. Required proof for home ownership would be a deed, mortgage, or land contract.

b. The owner must reside in the house being served. Services will not be provided to those who are trying to sell their homes.

c. Only households with a combined income of less than 80% of area median income (as determined annually by HUD) will be served.

d. Each job must utilize a job completion procedure which includes acknowledgment by home owner that work is acceptable, within 10 days of completion. Consultation only cases do not require job completion acknowledgement.

e. The program must utilize a written agreement with the owner (Purchaser) of each home to be repaired. The owner must be 60 years of age or older. This agreement must include at a minimum:
    i. a statement that the home is occupied and is the permanent residence of the owner:
    ii. statement that the Purchaser plans to live in the home for the next two years; and
    iii. specification of the repairs to be made by the program.

f. Program must establish and utilize written criteria for prioritizing homes to be repaired which address the condition of the home, client need and appropriateness of requested repairs.

g. Program will address primarily health and safety repairs and distribute funds reasonably among requested needs.

h. Ramps or other home modifications requested for individuals with disabilities must be determined necessary through an assessment conducted by a millage approved assessment agency. Referrals to the assessment agency must be documented by client with date requested. Subsequent assessment forms must be kept in client files and correspond to home modifications completed.

i. Consultations will be provided on a donation basis, but if Senior Millage funds are also used to offset the cost of the repair, a client co-payment will be charged. The amount will be determined by the household income and the estimated size of the job and according to a sliding fee schedule determined each fiscal year. Home Repair Services may make exceptions to this co-payment rule on a case-by-case basis.

j. Home repair services to mobile homes are allowed.

k. Rental units are not allowed except for access modifications and then only with the permission of the landlord. All other repairs to rental units are the responsibility of the landlord.

l. Services are not provided to houses that are deemed by Home Repair Services to be un-inhabitable.

m. The types of jobs accepted may be adjusted so that the number of jobs does not exceed the ability of the staff to provide services and so that the waiting list does not become excessive. The worst and most urgent cases will be served first.

n. The cost share may be paid by a loan from a bank or by payment plan set up by Home Repair Services. If after reasonable attempts to collect the unpaid balance of a payment plan, Home Repair Services is unable to collect the entire cost share, the unpaid balance may be billed to the contract with approval by SRWM.

o. When construction and payment is to be completed by an organization or individual besides service provider and SRWM, service provider may act as a consultant on the project and bill staff time to the contract.

2. Method of Reimbursement:

a. The Home Repair Services billing for each job will be the sum of the following:
   i. the labor of its repair staff charged to this program (both direct time charge to particular jobs and general time charged to the program) at an established hourly rate.
   ii. the job's materials (at cost)
   iii. the subcontractors hired for that job (at cost)
   iv. consulting time to approved project

Service Name: Home Repair: Major

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	The provision of major home repairs estimated to cost more than $1,000 and less than $7,000 Permanent improvement to an older person's home to prevent or remedy a sub-standard condition or safety hazard. Home Repair Service offers permanent restoration and/or renovation to extend the life of the home and may involve structural changes. Home repair does not involve making aesthetic improvements to a home, temporary repairs, chore or home maintenance that must be repeated.
UNIT OF SERVICE	One completed job (or one consultation).

Minimum Standards:

a. Each home repair program, prior to initiating service, must determine whether a potential client is eligible to receive services through a program supported by other funding sources, particularly programs funded though the Social Security act. If it appears that an individual can be served through other resources, an appropriate referral should be made.

b. Only households with a combined income of less than 80% of area median income (as determined annually by HUD) will be served.

c. Each program must develop working relationships with weatherization, home chore, and housing assistance service providers, as available, in the project area to ensure effective coordination of efforts.

d. Funds awarded for home repair service may be used for labor costs, to purchase materials and/or pay subcontractors used to complete the home repair tasks to prevent or remedy a substandard condition or safety hazard. The program must establish a limit on the amount to be spent on any one house in a twelve-month period. Equipment or tools needed to perform home repair tasks may be purchased or rented with funds up to an amount equal to 10% of total grant funds.

e. Each program must maintain a record of homes repaired including dates, tasks performed, materials used and cost.

f. No repairs may be made to a condemned structure.

g. Each job must utilize a job completion procedure which includes:
    i. Acknowledgment by homeowner that work is acceptable, within 10 days of completion
    ii. Consultation only cases do not require job completion acknowledgement.

h. The program must utilize a written agreement with the owner (Purchaser) of each home to be repaired. The owner must be 60 years of age or older. This agreement must include at a minimum:
    i. A statement that the home is occupied and is the permanent residence of the owner,
    ii. Statement that the Purchaser plans to live in the home for the next two years, and
    iii. Specification of the repairs to be made by the program.

i. Program must establish and utilize written criteria for prioritizing homes to be repaired which address the condition of the home, client need and appropriateness of requested repairs.

j. Program will address primarily health and safety repairs and distribute funds reasonably among requested needs.

k. Ramps or other home modifications requested for individuals with disabilities must be determined necessary through an assessment conducted by a millage approved assessment agency. Referrals to the assessment agency must be documented by client with date requested. Subsequent assessment forms must be kept in client files and correspond to home modifications completed.

l. A client co-payment will be charged. The amount will be determined by the estimated size of the job and according to a schedule determined each fiscal year. Home Repair Services may make exceptions to this co-payment rule on a case-by-case basis.

m. Home repair services to mobile homes are allowed.

n. Only homeowners who are eligible will be served (required proof would be a deed, mortgage or land contract). Rental units are not allowed except for access modifications and then only with the permission of the landlord. All other repairs to rental units are the responsibility of the landlord.

o. Services are not provided to houses that are deemed by Home Repair Services to be uninhabitable.

2. Allowable Tasks
    a. Allowable home repair tasks include but are not limited to:
        i. roof repair/replacement
        ii. siding repair/replacement
        iii. foundation repair/replacement
        iv. floor repair/replacement
        v. interior wall repair
        vi. plumbing and drain repair/replacement
        vii. insulation/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers and door sweeps.
        viii. stair and exterior step repair/replacement
        ix. heating system repair/replacement
        x. ensuring safe and adequate water supply
        xi. electrical wiring repair/replacement
        xii. obtaining building permits
        xiii. painting to prevent deterioration and in conjunction with repair.
        xiv. ramp installation

3. Method of Reimbursement
    a. The Home Repair services billing for each job will be the sum of the following:
        i. The labor of its repair staff charged to that job at an established hourly rate.
        ii. The job's materials (at cost)
        iii. The subcontractors hired for that job (at cost)

Procedural guidelines for Muskegon County Senior Millage home repair service providers

Please note the following procedural guidelines for organizations receiving funding to provide Major Home Repair services, Minor Home Repair services, or Ramps through the Muskegon County Senior Millage:

1) Service reimbursement amount
    a. Major Home Repairs are those estimated to cost more than $1,000 and less than $7,000. If a job requires more than $7,000, it can be reimbursed only if the average of reimbursements for all participants during that reporting period is $7,000 or less. If the final Financial Status Report (FSR) for the fiscal year (FY) average is above $7,000, it can only be reimbursed if the average reimbursement for all participants during the FY is $7,000 or less.
    b. Minor Home Repairs are those estimated to cost less than $1,000. If a job requires more than $1,000, it can be reimbursed only if the average of reimbursements for all participants during that reporting period is less than $1,000. If the final FSR for the FY average is above $1,000, it can only be reimbursed if the average reimbursement for all participants during the FY is $1,000 or less.
    c. Ramps are estimated to cost $10,000 or less. If a job requires more than $10,000 it can be reimbursed only if the average of reimbursements for all participants during that reporting period is $10,000 or less. If the final FSR for the FY average is above $10,000, it can only be reimbursed if the average reimbursement for all participants during the FY is $10,000 or less.
2) Administration fees: Major Home Repair, Minor Home Repair Services, and ramps allow for up to 10% in administration fees. Service providers must calculate the administration fees and add them to their reimbursable total for each participant. For example, a $7,000 reimbursement would include $6,364 (service) and $636 (Admin). Senior Resources does not calculate or add this number to your reimbursement. Providers must add the administration cost into their calculations before submitting for reimbursement.
    a. Minor Home Repair Services allow for up to 10% in administration fees with a $50 minimum. Service providers must calculate the administration fees and add them to their reimbursable total for each participant. For example, a $400 reimbursement would include $350 (service) and $50 (Admin). Senior Resources does not calculate or add this number to your reimbursement. Providers must add the administration cost into their calculations before submitting for reimbursement.
3) Invoices: Please provide Senior Resources with invoices for each participant when submitting your monthly reporting. Invoices should be attached to your folder in Box. Ideally invoices will include your breakdown of service fees and administration fees.
4) Frequency of service
    a. Major Home Repair and Minor Home Repair are considered separate services. Therefore, a participant can receive both services in the same year.
    b. Once a participant receives a Major Home Repair service, they are ineligible to apply for or receive another Major Home Repair service from any millage-funded provider for 2 years after that date.
    c. Once a participant receives a Minor Home Repair service, they are ineligible to apply for or receive another Minor Home Repair service from any millage-funded provider for 2 years after that date.
5) Avoiding duplication of services: Since each participant is only eligible for millage-funded home repair services once every 2 years, it is advised that your organization check applicants' names with Senior Resources staff before providing a service. Senior Resources staff can advise you if the applicant has already received home repair services through another millage-funded service provider. Doing this pre-check of applicants will protect your agency from funding a home repair that Senior Resources deems ineligible for reimbursement.
6) Collaboration between service providers: If your organization cannot meet the needs of a participant, please refer them to the other agencies that provide similar services. Senior Resources can provide you an updated list of service providers upon request.
7) Prioritization: When a waiting list exists for home repair services, the worst and most urgent cases will be served first.

Service Name: Home Repair Minor

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	The provision of minor but critical home repairs costing less than $1,000 such as plumbing, roof and furnace repairs. Only critical repairs related to health and safety will be provided. Nonessential repairs (e.g. garages), cosmetic repairs (e.g. painting) and improvements (e.g. attic insulation) will not be provided, except the improvements to enhance access for people with disabilities will be allowed (e.g. bathroom grab bars).
UNIT OF SERVICE	One completed job (or one consultation).

Minimum Standards:

a. The maximum amount of Senior Millage money that will be used on a job is $1,000. Services may be provided more than once a year but no homeowner will receive more than $1,000 of service in a calendar year.

b. Only homeowners who are eligible will be served (required proof: deed, mortgage, land contract). Minor home repair services are not allowed on rental units.

c. The owner must reside in the house being served. Services will not be provided to those who are trying to sell their homes.

d. Only households with a combined income of less than 80% of area median income (as determined annually by HUD) will be served.

e. Repairs to mobile homes are allowed.

f. Minor home repair services will not be provided on rental property.

g. A client co-payment will be charged. The amount will be determined by the estimated size of the job and according to a schedule determined each fiscal year. Home Repair Services may make exceptions to this co-payment rule on a case-by-case basis.

h. Service will not be provided to houses that are deemed by Home Repair Services to be un-inhabitable.

i. The types of jobs accepted may be adjusted so that the number of jobs does not exceed the ability of the staff to provide services and so that the waiting list does not become excessive. The worst and most urgent cases will be served first.

2. Method of Reimbursement:

a. The Home Repair Services billing for each job will be the sum of the following:
   i. the labor of its repair staff charged to that job at an established hourly rate.
   ii. the job's materials (at cost)
   iii. the subcontractors hired for that job (at cost)

Service Name: Weatherization

SERVICE CATEGORY	Supportive Services
SERVICE DEFINITION	Weatherization measures are installed for the purpose of rendering the heated portions of dwellings energy efficient and to ensure the protection of such measures. Measures may also be installed to eliminate health and safety hazards that are necessary before or because of the installation of weatherization measures
UNIT OF SERVICE	One weatherized home of an eligible client.

Minimum Standards

a. All weatherization measures installed are required to have a minimum of a 10-year return on investment and must conform to the State Weatherization Guidelines of performance standards, quality and workmanship.

b. Insured licensed contractors must perform all work.

c. Work performed does not include any cosmetic work to the dwelling.

d. Each client file reflects documentation of material/labor and support costs, not to exceed an average cost of $4,000 per weatherized home, per contract period.

e. No repairs may be made to a condemned structure.

f. Each program must develop working relationships with weatherization, home chore, and housing assistance service providers, as available, in the project area to ensure effective coordination of efforts.

g. Each job must utilize a job completion procedure which includes:
    i. Acknowledgment by home owner that work is acceptable, within 10 days of completion
    ii. Consultation only cases do not require job completion acknowledgement.

h. A client co-payment will be charged. The amount will be determined by the estimated size of the job and according to a schedule determined each fiscal year. Service Provider may make exceptions to this co-payment rule on a case-by-case basis.

i. Weatherization services to mobile homes are allowed.

j. Services are not provided to houses that are deemed to be un-inhabitable.

2. Allowable Service

a. Allowable weatherization jobs may include:

i. Major by-pass and air sealing
ii. Wall insulation
iii. Attic insulation
iv. Attic ventilation
v. Foundation Insulation
vi. Furnace turn-up
vii. Clock Thermostat
viii. Combustion Appliance Repair
ix. Health and Safety Measures
x. Duct Sealing/Insulation

3. Method of Reimbursement:

a. The Weatherization billing for each job will be the sum of the following:

i. the labor of its repair staff charged to that job at an established hourly rate.
ii. the job's materials (at cost)
iii. the subcontractors hired for that job (at cost)

Access Services Category Service Standards

Service Name: Case Coordination & Support

SERVICE CATEGORY	Access
SERVICE DEFINITION	The provision of a comprehensive assessment of persons age 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible. Case Coordination and Support (SSC) includes the assessment and reassessment of individual needs, development and monitoring of a service plan, identification of and communication with appropriate community agencies to arrange for services, evaluation of the effectiveness and benefit of services provided, and assignment of a single individual as the caseworker for each participant.
UNIT OF SERVICE	One unit per month when any CCS activity is provided for an individual.
COMPONENT	Intake, assessment, reassessment, development of a service plan. FUNCTIONS: Arrangement for each service.

Minimum Standards

1. Each CCS program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each potential participant must include at a minimum:
    a) Individual's name, address and telephone number
    b) Individual's age or birth date
    c) Physician's name, address and telephone number
    d) Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency
    e) Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems
    f) Perceived supportive service needs as expressed by individual and/or his/her representatives
    g) Race (optional)
    h) Gender (optional)
    i) An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes and at or below 125 percent of poverty level for referral purposes
2. If intake indicates a single service need on a one-time or infrequent basis, a less intensive level of support such as information and assistance or options counseling should be offered to the individual. When intake suggests ongoing and/or multiple service needs, a comprehensive individual assessment of need shall be performed within 10 working days of intake. If intake/assessment suggests ongoing or multiple complex service needs at a level beyond the scope

of the CCS program, a more intensive level of support such as Care Management (CM) should be offered to the individual.

3. All assessments and reassessments shall be conducted in person. Each assessment shall provide as much of the following information as is possible to determine the following.

Note: Staff must attempt to acquire each item of information listed below but must also recognize and accept the participant's right to refuse to provide requested items. a. Basic Information

(1) Individual's name, address, and telephone number
(2) Age, date and place of birth
(3) Gender
(4) Marital status
(5) Race and/or ethnicity
(6) Living arrangements
(7) Condition of environment
(8) Income and other financial resources, by source (including SSI and GA)
(9) Expenses
(10) Previous occupation, special interests and hobbies (11) Religious affiliation, if applicable

b. Functional Status

(1) Vision
(2) Hearing
(3) Speech
(4) Oral status (condition of teeth, gums, mouth and tongue)
(5) Prosthesis
(6) Psychosocial functioning
(7) Limitations in activities of daily living (ADLs and IADLs)
(8) History of chronic and acute illnesses
(9) Eating patterns (diet history)
(10) Prescriptions, medications, and other physician orders

c. Supporting Resources

(1) Physician's name, address, and telephone number
(2) Pharmacist's name, address and telephone number
(3) Services currently receiving or received in past (including identification of those funded through Medicaid)
(4) Extent of family and/or informal support network
(5) Hospitalization history
(6) Medical/health insurance information
(7) Clergy name, address and telephone number, if applicable

d. Need Identification

(1) Participant/family perceived
(2) Assessor perceived and/or identified from referral source/professional community

Each participant shall be reassessed every six months, or as needed to determine the results of implementation of the service plan.

4. A service plan shall be developed for each person determined eligible and in need of CCS. The service plan shall be developed in cooperation with, and be approved by, the participant, the participant's guardian or designated representative. The service plan shall contain at a minimum:

a. Statement of the participant's problems, needs, strengths, and resources.

b. Statement of the goals and objectives for meeting identified needs.
c. Description of methods and/or approaches to be used in addressing needs.
d. Identification of services and the respective time frames they are to be obtained/provided from other community agencies.
e. Treatment orders of qualified health professional, when applicable.

Each program shall have a written policy/procedure to govern the development, implementation and management of service plans.

5. Each program shall maintain comprehensive and complete case files which include at a minimum:
   a. Details of participant's referral to CCS program.
   b. Intake records.
   c. Comprehensive individual assessment and reassessments.
   d. Service plan (with notation of any revisions).
   e. Listing of all contacts (dates) with participants (including units of service per participant).
   f. Case notes in response to all participant or family contacts (telephone or personal).
   g. Listing of all contacts with service providers on behalf of participant.
   h. Comments verifying participant's receipt of services from other providers and whether service adequately addressed participant need.
   i. Record of all release of information about the participant, signed release of information form, and all case files shall be kept confidential in controlled access files. Each program shall use a standardized release of information form, which is time-limited and specific as to the information being released.
6. Each case file must be assigned status in one of the following categories:
   a. Open. From initial referral or reassessment of inactive case through current activity in implementing a service plan; or
   b. Closed. Participant decides to discontinue service, participant needs have been met, another program or agency has assumed responsibility for participant, participant unable to be served and referral of case is not possible, or participant's death.
7. Each program shall maintain a current listing of isolated older persons, with active case files, which can be made readily available to agencies providing emergency services in the event of a disaster.
8. Each program shall employ caseworkers who have a minimum of a bachelor's degree in a human service field or who, by experience or training, have the ability to effectively determine an older person's needs and match those needs with appropriate services. If the program does not employ staff with an appropriate bachelor's degree, access to such a caseworker(s) in the community shall be arranged for purposes of technical support and/or consultation. Participants with identified unmet health needs (physical and/or mental) shall be referred to an appropriate health care agency. Only one caseworker may be currently assigned to each individual case.
9. Each CCS program shall provide information and assistance and outreach as supporting services. However, it is not required that such service provision be reported to AASA.
10. Program staff shall receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and participants, and to improve their skills in completion of job tasks.

Service Name: Community Services Navigation (Outreach)

SERVICE NAME	Community Services Navigation (Outreach)
SERVICE CATEGORY	Access Services
SERVICE DEFINITION	Community Services Navigation is the effort to identify and make contact with isolated older persons age 60+ in areas of Muskegon County that have difficulty accessing services who have service needs. An outreach worker will assist the older persons in gaining access to services through referrals to community programs and may assist with determining eligibility for and/or with completing applications for a wide-variety of appropriate community services. Applicable community services may include, but are not limited to, food/meal assistance, case/health management programs, transportation, health education/disease prevention programs, social/recreation programs and home care. Outreach does not include comprehensive assessment of need or development of a service plan.
UNIT OF SERVICE	One hour of outreach service including identification and contact of isolated older persons, assistance in their gaining access to needed services, and follow up.

Minimum Standards:

1. Program will establish a uniform intake procedure which helps identify and document the older person's needs and logs referrals made.

2. Program will establish linkages with a wide variety of community programs in Muskegon County to be able to assist clients in gaining access to available services.

3. Program will develop partnerships with municipalities, senior centers and other focal points within Muskegon County, particularly in rural areas, to establish a monthly schedule of availability in those areas to allow persons to meet with the outreach worker.

3. A follow-up contact will be made with all individuals served to determine whether needed services have been received.

4. Program will target older persons residing in isolated or rural areas of Muskegon, those with greatest social need and economic need.

5. For locations in areas where non-English or limited English-speaking older persons are concentrated shall have bilingual personnel or translation /interpretation available. Such interpreters do not have to be paid staff persons.

Service Name: Emergency Need Fund

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	Financial assistance up to $250.00 per client in one year for financial crisis situations such as: Utility shut-off Home Repair Costs Housing Costs Medical Costs Back Taxes
UNIT OF SERVICE	One unit of financial assistance up to $250.00 for one client in one calendar year.

Minimum Standards:

1. Each client served must have an assessment completed.

2. Staff must first explore what resources are available to the client including their income, assets, family, church or community.

3. Staff will explore community resources to find matching funds.

4. Appropriate accounting procedures must be developed and implemented. They include a supervisory level review and approval process for all requests. This request must include a review of the client's income and must have a good explanation of the reason for the request.

5. The emergency need fund costs are limited to a maximum of $250.00 provided on a client's behalf for the problems mentioned above.

6. Emergency funds must resolve the problem and there must be evidence that the problem will not recur due to the income limits of the client.

Service Name: Fair Housing Services

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	Provision of education, outreach, counseling, reasonable accommodation assessments, testing, and enforcement activities related to Federal, State and Local Fair Housing Laws and Ordinances.
UNIT OF SERVICE	Provision of one hour of testing, counseling, outreach, assessments, education or enforcement activities.

Minimum Standards:

1. Each program must be a Qualified Fair Housing Enforcement Organization pursuant to 24 CFR 125.103 that is formulating or carrying out programs to prevent or eliminate discriminatory housing practices.

2. The program must address housing discrimination for residents 60 and older based upon all local, state and federal protected classes including race, religion, sex, national origin, disability status, age, marital status, legal source of income.

3. All services and activities must be available to the protected class members who are residents aged 60 or older, their primary caregiver, legal representative, counselor, advocate and/or family member.

4. All activities, facilities, and materials funded by this program must be accessible and visitable to persons with disabilities pursuant to 24 CFR 8.2, 8.6 and 8.54.

5. The program must provide access to the program benefits and information to "Limited English Proficient" residents through translation and interpretive services.

6. Program administrator must have an advanced degree and at least two years' experience in civil rights/fair housing advocacy.

7. Each program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. The program will maintain records of client contacts, case notes, and results of investigation. The program shall work with the client to discuss their rights and help them pursue their fair housing rights including but not limited to conciliation, mediation, administrative proceedings and/or litigation.

8. Each program must demonstrate collaborative relationships with the immediate community and other service providers including but not limited to linkages with potential sources for volunteers, working with human service agencies serving residents over 60 years old to develop relevant educational materials, to market educational opportunities and to conduct the presentations, working with agencies advocating for seniors to conduct better informed testing of the relevant housing industries, linkages with legal assistance programs and services, management programs, and advocacy agencies.

9. The program must assure that recruited testing volunteers receive U.S. Department of Housing and Urban Development approved tester training and updates and that all other volunteers receive training as necessary to complete the required functions.

10. The program must assure appropriate case supervision of all open cases and that when the program identifies systemic discrimination which may be remedied by legislative action or other collaborative effort, such issues should be brought to the attention of SRWM, as permissible and appropriate.

11. Each program must provide assurance that it operates in compliance with regulations promulgated under the Older Americans Act as set forth in 45 CFR Section 1321.73.

12. <u>Allowable Service</u>

    Fair Housing allowable service activities include:

    a. Intake of fair housing complaints for Muskegon County residents over the age of 60.
    b. Develop and update written and other educational materials geared toward the senior population regarding protections under fair housing laws.
    c. Conduct educational sessions for older adults, caregivers, and social service personnel on protections and obligations under fair housing law.
    d. Conduct and analyze at least 50 housing discrimination tests where the claimant is a resident of Muskegon County over the age of 60, or on a survey basis at independent and assisted living facilities.
    e. Recruit, train and utilize older adult volunteers to conduct testing and to review newspaper and other marketing materials to ensure compliance with fair housing laws.

Service Name: Foreclosure Intervention Counseling

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	Professional-level financial counseling services.
UNIT OF SERVICE	One hour of counseling.

Minimum Standards

1. Each case must begin with an initial assessment with the client, at which time the counselor will assist the client in assembling and reviewing the household budget. In addition, there will be a full examination of the current mortgage situation and the events leading to the financial crisis.

2. A counseling plan will be developed for each client. This plan will include a goal and subsequent objectives that are agreed upon by both the counselor and client.

3. The counseling staff can provide services at the client's home, as well as at the program offices.

4. Each counselor must be certified by the Michigan State Housing Development Authority (MSHDA) as a Housing Counselor.

5. Counseling services can include direct client contact and indirect client support. Indirect client support may include information gathering, maintenance of case records, and communication with mortgage companies and/or community organizations on behalf of the client.

6. Foreclosure Intervention counseling, consisting of an initial assessment, budget counseling, advocacy/mediation between client and mortgage company and client and community organizations. These services are offered to older adults who are currently delinquent on their mortgage payments and/or property taxes and are facing the loss of their home.

7. Professional counseling regarding reverse mortgage will be provided to older adults seeking such a loan and that require a counseling certificate.

8. Refinance counseling will be provided to older adults seeking to refinance their current mortgage in order to prevent predatory lending and the potential future loss of their home and/or equity.

9. Referrals should be made to Legal Aid of West Michigan when appropriate.

Service Name: Guardianship

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	The Muskegon County Guardianship Program provides guardianship and/or conservatorship services to legally incapacitated, and/or developmentally disabled adult residents of Muskegon County who have no one to serve in that capacity. A guardian is a person lawfully invested by the Probate Court with the power, and charged with the duty of ensuring that the daily and personal needs of the person are met. A conservator is a person lawfully invested by the Probate Court with the power, and charged with the duty of protecting a person's property (estate).
UNIT OF SERVICE	One month guardianship service to one client.

Minimum Standards:

1. The Muskegon County Department of Health and Human Services (DHHS) and Muskegon County Probate Court have created standards for guardianship/conservatorship services. The program standards and guardianship responsibilities are:

    a. Accept wards determined in need of guardianship/conservatorship services by the Muskegon County Probate Court.
    b. Participate in bi-monthly training sessions/meetings provided by the Muskegon County DHHS and the Probate Court.
    c. Service at maximum 65 adult guardianship or conservatorship cases at any given time.
    d. Complete the following activities:
        i. Make face-to-face contact with the ward within two weeks of Probate Court appointment, either as a temporary guardian/conservator or permanent guardian/conservator.
        ii. Explain to the ward the role of the guardian/conservator as well as the rights retained by the ward.
        iii. Complete initial assessment within 30 days of the case assignment, using the court Ward Face Sheet form. This assessment will include the ward's physical and social situation, the educational needs, likes and preferences, living conditions, and available support systems.
        iv. The guardian/conservator shall take immediate steps to resolve any crisis situations brought to the attention of the guardian.

2. The guardian/conservator shall make and document on the Court Ward Quarterly Report from face-to-face visits with each ward at least once every three months after case opening. These visits will consist of the following activities:
    a. Conference with the ward's Service Provider or caregiver.
    b. Examination of charts or notes regarding the ward (guardian only).
    c. Assessment of the ward in maintaining current living situation, taking into consideration social, psychological, educational, vocational, health, and personal care needs (guardian only).
    d. Assessment of the ward's physical appearance, psychological, and emotional state (guardian only).
    e. Assessment of the repair, cleanliness, and safety of the ward's home or apartment.
    f. Assessment of the adequacy and condition of the ward's personal possessions if the ward resides in a facility, for example, clothing, furniture, TV, etc.

3. The guardian/conservator shall, in addition to the quarterly face-to-face contacts, have a monthly contact with either the ward or some suitable individual who has personal contact with the ward such as adult foster care home operator, or nursing home staff.

4. The guardian/conservator shall maintain an individual ward case record, which will include the Probate Court "Letters of Authority," and a record of all contacts, assessment information, progress notes, reports, and correspondence and all the records and reports required by the Probate Court.

5. The guardian/conservator shall submit the "Court Ward Face Sheet" report due thirty (30) days from case assignment and the subsequent three month "Court Ward Quarterly Report" on each ward. An invoice for the per month guardianship service fee is to be attached to these reports on all Medicaid or Medicaid-eligible clients with the following exception:

a. A ward that receives Medicaid or a Medicaid-eligible and whose estate level (less an irrevocable funeral agreement if one exists) is $700 available cash or more. In these cases, the guardianship service fee will be paid from the ward's estate at a rate not to exceed $60 per month. If the ward's estate falls below $700, the fee will be billed to DHS. Medicaid eligible clients are those who would be on Medicaid if they were not in state facilities.

6. The guardian/conservator shall make sure that the annual accounts on Medicaid cases are allowed as required by the Probate Court and shall provide copies of such documents to DHHS.

7. The guardian/conservator shall arrange for the "direct deposit" of all income for the ward whenever possible.

8. The guardian/conservator shall apply for all benefits (financial and non-financial) for which the ward may be eligible. Application is to be made within 30 days of becoming aware of the benefit.

9. The guardianship/conservator, upon the death of a ward, shall exercise appropriate authority by:
    a. Notifying the Probate court and the Muskegon County DHHS Guardian Monitor. Notifying any agency providing benefits to the ward or beneficiary including
        i. Social Security Administration, the Veterans Administration, and DHHS.

        ii. Turning the ward or beneficiary's assets over the individual designee by the Probate Court to receive such assets.

        iii. Submitting a final accounting of the ward's estate to the Probate Court.

Service Name: Housing Coordination

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	To identify, contact, and provide service to people in need of housing interventions that prevent them from being homeless. This includes helping find ways to maintain current housing or helping to find new, more appropriate housing options if current housing no longer fits the person's needs or financial resources.
UNIT OF SERVICE	Each person served or one training presentation.

1. Allowable Service Components

   a. Initial efforts to identify and contact potential clients.
   b. Initial intake, assessment and completion of the associated paperwork.
   c. Accompanying clients to professional visits when necessary. Examples might include: local Housing Commissions, legal or Department of Health and Human Service appointments. This component does not include transportation for the client.
   d. Telephone calls/home visits for coordination and follow-up.
   e. Presentations to the community to increase awareness and access to appropriate housing for older adults.
   f. All of these components are subject to approval by the SRWM Contract Coordinator.

2. Minimum Standards

   a. The program must have comprehensive intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each potential client must include as much of the following information as is appropriate and is able to be determined:
   b. Individual's name, street and mailing address
   c. Telephone number
   d. Birth date
   e. Physician's name, address and telephone number

   f. Name, address and phone number of person, other than spouse or relative

with whom individual resides, to contact in case of emergency

g. Individual or their representatives
h. Race/ethnicity
i. Gender
j. Income status
k. Date of first client or family contact requesting service or referral date and source
l. List of service(s) currently receiving including identifying if care management, Department of Health and Human Services (DHS) or other provider is coordinating services.
m. The program will utilize staff that have training and experience in the area of housing intervention and will have at minimum a basic understanding of mortgages, home ownership, rental services and tenant rights.
n. The program must identify, determine, and document client needs.
o. Each program must provide documentation of all contact with and assistance to clients and referrals to other Service Providers in community.
p. Must demonstrate an effort to assist clients in understanding their current housing needs and facilitate clients' efforts to find the best housing options available.
q. The program must provide follow-up as often as is appropriate but for at least 50% of clients served to determine whether the need(s) were addressed and to determine any problems with the service delivery system.
r. The program is required to use bilingual personnel (paid or unpaid) when non-English or limited English-speaking older adults use this service.
s. The program must demonstrate collaborative relationships with the immediate community and other Service Providers. Suggestions of collaborative relationships would include providing public presentations to educate the greater community about housing options, potential scams and abuse and participating in collaborative meetings with other Service Providers in the community.

Service Name: Information & Referral

REQUIREMENT	**Information and Referral services must be provided in collaboration with Community Access Line of the Lakeshore 2-1-1**
SERVICE CATEGORY	Access Services
SERVICE DEFINITION	Assistance to individuals in finding appropriate health and human service providers which address their needs including information-giving (e.g., listing the providers of a particular service so an individual may make their own contact directly), referral (making contact with a particular provider on behalf of an individual and follow-up contacts to clients), and locating or arranging services.
UNIT OF SERVICE	One contact with an individual or service agency seeking information and referral (Note: Newsletters, media spots, group presentations etc., are encouraged but are not counted as information and referral contacts.) In addition, enhanced or specialized information and referral service units may be developed.

Minimum Standards:

1. Each Information and Referral (I&R) Program must have and maintain an up to date resource file that includes a list of health and human service agencies, services available, pertinent information about resources, ability to accept new clients and eligibility requirements. The program must be able to provide information about community resources and agencies to older persons so the caller can make their own direct contact with the referral agency or program.

2. Each Information and Referral Program must be capable of establishing conference calls between clients and agencies.

3. The resource database shall be updated through continuous revision or at intervals sufficiently frequent to ensure accuracy of information and comprehensiveness of its contents.

4. The I&R service shall safeguard its resource database through duplication or computerized back-up. The back-up database shall be kept in a secure location where it will be protected from destruction or theft.

5. A follow-up contact must be made on 10% of the referrals, preferably within 10 working days but allowed up to 30 working days, to determine whether services were received and the identified need met. Follow-up contacts are not required for information giving contacts.

6. Each Program must have bi-lingual personnel available or make arrangements for translation services.

7. Where walk-in service is available, there must be adequate space to ensure client comfort and confidentiality during intake and interviewing.

8. The I&R service shall strive to provide access to community resource information in a variety of formats including mediated access through an I&R worker and options for independent access, such as directories or web sites.

9. Each program must maintain records for three years or until an audit has been closed. Records need to include the nature of calls received, the agencies and/or organizations to which referrals are made and the service for which referrals are made and results of follow-up contacts.

Service Name: Medicare Medicaid Assistance Program (MMAP)

SERVICE CATEGORY	Access Services
SERVICE DEFINITION	The provision of Medicare presentations, and counseling for clients (aged 60+) needing information, assistance and guidance in applying for Medicare, how to apply for Medicaid and where to turn with questions regarding anticipated and/or existing coverage.
UNIT OF SERVICE	One hour of allowable service.

Minimum Standards

1. Program must identify, market and present Medicare information in settings which 60+ Muskegon County residents can receive the information.

2. The program must complete an initial intake in a timely manner for one-on-one service. Record must also be kept on requests for service which program is unable to meet.

3. Service provided in areas where non-English or limited English speaking older adults are concentrated are encouraged to have bilingual personnel available (paid or non-paid).

4. Staff will be knowledgeable in Medicare Part D, Medicare and Medicaid prescription programs and local prescription programs. The program must demonstrate that staff participates in education programs related to these topics (i.e. attendance at monthly MMAP refresher trainings.)

5. Program must be able to provide MMAP outreach and counseling throughout Muskegon County.

6. Program must demonstrate collaborative relationships with the immediate community and other service providers.
7. Allowable Service
    a. Group presentations
    b. One-on-one Medicare counselling

8. Program is required to report all qualified contacts and outreach in the MMAP Shiptalk database as they occur.

Service Name: Transportation

SERVICE CATEGORY	Access
SERVICE DEFINITION	Centrally organized services for transportation of older persons to and from community facilities in order to receive services, reduce isolation, and otherwise promote independent living. a. Assisted Transportation: Provide assistance, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation. b. Public Transportation: Provide means of transportation for a person who requires help in going from one location to another, using a vehicle. (i.e.: Go! Bus or mass transit). This service would not include any other activity.
UNIT OF SERVICE	A single one-way trip per person, or one educational session.

3.1 Minimum Standards:

a. Muskegon County Senior Millage funds may be used to fund all or part of the operational costs of transportation programs based on the following modes:

i. Demand/Response - characterized by scheduling of small vehicles to provide door to door or curb-to-curb service on demand. The program may include a passenger assistance component.

ii. Route Deviation Variation - where a normally fixed route vehicle leaves scheduled route upon request to pick up client.

iii. Flexible Routing Variation - where routes are constantly modified to accommodate service requests.

iv. Volunteer Reimbursement - characterized by reimbursement of out-of-pocket expenses for individuals who transport older persons in their private vehicles. The program may include a passenger assistance component.

v. Public Transit Reimbursement - characterized by partial or full payment of the cost for an older person to use an available public transit system, (either fixed route or demand/response). The program may include a passenger assistance component.

vi. Older Driver Education – characterized by systematic presentation of information and training in techniques designed to assist older drivers in safely accommodating changes in sensory and acuity functioning.

b. Muskegon County Senior Millage funds may not be used for the direct purchase or lease of vehicles for providing transportation services, unless approved by MCSAC.

c. All drivers and vehicles used for transportation programs supported all or in part by Muskegon County Senior Millage funds must be appropriately licensed and inspected as required by the Secretary of State and all vehicles used must be covered by liability insurance. State driver checks must be performed at least annually for all volunteer and staff who transport clients. Documentation of driver checks must be in employee/volunteer files.

d. All paid drivers for transportation programs supported all or in part by Muskegon County Senior Millage funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. Such assistance must be available unless expressly prohibited by either a labor contract or insurance policy.

e. All paid drivers for transportation programs supported all or in part by Muskegon County Senior Millage funds shall be trained to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

f. Each program must operate in compliance with the state of MI P.A. 1 of 1985 regarding seat belt usage.

g. Each program must attempt to receive reimbursement from other funding sources, as appropriate and available. Examples include American Cancer Society, Veterans Administration, MI Department of Health & Human Services, MI Department of Community Health, Medical Services Administration, United Way, MI Department of Transportation programs, etc.

Service Name: Transportation Coordination

SERVICE CATEGORY	Access Service
SERVICE DEFINITION	Scheduling and coordination of transportation services for MCSM funded agencies, intended to increase the independence of the individual(s) using the service.
UNIT OF SERVICE	One hour

Allowable Service Components

1. Qualified staff will perform coordination functions.
2. Coordination staff receives ongoing training and supervision as appropriate.
3. Coordination staff will provide efficient and customer focused service.
4. Coordination staff will inform all clients about the opportunity to donate the requested $2.00 donation.
5. Quality assurance protocol will verify level of service provision.
6. In the event bi-lingual staff is not readily available, arrangements will be made for translation services.
7. The program must maintain records for three years or until an audit has been closed. Records must include at minimum, the number of scheduled trips, nature of the trips and number of trips that were unable to be scheduled due to capacity issues.

Minimum Standards

Qualified staff will have experience with customer service, working with older persons and persons with disabilities, and transportation issues such as geographic area being served and scheduling.

Operation will accept ride requests six hours a day, five days a week.

General Service Category Service Standards

Service Name: Adaptive Equipment

SERVICE CATEGORY	General Services
SERVICE DEFINITION	The temporary loan of assistive technology, adaptive equipment or other aids for the personal use of a client who does not reside in an assisted living facility.
UNIT OF SERVICE	The exchange of one piece of equipment.

Minimum Standards:

1. The program must assure that an individual is trained in how to inspect, care for, and use types of equipment loaned from the program. This person must be certain that the client receiving the loaned equipment knows how to use it safely.

2. All equipment that is returned from a loan must be inspected, cleaned and sanitized before it is to be loaned out again.

3. Documentation must be maintained for each loan, listing name, address, and phone number of client; their disabling condition; what was loaned; receipt of fee, if applicable, targeted date of return, and certification that the equipment was clean and had no defects at the time of the loan. Both parties to the loan will receive a copy of this documentation.

4. The program will maintain an inventory of all equipment utilized by the program and a log showing whether individual items are on loan or in storage.

5. A minimum $10 copay (or a minimum as determined by Service Provider) is requested which covers both assessment and equipment services. The copay is good for one year and is waived if there is inability to pay or financial hardship. However, expensive equipment purchased may require a higher copay. Additionally, the Senior Millage cost share policy, based on ones' income, liquid assets and the cost of the service provided, is applied to individuals. If one cannot afford the cost share because of necessary excessive and additional expenses (medical, health care, etc.), a more thorough financial evaluation is completed.

Service Name: Aging in Place: Training and Support

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Formalized group education modules for seniors for successful Aging in Place. Programs that provide information, training, networking and support to seniors who wish to stay in their own homes. Group education and training is intended to increase the safety, ease, success, and satisfaction of Aging in Place in the community. Modules will focus on fall prevention, energy conservation, adaptive equipment, preparing you and your home for surgery and hospitalizations, accessing community resources, and benefits consultation.
UNIT OF SERVICE	One hour of training, follow-up, and reporting.

Minimum Standards:

1. Educational trainings will be provided at locations convenient to seniors.

2. Programs will be episodic and based on classes scheduled. Participants will be able to select the training module they need and sign up.

3. After completing each training module, participants have the option to select other modules.

4. Modules will be scheduled based on a rotating basis.

5. Each program will utilize staff that has specific training and /or experience in the particular training being provided. Educational modules will be developed and taught by Occupational Therapists, Certified Occupational Therapy Assistants, Social Workers, and Independent Living Specialists.

6. Evidence based educational models will be incorporated into core curriculum when available. Training will be in small groups with hands on participation.

7. Course pack will be available to participants of educational sessions.

8. Pre and post surveys will be conducted, documented, and reported.

9. Outreach materials and direct contact will be made to seniors and selected community partners via: direct mail, phone outreach, radio, social media, direct consumer interaction, and active partnering with service providers (hospitals, rehabilitation centers, home care providers, etc.) Information will be available in print, on our website, and presentations in the community.

Service Name: Dementia Care Program

SERVICE CATEGORY	General Services
SERVICE DEFINITION	An in-home, person-centered consultation and counseling program intended to provide assistance to caregivers in understanding and coping with a range of issues related to caregiving and Alzheimer's disease or dementia. Services may include: (1) Hands on education training, including development and distribution of printed materials, pertaining to the physical, emotional and spiritual aspects of caregiving for those affected by Alzheimer's or dementia, along with current research and public policy concerns; (2) Home visits to address behaviors exhibited by individuals with Alzheimer's or dementia; (3) Follow-up phone consultations and in-home follow-up consults as needed; and (4) Referrals to other dementia-specific services, such as support groups, community education programs, respite, and healthcare professionals.
UNIT OF SERVICE	One hour of consultation, referral, education, support, and/or training service provision, including travel to client locations, phone consultations, and referrals to other dementia-specific professional services.

Minimum Standards:

1. Each client shall be served for no less than six months and will be provided with at least one intake phone assessment, one home visit, and five follow-up visits or consults. Follow-up consults may be conducted by phone depending on need and severity of the caregiver's needs; greater needs will require in-home follow up visits (no more than one follow-up visit per month per client).

2. Dementia-specific education and counseling shall use trained and experienced staff in the areas of dementia and Alzheimer's disease. Continuing education of staff in dementia and Alzheimer's disease is encouraged.

3. Services may be provided to caregivers over age 60 regardless of the age of the respective care recipient and to caregivers under age 60 when the respective care recipient is aged 60 or over.

4. Service may be provided in a community setting if the caregiver requests it; otherwise, services will be provided through in-home settings.

5. Dementia-specific counselors will work closely with referring organizations and report on outcomes.

6. Dementia-specific services will require the creation of person-centered plans addressing the needs and concerns of caregivers and clients; these plans will be used to evaluate success of the services.

Service Name: Dentures

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Evaluation, preparation and provision of complete or partial dentures for uninsured older adults
UNIT OF SERVICE	One set of dentures or partial dentures

Minimum Standards:

1. Age 60 and older who are uninsured for dental care, are edentulous, in whole or part, and in poverty (at or below poverty levels).

2. Clients will complete a questionnaire and consent form for service prior to fittings.

3. Client will be evaluated for denture needs (full or partial), mouth preparation will be conducted (removing teeth and gum preparation) and dentures made and fitted.

4. A care plan will be established to endure visits are arranged in sequence.

5. Clients will receive a minimum of two (2) follow-up visits to assure dentures have a proper fit.

6. Clients will receive education on the need for a preventative maintenance schedule and future adjustment education.

Service Name: Health Education/Health Promotion

SERVICE CATEGORY	General Services
SERVICE DEFINITION	A service program that provides information and support to older individuals with the intent of assisting them in avoiding illness and improving health status. Allowable programs must be evidence-based for adults and approved by SRWM: *Definition of evidence-based programming: the program has undergone experimental or quasi- experimental design AND, Has full translation at community sites Has products that have been disseminated and are readily available for use.
UNIT OF SERVICE	One activity session or hour of related service provision, as appropriate.

Minimum Standards

1. Each program shall utilize staff that has specific training and/or experience in the particular service area(s) being provided. Continuing education of staff in specific service areas is encouraged.

2. Each program, in targeting services, shall give priority to geographic areas which are medically underserved and in which there are a significant number of older individuals who have the greatest economic need for such services.

3. Each program is encouraged to facilitate and utilize a regional health coalition to plan for and implement services. Members of the regional health coalition should include one or more members of the Michigan Primary Care Association and other organizations such as: local public health departments; community mental health departments; cooperative extension agents; local aging Service Providers; local health practitioners; local hospitals; and local MMAP providers.

4. Health education/health promotion services should be provided at locations and in facilities convenient to older participants.

5. In accordance with the health promotion/disease prevention program guidelines, classes will only be reimbursed when the required minimum number of participants registered and planning to attend is met. If there is no stated minimum number of participants listed for the program; the minimum number of participants would be 5 or more participants registered and planning to attend.

Service Name: Flu/Pneumonia Vaccinations

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Muskegon County residents, between the ages of 60-64 who are at risk, at need and uninsured, will be able to receive one Influenza or Pneumonia vaccination at a regularly scheduled Influenza/Pneumonia clinic. Individual vaccinations can be arranged for home bound clients.
UNIT OF SERVICE	One Influenza or Pneumonia vaccination.

Minimum Standards:

1. This service may be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a RN. Upon approval, a licensed paramedic may also provide the vaccines. This staff will be licensed in the State of Michigan. The Service Provider shall provide supervision of the nurse and will:
    a. Assess the client's response to contraindicated medications, and conditions as established by the Centers for Disease Control and the manufacturer of the vaccine
    b. Answer client questions and obtain a current consent for care signed by the client or their Power of Attorney or Guardian.
    c. Administer the injection according to protocols and procedures
    d. Observe, record, and report any client reactions outside of normal reactions and take measures as indicated by protocols and procedures.
    e. Provide the client with a receipt for service as well as a number to call in case of questions or concerns.
    f. The Program will maintain the releases as dictated by medical standards and other record maintenance provisions that may be applicable

Service Name: Friendly Visitor

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Making regular visits to homebound (not in assisted living facilities) isolated older persons to provide companionship and social interaction. This service is for individuals who do not have socialization activities associated with their residence, or who cannot participate in those activities due to physical/ behavioral limitations.
UNIT OF SERVICE	A unit is equal to one hour of time spent visiting an older person in their residence to provide companionship and social interaction.

Minimum Standards:

1. Friendly visitor program may not use Muskegon County Senior Millage funds to pay wages for friendly visitors. Service funds may be used to reimburse out of pocket expenses for volunteer friendly visitors. Service funds may also be used to pay for calling expenses, out of pocket expense for in home visits, and program supplies.

2. Volunteer friendly visitors should receive an orientation training which covers at a minimum: the needs of isolated homebound elderly persons; the functions and limitations of a friendly visitor; communication and interpersonal skills; and, emergency procedures.

3. Each friendly visitor must agree not to solicit contributions of any kind, attempt the sale of any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy while making a friendly visit.

4. The program must develop procedures for screening prospective clients and volunteers to attempt to match persons who are compatible.

5. Each program must have a staff person designated to provide direction to volunteer visitors and to be available to contact in emergencies or problem situations.

6. Friendly visits can include the occasional trip to the grocery store, church, and/or social activity. The Friendly Visitor must provide current driver's license and insurance verification.

7. Friendly visits can continue to an existing client who temporarily (60 days) is hospitalized or is in a rehabilitation facility.

Service Name: Health Education Coordination

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Implementing and promoting evidence-based health education programs in Muskegon County. This includes collaborating with a wide variety of organizations, both in and out of the aging service network.
UNIT OF SERVICE	One hour of allowable service component.

1. Allowable Service Components

    a. Membership on collaboration committees local and state wide.
    b. Recruitment of participants for the healthy aging programs.
    c. Assisting with the recruitment, retention and training of qualified instructors and volunteers for the healthy aging programs.
    d. Presentations to the community to increase awareness and access to appropriate healthy aging programs.

All of these components are subject to approval by SRWM staff.

2. Minimum Standards

    a. The program must provide at least two lay leader trainings per year to maintain the adequate number of trained volunteers/staff to lead healthy aging programs.
    b. The program will utilize staff that have master training license and experience in the area of evidence based health promotion programming.
    c. Must demonstrate an effort to build collaborations with organizations in and outside the aging services network to promote, implement and expand healthy aging programming opportunities. Suggestions of collaborative relationships would include providing public presentations to educate the greater community about health promotion opportunities.

Service Name: Hearing Aid Assistance Program

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Low income older adults in Muskegon County will receive assistance in obtaining hearing aid(s) through working with various programs designed by the MCSM Provider.
UNIT OF SERVICE	One unit of service equals two hearing aids.

The unit of service will include fitting for hearing aid(s) and aural rehabilitation to get used to the hearing aids. (Client will pay for their own audiological exam.) Additionally, the unit of service will include the making of ear mold(s), and whatever follow-up appointments are deemed necessary by the audiologist.

Minimum Standards

1. Client is referred to participating audiologist. Audiologist confirms hearing loss and type of hearing aid(s) recommended.
2. Staff may assist client to complete both the application to the designated hearing aid provider and a signed release of information form.
3. Staff will obtain copies of client audiogram for client files.
4. Staff will maintain case notes for client files.
5. Staff manages reimbursement to hearing aid provider.

Service Name: Independent Living Program

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Client-driven, goal-oriented instruction and practice in skills which increase independence and functioning. May include training in the use of assistive devices. Services are performed in the client's home (not assisted living facilities). The purpose of the program is to help the client gain the functional skills needed so he or she will not have to move into a dependent care living arrangement, such as a nursing home. The goal is to decrease dependency on care givers.
UNIT OF SERVICE	An hour of service performed by an Occupational Therapist with a client or on the behalf of a client accepted into the program. (When an hour of service is provided to a group an appropriate unit rate will be established.)

Minimum Standards:

1. All training and instruction must be performed by a licensed Occupational Therapist with geriatric training and/or experience working with geriatric clients of at least one year.

2. Services must begin with a functional assessment of the client conducted by the Occupational Therapist using appropriate professional assessment measures.

3. An Intervention Plan must be developed for each client, created with and approved by the client, client's guardian or designated representative. The client and or designee may elect to include others such as family members, care givers or health care professionals in the planning. The Intervention Plan will include, at a minimum:
    1. a statement of the client's problems, needs, strengths, resources and preferences.
    2. a statement of the goals and objectives for meeting identified needs.
    3. a description of the methods and/or approaches to be used with frequencies and responsible parties identified.
    4. physical treatment orders when applicable

4. The program must be able to provide services at the client's place of residence.

5. The program must identify a care giver to assist the client with practice of learned skills at a frequency and duration to be determined by the Occupational Therapist. The caregiver must be physically able to handle the assigned duties.

6. The Occupational Therapist must monitor the practice sessions of caregivers by direct observation or by conferring with the caregiver at the appropriate frequency.

7. The Occupational Therapist will maintain progress notes of all interventions performed and each contact with caregivers.

8. The Occupational Therapist will not approve any intervention plan, engage in any activity, or provide any direction to a caregiver that is considered unsafe for the client. The Occupational Therapist will advise the client and other responsible parties, including appropriate protective services, if he or she considers the client unable to safely live with the existing level of care.

9. At the anticipated termination of services, a functional assessment of the client using professionally accepted measures must be administered by the Occupational Therapist.

10. A full case record will be maintained for each client including the intervention plan, progress notes, assessments and other pertinent information.

Service Name: In-Home Recreation Therapy

SERVICE CATEGORY	General Services
SERVICE DEFINITION	The provision of therapy utilizing various interventions to treat physical, social, cognitive and emotional conditions associated with illness, injury, or chronic disability of homebound older persons, and including educational components enabling individuals to become more informed and active partners in their own health care by using activities to cope with the stress of illness and disability.
UNIT OF SERVICE	One unit of service will include one hour of direct and/or indirect client support. Direct support shall be defined as: intake, assessment, and direct client therapy. Indirect client support means information gathering, maintenance of case records, supervisory/implementation consultations on behalf of the client.

Minimum Standards

1. Each program must conduct an intake and assessment. Assessment must include a Functional Assessment of Characteristics for Therapeutic Recreation (FACTR) and Community Reintegration Evaluation.

2. A therapy plan must be developed for each client. This plan shall be based on the assessment and in conjunction with the client's personal goals.

3. Each program must have a written policy/procedure to govern the development, implementation and management of therapy plans.

4. Clients shall receive a minimum of 45 minutes of one-on-one therapy (once per week), twice per month (on an every other week principle) in their own home, by a Certified Therapeutic Recreation Specialist (CTRS).

5. Paid staff must have a bachelor's degree in one of the following fields: Occupational Therapy, Physical Therapy, or Therapeutic Recreation. Paid staff must maintain a current CTRS status.

6. The CTRS shall be responsible for the assessment, treatment planning, therapy, documentation, discharge planning, and referral to community agencies.

7. Volunteers shall be recruited by contacting client's children, grandchildren, friends and neighbors.

Service Name: Prescription Assistance Program

SERVICE CATEGORY	General Services
SERVICE DEFINITION	The provision of counseling for clients (aged 60-64) needing assistance for prescription medication receive guidance in applying for proprietary pharmaceutical company programs and clients (aged 65+) needing assistance in how to select a Medicare Part D program, how to apply for Medicaid and where to turn with questions regarding existing coverage.
UNIT OF SERVICE	One hour of allowable service.

Minimum Standards

1. Program must identify, determine, and document client needs.

2. Program must provide documentation of all contact with and assistance to clients and referrals to other service providers in the community.

3. Program must provide follow-up as often as is appropriate but at a minimum to determine whether the need(s) were addressed and to determine any problems with the prescription assistance.

4. Program must complete an initial intake in a timely manner for one-on-one service. Record must also be kept on requests for service which program is unable to meet.

5. Service provided in areas where non-English or limited English speaking older adults are concentrated are encouraged to have bilingual personnel available (paid or non-paid).

6. Staff will be knowledgeable in Medicare Part D, Medicare and Medicaid prescription programs, local prescription programs and proprietary pharmaceutical company programs. The program must demonstrate that staff participates in education programs related to these topics (i.e. attendance at monthly MMAP refresher trainings.)

7. Program must be able to provide service at a client's home, in a community setting and by telephone.

8. Program must demonstrate collaborative relationships with the immediate community and other service providers.

9. Allowable Service
    i. One-on-one counselling
    ii. Telephone counselling
    iii. Work on behalf of a client to acquire prescription assistance
    iv. Group presentations
    v. Medicare Part D assistance counselling

10. Program will develop annual outcomes based on performance measurement goals required by the Center for Medicare and Medicaid Services.

11. Program is required to report all qualified contacts in the MMAP Shiptalk database on the day they occur.

Service Name: Prevention of Elder Abuse, Neglect and Exploitation

SERVICE CATEGORY	General
SERVICE DEFINITION	Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation
UNIT OF SERVICE	One hour of contact with organizations to develop coordinated, comprehensive services for the target population. In addition to contact with other aging subcontract organizations, elder abuse subcontract agencies shall count contact with the Department of Human Services, Adult Protective Services, law enforcement, health care professionals, community mental health, and other relevant service entities when the reason for the contact is to meet the above service definition.

Minimum Standards

1. Professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.

2. The coordinated, comprehensive approaches to prevent elder abuse, neglect, and exploitation shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long-term care ombudsman/advocacy programs, and legal assistance programs operating in the service area.

Service Name: Retired & Senior Volunteer Program

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Offer challenging and meaningful volunteer opportunities to people 60 years of age and older, resulting in high quality of life for seniors who have an opportunity to share their expertise and experience with other residents of Muskegon County.
UNIT OF SERVICE	One hour of volunteer service constitutes one unit.

Minimum Standards

1. All members must be 60 years of age or older.

2. All members must complete an enrollment form to be kept on file in the RSVP office. Intake information consists of name, address, birth date, telephone, ethnicity, previous occupation, education, previous volunteer service, and interest (i.e.: friendly visiting, meal delivery, Hospice, food banks, environment, children, advocacy groups, computer, disability assistance, in-home care).

3. All members must attend a one-time RSVP orientation. Volunteers receive ongoing on-site training appropriate for their chosen jobs at their chosen stations.

4. All active members are required to submit a monthly timesheet of their volunteer hours.

5. RSVP staff will recruit appropriate volunteer and volunteer stations.

6. RSVP staff will comply with all required funding rules and regulations.

7. RSVP will support all volunteers and volunteer stations as is appropriate.

Service Name: Senior Center Activities

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Provision of support for the outreach, educational and recreational activities of a senior center. A senior center is defined as a community facility where older persons can come together for services and activities which enhance their dignity, support their independence, and encourage their involvement in and with the community.
UNIT OF SERVICE	One hour of senior center operation.

Minimum Standards

1. Each senior center shall be certified as an accessible facility. Accessibility is defined as the ability of a person with a disability to enter the facility, use the restroom and receive service that is at least equal in quality to that provided to able-bodied participants.

2. Each senior center shall be open a minimum of three days per week and at least 24 hours per week.

3. Each senior center shall provide directly or make arrangements for the provision of the following services:
    a. Outreach
    b. Information and assistance
    c. Socialization/recreation
    d. Education
    e. Volunteer opportunities

5. Each senior center shall demonstrate that it is in compliance with fire safety standards and applicable Michigan and local public health codes regulating food service establishments.

6. Each senior center shall document that appropriate preparation has taken place for procedures to be followed in case of an emergency including:
    a. An annual fire drill.
        i. Posting and training of staff and regular volunteers on procedures to be followed in the event of severe weather or a natural disaster.
        ii. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

7. Each senior center shall be appropriately incorporated under Michigan law or be operated by an organization which is appropriately incorporated or a local unit of government. Each senior center should seek 501 (c)(3) tax exemption unless prohibited by the nature of its incorporation.

8. Each senior center shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.

9. Each senior center shall provide an opportunity for center participants to have input regarding the governance of the center at the policy making level as well as in daily operations.

Service Name: Senior Center Staffing

SERVICE CATEGORY	Community
SERVICE DEFINITION	Provision of funding to support staff positions at senior centers which may include: A senior center director, a senior center program coordinator, or a senior center specialist. Programming must be offered that is intended to attract and retain the broad spectrum of older adults from baby boomers to centenarians.
UNIT OF SERVICE	Each hour of staff time worked.

Minimum Standards:

1. Each program must strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.

2. Where the program supports a senior center director position, the person occupying this position must have the authority to perform administrative functions of the senior center.

3. Where the program supports a senior center program coordinator position, the person occupying this position must be involved in the development of three or more programs at any given time.

4. Where the program supports a senior center specialist position, the person occupying this position must oversee the operation of a variety of programs and/or services within the senior center.

5. Allowable senior center staffing costs are limited to:

    a. Wages
    b. Fringes
    c. Travel
    d. Training
    e. Supplies (reasonable expenses for each position and to be used only in support of that position.)

6. Programs must be geared to addressing the future needs and expectations of the "Baby Boomer" generation, those born between 1946 and 1964.

Service Name: Senior Companion

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Senior Companions are persons with low-incomes, aged 60 and older, who provide individualized support, assistance and companionship to other older adults with physical, mental, or emotional impairments. Each Companion serves 20 hours per week and receives a non- taxable stipend per hour, which enables those living on established program incomes guidelines to volunteer at no cost to them. In addition to the hourly stipend, Companions are provided assistance with the cost of transportation and a daily meal, a physical exam, and on-duty accident/liability insurance.
UNIT OF SERVICE	One hour of senior companion service provided.

Minimum standards:

1. Senior Companions receive a 40-hour pre-service orientation and four hours of monthly in-service training on the following topics:
    a . SCP policies and procedures
    b. communication and interpersonal skill
    c. recipient rights, confidentiality
    d. aspects of mental illness
    e. working with developmentally disabled older adults
    f . friendship
    g. and universal precautions

2. Under the supervision of health care/social service agency/senior center staff, Congregate site staff should be utilized to link Senior Companions with frail and disabled clients. Care plans identifying client information, days and times of service, and specific goals/ appropriate activities, are developed for each client receiving Senior Companion service.

3. Senior Companion Program staff monitors Senior Companions on a monthly basis, and are available by telephone.

4. Forms reporting hours of service are verified by Senior Companion Program staff.

5. Senior Companions are evaluated by program staff on an annual basis.

Service Name: Senior Fun and Fitness

SERVICE CATEGORY	General Services
SERVICE DEFINITION	The delivery of one-hour of group wellness sessions that integrate behavioral and health education, health screenings and exercise for the purpose of self-directed care of the body, mind, and spirit. The sessions will be provided weekly in a group setting.
UNIT OF SERVICE	One unit of service equals one hour of participation by one person

Minimum standards:

Seniors will have access to health information, screenings, supervised exercise, and monitor progress of their own health status.

1. **Service Components** – Each session will include the following components:
    a. Educational component – Approximately 15 minutes to increase the recipient's knowledge base related to the process of aging, disease management and prevention, behavioral health or other related topics and improve recipient's capacity to make informed decisions related to their health.
    b. Screenings – A minimum of two types of screening per session may include:
        i. Blood pressure
        ii. Blood sugar
        iii. Pulse oximetry
        iv. Pulse Rate
        v. Weight
        vi. Body Mass Index
        vii. Cholesterol – quarterly
    c. Exercise – Approximately 20 minutes to improve mobility, flexibility and strength
    d. Mental/Behavioral Health Screenings – Suggested
        i. Memory Screening
        ii. Depression Screening
2. **Participant Analysis** – A Participant Analysis will be conducted by a nurse, or fitness expert, when the recipient begins the program and will include:
    a. Basic information including name, address, phone, birth date, gender (optional), and race/ethnicity (optional)
    b. Vitals including blood pressure, blood sugar, pulse ox, weight

c. Signature of recipient acknowledging willingness to participate and have data (without name) collected and reported.

3. **Participant tracking and monitoring**
    a. Recipients will track their progress on a weekly basis. Quarterly progress reports will assist recipients in measuring their improvement using the Healthy Days Survey and Fitness Profile (or other recognized profile).
    b. Follow-up contacts will be made to determine if linkage was successful and determine if further referral is needed
4. **Referrals and Collaboration** – Where appropriate, referrals will be made to physicians, mental health, and other services that support whole person wellness. Collaboration with other organizations serving older adults will be encouraged. Appropriate entities will be given the opportunity to provide information or services at weekly sessions.
5. This program will work closely with sites that have congregate meal services and other rural sites that may be developing locally initiated senior outreach/lifestyle centers.

Service Name: Specialized Hearing Services

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Provision of Specialized Hearing Services for hearing loss for the hard of hearing, the late deafened, and deaf persons which includes: orientation to hearing loss, rehabilitation for activities of daily living, and assistance in finding devices and other resources to assist in the adjustment to hearing loss.
UNIT OF SERVICE	One hour of individualized specialized hearing services or one group session

Minimum Standards:

1. Staff providing rehabilitation training must have experience and be trained in communication skills including: lip reading, sign language, use of adaptive devices and assistive hearing devices, TTY and videophone.

2. Staff providing lip reading must have experience and be trained in the techniques, methods and use of lip reading and/or auditory training for individuals with a hearing loss.

3. Each client will provide the agency with an audiogram or visit an audiologist for a clear assessment of the hearing loss.

4. The program coordinator must have a minimum of a bachelor's degree in deaf education, social work for hearing impaired or other related field or experience.

5. Each hearing services program must demonstrate a working relationship with local agencies and organizations offering programs for the hearing impaired and with the Michigan Department of Rehabilitation Services.

6. A treatment plan shall be developed for each client based on a comprehensive assessment. The treatment plan shall be developed in cooperation with and be approved by the client. The treatment plan shall contain at a minimum:

    i. A statement of the client's problems, needs, strength and resources.

    ii. A statement of the goals and objectives form meeting identified needs.

iii. A description of methods and/or approaches to be used.

iv. Identification of services to be obtained from or provided by other community agencies.

v. Treatment orders of qualified health professionals, when applicable

7. The program may provide individual, family and/or group counseling sessions. Family members of clients are eligible for family counseling when appropriate to resolve the problems of the client.

8. All open cases must undergo a quarterly case review by the appropriate supervisory staff.

Service Name: Vision Services

SERVICE CATEGORY	General Services
SERVICE DEFINITION	Provision of specialized vision services for older visually impaired and blind persons.
UNIT OF SERVICE	Each hour of service provided. Each group education session.

1. Minimum standards – Vision Clinics

    a. Provide glaucoma detection visits for adults ages 60 and over who are low income and uninsured. In addition, provide treatment and ongoing care for glaucoma, including appropriate referrals to area specialists.

    b. Provide detection and treatment for eye conditions such as macular degeneration and cataracts.

    c. Provide comprehensive diabetic retinal examinations as part of the comprehensive examination using Retinal photography.

    d. Provide eye glasses to those in need using cost share/sliding scale for payment.

2. Minimum standards - Rehabilitation

    a. Program staff providing rehabilitation training must have experience and be trained in communication skills including Braille, typing, handwriting, use of recording devices, telephone dialing, manual alphabet, and other appropriate skills.

    b. Program staff providing orientation and mobility training must have experience and be trained in techniques, methods, and use of travel aids to visually impaired clients.

    c. Optometric services must be provided by an optometrist that has graduated from an accredited College of Optometry and is licensed to practice optometry in the State of Michigan.

    d. The program must have a coordinator with a minimum of a bachelor's degree in Blind rehabilitation, Occupational therapy, Rehabilitation Teaching, or a related field.

e. Each vision services program must demonstrate working relationships with other local agencies and organizations offering programs for the blind and with the Bureau of Rehabilitation and Disability Determination of the Michigan Department of Education.

3. Allowable Service

a. Provision of specialized vision services include:

i. orientation and mobility training;
ii. rehabilitation for activities of daily living:
iii. optometric services to help persons with severe vision loss to utilize remaining vision as effectively as possible; and
iv. group education on prevention of or adjustment to visual impairment.

Nutrition Services Category Service Standards

General Requirements for Nutrition Programs for the Elderly

Meals may be presented hot, cold, frozen or shelf-stable and shall conform to the following Meal Planning Guidelines:

1. Each program shall utilize a menu development process, which places priority on healthy choices and creativity and includes, at a minimum:
    a. Use of written or electronic standardized recipes.
    b. Cycle menus are encouraged for costs containment and/or convenience, but are not required.
    c. Provision for review and approval of all menus by the regional dietitian who must be a registered dietitian, an individual who is dietitian registration eligible or a Registered Dietetic Tech.
    d. Posting of menu to be served in a conspicuous place at each meal site and at each place food is prepared. The program must be able to provide information on the nutrition content of menus upon request.
    e. Modified diet menus may be provided, where feasible and appropriate, which take into consideration client choice, health, religious and ethnic diet preferences.
    f. A record of the menu actually served each day shall be maintained for each fiscal year's operation.
    g. Nutrition providers are strongly encouraged to use computerized nutrient analysis to assure meals are in compliance with nutritional requirements.

2. The nutrition program must operate according to current provisions of the Michigan Food Code. Minimum food safety standards are established by the respective local Health Department. Each program must have a copy of the Michigan Food Code available for reference. Programs are encouraged to monitor food safety alerts pertaining to older adults.

3. Each program, which operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program that has been approved by the Michigan Department of Agriculture. A trained and certified staff member is preferred, but not required, at satellite serving and packing sites. Please refer to your local Health Department for local regulations on this requirement.

4. The time period between preparation of food and the beginning of serving shall be as minimal as feasible. Food shall be prepared, held and served at safe temperatures. Documentation requirements for food safety procedures shall be developed in conjunction with, and be acceptable to, the respective local Health Department.

5. The safety of food after it has been served to a participant and when it has been removed from the meal site, or left in the control of a homebound participant, is the responsibility of that participant.

6. Purchased Foodstuffs – The program must purchase foodstuff from commercial sources which comply with the Michigan Food Code. Unacceptable purchased items include:

home canned or preserved foods; foods cooked or prepared in an individual's home kitchen (this includes those covered under the Cottage Food Law); meat or wild game not processed by a licensed facility; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and any un-pasteurized products (i.e., dairy, juices and honey).

7. Contributed Foodstuffs – The program may use contributed foodstuff only when they meet the same standards of quality, sanitation and safety as apply to food stuffs purchased from commercial sources.

8. Acceptable contributed foodstuff include: fresh fruits and vegetables, and wild game from a licensed processor. A list of licensed processors can be found on the Michigan Department of Agriculture and Rural Development website.

9. Each program shall use standardized portion control procedures to ensure that each meal served is uniform. Standard portions may be altered at the request of a participant for less than the standard serving of an item or if a participant refused an item. Less than standard portions shall not be served in order to "stretch" available food to serve additional persons.

10. Each program shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).

11. Each program shall use an adequate food cost and inventory system at each food preparation facility. The inventory control shall be based on the first in/first-out method and conform to generally accepted accounting principles. The system shall be able to provide daily food costs, inventory control records, and monthly compilation of daily food costs.

12. For program operating under annual cost-reimbursement contracts, the value of the inventory on hand at the end of the fiscal year shall be deducted from the total amount expended during that year. For programs operating under a unit-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year does not have to be considered. Each program shall be able to calculate the component costs of each meal provided according to the following categories:

    a. Raw Food – All costs of acquiring foodstuff to be used in the program.
    b. Labor – (i) Food Service Operations: all expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving and cleaning of meal sites, equipment and kitchens; (ii) Project manager: All expenses for salary wages for persons involved in project management
    c. Equipment – All expenditures for items with a useful life of more than one year and an acquisition cost of greater than $5,000.
    d. Supplies – All expenditures for items with a useful life of less than one year with an acquisition cost of less than $5,000.
    e. Utilities – All expenditures for gas, electricity, water, sewer, waste disposal, etc.
    f. Other – Expenditures for all other items that do not belong in any of the above

categories (e.g. rent, insurance, fuel etc.) to be identified and itemized.

g. Where a provider operates more than one meal/feeding program (congregate, home-delivered meal, waiver, catering, etc.) costs shall be accurately distributed among the respective meal programs. Only costs directly related to a specific program shall be charged to that program.

13. Each program shall provide or arrange for monthly nutrition education sessions at each meal site and to home delivered meal participants. Topics shall include, but are not limited to, food, nutrition, wellness issues, consumerism and health. Nutrition education materials must come from reputable sources. Questions pertaining to appropriateness of materials and presenters are to be directed to the regional dietician. Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited proficiency.

14. Senior Resources may adjust the number of nutrition grantees to meet the needs of the region.

15. Each meal program is encouraged to use volunteers, as feasible, in program operations.

16. Each program shall develop and utilize a system for documenting meals served. Meals eligible to be reported are those served to eligible individuals (as described under respective program eligibility criteria) and which meet the specified meal requirements.

17. The most acceptable method of documenting meals is by obtaining signatures daily from participants receiving meals. Other acceptable methods may include, for example, for home delivered meals, maintaining a daily or weekly route sheet signed by the driver which identifies the client's name, address, and number of meals served to them each day.

18. Each program shall use a uniform intake process and maintain a registration for each program participant. The intake process shall be initiated within one week after an individual becomes active in the program. Completion of the registration is not a prerequisite to eligibility and may not be presented to potential participants as a requirement for starting the program, but does need to be completed within one week of receiving service.

19. Each nutrition program shall carry product liability insurance sufficient to cover its operation.

20. Each program, with input from program participants, shall establish a suggested donation amount that is to be posted at each meal site and provided to home delivered meal participants. The program may establish a suggested donation scale based on income ranges, if approved by Senior Resources. Volunteers under the age of 60 who receive meals shall be afforded the opportunity to donate toward the cost of the meal received.

21. Program income from participant donations must be used in accordance with the additive alternative, as described in the Code of Federal Regulations (CFR). Under this alternative,

the income is used in addition to the grant funds awarded to the provider and used for the purposes and under the conditions of the contract. Use of program income is approved by Senior Resources as a part of the budget process.

22. Each program shall have a written procedure in place for handling all donations which includes at a minimum:
    a. Daily counting and recording of all receipts by two individuals.
    b. Provisions for sealing, written acknowledgment and transporting of daily receipts to either deposit in a financial institution or secure storage until a deposit can be arranged.
    c. Reconciliation of deposit receipts and daily collection records by someone other than the depositor or counter.

23. Each program shall take steps to inform participants about local, State and Federal food assistance programs and provide information and referral to assist the individual with obtaining benefits. When requested, programs shall assist participants in utilizing Supplemental Nutrition Assistance Program (SNAP, formerly known as "food stamps") benefits as participant donations to the program.

24. Programs shall not use funds from MCSM to purchase vitamins or other dietary supplements

25. Staff and volunteers of each program shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and to improve their skills at tasks performed in the provision of service. Records shall be maintained which identify the dates of training, topics covered and persons attending. All staff and volunteers who handle or prepare food at any time must have food service sanitation training at least once per year.

26. Complaints from participants should be first dealt with at the provider level. Each nutrition provider shall have a written procedure for handling complaints. Senior Resources staff is to be notified if a participant appeals, in writing, a complaint resolution.

27. Nutrition providers shall work with Senior Resources of West Michigan to develop a written emergency plan. The emergency plan shall include, but not be limited to:
    a. Uninterrupted delivery of meals to home delivered meals participants, including, but not limited to use of family and friends, volunteers and informal support systems.
    b. Maintenance of shelf-stable meals and instructions on how to use for home delivered participants. Every effort should be made to assure that emergency, shelf-stable, emergency meals will not be required to adhere to the guidelines.
    c. Back-up plan for food preparation if usual kitchen facility is unavailable.
    d. Agreements in place with volunteer agencies, individual volunteers, hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation and delivery.
    e. Communications system to alert congregate and home delivered meals clients of changes in meal/site delivery.

f. The plan shall cover all the sites and home-delivered meals participants for each nutrition provider, including sub-contractors of Senior Resources.
g. The plan shall be reviewed and approved by Senior Resources.
h. As a part of yearly evaluation that must be completed on each employee, congregate sites should receive a yearly site evaluation inspection and home delivered meal drivers should receive a ride along. These should be completed by a supervisor.

MEAL PLANNING GUIDELINES

1. Menus should be created to ensure that each meal shall provide, at a minimum, 1/3 of the daily recommended dietary intake (DRI) allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

2. Increased 'scratch' cooking with less use of processed and ready-to-serve foods whenever possible.

3. Increased use of fresh or frozen fruits and vegetables, especially those high in potassium.

4. Vegetarian meals can be served as part of the menu cycle or as an optional menu choice based on participant choice, cultural and/or religious needs and should follow the Meal Planning Guidelines to include a variety of flavors, textures, seasonings, colors and food groups at the same meal.

5. Plant sources include legumes (such as cooked dried beans) and protein sources from whole grains such as brown rice, whole wheat bread and pasta. Vegetarian meals are a good opportunity to provide variety to menus, feature Michigan produce and highlight the many ethnic, cultural or religious food traditions that use vegetables and grains in greater amounts at the center of the plate and in different combinations with fruits, vegetables, grains, herbs and spices for added flavor, calories and key nutrients.

6. Breakfast meals may include any combination of foods that meet the Meal Planning Guidelines.

7. Each meal should have the following food groups:
    a. Bread or bread alternate
    b. Dairy
    c. Vegetables
    d. Meat or meat alternatives
    e. Fruit

8. Please refer to http://www.choosemyplate.gov for serving sizes of each meal component.

9. Bread or bread alternate:
    a. May include but not limited to:

Muffin	Cornbread	Biscuit	
Waffle	French toast	English muffin	Tortilla

Pancakes	Bagel	Crackers	Granola
Graham cracker squares		Dressing	Stuffing
Pasta	Sandwich bun	Cooked cereal	Bread, all types

b. A variety of enriched and/or whole grain bread products, particularly those high in fiber are recommended.

10. Vegetables
    a. Along with traditional vegetables, this category may include, but is not limited to:

Dried beans	100% vegetable juice
Peas	Lentils

Raw, leafy vegetables (Fresh, frozen or freeze-dried juice or canned vegetable)
Other beans

11. Fruits
    a. Along with traditional fruits, this category may include, but is not limited to:
       Chopped, cooked or canned fruit
       100% juice
       Fresh, frozen, freeze-dried, juice or canned fruits are acceptable.

12. Milk or milk alternatives
    a. Along with traditional milk products, this category may include, but is not limited to:

Buttermilk	Yogurt
Low-fat chocolate milk	Cottage Cheese
Lactose-free milk	Tofu

Natural or processed cheese
Calcium fortified soy, rice or almond milk
Powdered dry milk
Evaporated milk

13. Meat or meat alternatives – Meat serving weight is the edible portion, not including skin, bone or coating.
    a. Along with traditional meat products, this category may include, but is not limited to:

Eggs	Nuts
Cheese	Cottage cheese
Dried beans or lentils	Tofu
Nut butter	Tempeh

A meat or meat alternative may be served in combination with other high protein foods.
    b. Except to meet cultural and/or religious preferences and for emergency meals, avoid serving dried beans, nut butter or nuts, and tofu for consecutive meals or on consecutive days.
    c. Imitation cheese is not made from milk, or milk products, but from vegetable oil and may not be served as a meat alternative.

d. In order to limit the sodium content of the meals, programs should consider serving cured and processed meats (e.g., ham, smoked or polish sausage, corned beef, dried beef) no more than once a week.

14. Accompaniments
    a. Include traditional meal accompaniments as appropriate, e.g., condiments, spreads and garnishes. Examples include: mustard and/or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide fat alternatives. Minimize use of fat in food preparation. Fats should be primarily from vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, trans-fats and cholesterol.

15. Desserts
    a. Serving of dessert is encouraged, though it is optional. Suggested, (but not limited to) desserts are: fruit, fruit crisps with whole grain toppings, pudding with double milk, gelatin with fruit, low-fat frozen yogurt, Italian ices. Use of baked, commercial desserts should be limited to once per week.

16. Beverages
    a. Fluid intake should be encouraged, as dehydration is a common problem in older adults. It is a good practice to have drinking water available.

Service Name: Congregate Meals

SERVICE CATEGORY	Nutrition
SERVICE DEFINITION	The provision of nutritious meals to older individuals in congregate settings.
UNIT OF SERVICE	Each meal served to an eligible participant.

Minimum Standards:

1. Each program shall have written eligibility criteria that places emphasis on serving older individuals in greatest need and includes, at a minimum:
    a. That the eligible person must be 60 years of age or older.

2. At the provider's discretion, persons not otherwise eligible may be served, if meals are available and they pay the full cost of the meal. The full cost includes raw food, preparation costs, and any administrative and/or supporting services costs. Documentation that full payment has been made shall be maintained.

3. Each congregate nutrition provider shall be able to provide information relative to eligibility for home delivered meals and be prepared to make referrals for persons unable to participate in the congregate program and who appear eligible for a home delivered meals program.

4. Each congregate meal site shall be able to document:
    a. That it is operated within an accessible facility. Accessibility is defined as a participant living with a disability being able to enter the facility, use the rest room and receive service that is at least equal in quality to that received by a participant not living with a disability. Documentation from a local building official or licensed architect is preferred. A program may also conduct accessibility assessments of its meal sites when utilizing written guidelines approved by the Senior Resources.

b. That it complies with local fire safety standards. Each meal site must be inspected, by a local fire official, no less frequently than every three years. For circumstances where local fire official is unavailable after a formal (written) request, a program may conduct fire safety assessments of its meal sites when utilizing written guidelines approved by Senior Resources.

c. Compliance with Michigan Food Code and local public health codes regulating food service establishments. Each meal site and kitchen operated by a congregate meal provider shall be licensed, as appropriate, by the local health department. The local health department is responsible for periodic inspections and for determining when a facility is to be closed for failure to meet Michigan Food Code standards. The program shall submit copies of inspection reports on all facilities to Senior Resources within ten days of receipt. It is the responsibility of the program to address noted violations promptly.

28. Congregate meal sites currently in operation by the program may continue to operate unless Senior Resources determines relocation is necessary in order to more effectively serve socially or economically disadvantaged older persons. New and/or relocated meal sites shall be located in an area which has a significant concentration of the over aged 60 population. Senior Resources must approve, in writing, the opening of any new and/or relocated meal site prior to the provision of any meals at that site.

29. When a meal site is to be permanently closed, the following procedures shall be followed:
    a. The program shall notify Senior Resources in writing of the intent to close a meal site.
    b. The program shall present a rationale for closing the meal site which based on lack of attendance, inability to meet minimum standards and/or other requirements, loss of resources, or other justifiable reason.

30. Senior Resources shall review the rationale and determine that all options for keeping the site open or being relocated have been exhausted. If there remains a need for service in the area that was served by the meal site, efforts should be made to develop a new meal site and/or assist participants to attend another existing meal site.
    a. Senior Resources and the MCSAC shall approve in writing the closing of all meal sites operating with Muskegon County Millage funds. If a meal site to be closed is located in an area where low-income and/or minority persons constitute 25% or more of the population, or if low-income and/or minority persons constituted more than 25% of meal participants served over the past 12 months.
    b. The program shall notify participants at a meal site to be closed of the intent to close the site at least 30 days prior to the last day of meal service.

31. Each program shall document that appropriate preparation has taken place at each meal site for procedures to be followed in case of an emergency including:
    a. An annual fire drill.
    b. Staff and volunteers shall be trained on procedures to be followed in the event of a severe weather storm or natural disaster and the county emergency plan.
    c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

32. Each program shall have written agreements with the owners of all leased facilities used as meal sites. Written agreements are recommended for donated facilities, but not required. The agreements shall address at a minimum:
    a. Responsibility for care and maintenance of facility, specifically including restrooms, equipment, kitchen, storage areas and areas of common use.
    b. Responsibility for snow removal.
    c. Agreement on utility costs.
    d. Responsibility for safety inspections.
    e. Responsibility for appropriate licensing by the Public Health Department.
    f. Responsibility for insurance coverage.
    g. Security procedures.
    h. Responsibility for approval of outside programs, activities and speakers.
    i. Other issues as desired or required.

34. Each program shall make available, upon request, food containers and utensils for participants who are living with disabilities.

35. Congregate meal programs receiving funds through Muskegon County Senior Millage may not contribute toward, provide staff time, or otherwise support potluck dining activities.

36. Temporary Meal Site Closings. If a meal site must be closed, or moved temporarily, the nutrition provider must notify Senior Resources. Notification must include information on why the closing occurred, how long it will last, how participants will be notified.

37. Food taken out of Meal Site (leftovers). Nutrition providers may allow leftovers (food served to participants and not eaten) to be taken out of the site if the following conditions are met:
    a. A sign shall be posted near the congregate meal sign informing the meal participants that all food removed from the site becomes the responsibility of the individual.
    b. All new congregate participants receive written material about food safety and preventing food-borne illness when they sign up.
    c. All participants receive written material annually about food safety and preventing food-borne illness annually
    d. The individual is required to sign a waiver statement that states the individual understands that they are responsible for food taken out of the site.
    e. Containers are not provided for the leftovers.

38. If a regular congregate meal participant is unable to come to the site due to illness, the meal may be taken out of the site to the individual for no more than seven days. If needed for more than seven days, the participant should be evaluated for home delivered meals. If the person taking out the meal is also a regular congregate participant, they may also take their meal out.

41. Off-Site Meals. Off-site meals that are part of an organized older adult activity are allowed if the following conditions are met:
    a. The activity must be sponsored by an aging network agency/group. (For example, Council/Commission on Aging, senior center, etc.).
    b. The sponsoring agency has worked with the nutrition provider to meet the standards.
    c. The activity, including the meal, must be open to all eligible participants.
    d. The take away meal must meet all the requirements of food safety, and be foods that are low risk for food borne illness.
    e. Local health department rules and regulations, if any, supersede this standard and must be followed.
    f. The meal site must provide written notification to Senior Resources contract staff prior to the event.

42. Second Meal Option. Nutrition providers may elect to offer second meals at specified dining sites. A second meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food borne illness, but not the same hot meal served at the site that day. A congregate meal participant may qualify for a second meal if:
    a. The participant ate a hot meal at the site that day
    b. The participant has requested a second meal following the nutrition provider's process; (i.e. phone request).
    c. The second meal must be clearly documented on a sign-in sheet for verification purposes.

43. The second meal must meet the nutrition standards. Donations may be accepted for second meals. The second meal is given to the participant when they leave the congregate site. It must be stored properly until the participant is ready to leave for the day. The second meal is to be counted as a congregate meal in all record keeping.

44. Voucher Meals. Nutrition providers may develop a program using vouchers for meals to be eaten at a restaurant, café, or other food service establishment. The program must meet the following standards:
    a. The restaurant, café, or other food service establishment must be licensed, and follow the Michigan Food Code, and is inspected regularly by the local health jurisdiction.
    b. The restaurant, café, or other food service establishment agrees to provide at least one meal that meets these nutrition standards for meals.
    c. The restaurant, café or other food establishment must be barrier-free and Americans with Disabilities (ADA) compliant.
    d. The nutrition provider and restaurant, café or other food establishment must have a written agreement that includes: 1) how food choices will be determined; 2) how food choices will be advertised/offered to voucher holder; 3) how billing will be handled (will a tip be included in the unit price, i.e. if the meal reimbursement is $6.25, will $.25 be used toward the tip?); 4) how reporting takes place (frequency

and what is reported); 5) evaluation procedures; and 6) a statement that voucher holders may take leftovers home, and that they may purchase additional beverages and food with their own money.

a. A copy of the written agreement shall be given to the Senior Resources contract coordinator.

e. A written plan must be developed and kept on file that includes consideration of the following items:
    1. the location of the restaurant, café, or other food service establishment in regard to congregate meal site locations;
    2. establishment of criteria for program participation – how restaurant, café, or other food service establishment are selected to participate and how new establishments can apply to participate;
    3. how older adults qualify for and obtain their vouchers i.e. senior centers, nutrition provider office, nutrition program representative meets with older adults and the restaurant, café, or other food service establishment to issue vouchers and collect donations; and,
    4. how frequently menu choices will be reviewed and revised by the AAA dietitian or equivalent.

f. Nutrition providers must allow older adults to use congregate meal sites and voucher programs interchangeably.

45. Adult Foster Care/other Residential Care. Adult Foster Care (AFC) or other residential providers that bring their residents to congregate meal sites shall be requested to pay the suggested donation amount for meals provided to residents and staff 60 years of age or older. For those AFC residents and staff under the age of 60, the guest charge must be paid as posted at each meal site. The congregate meal provider may request the AFC program to provide staff to assist the residents they bring with meals and other activities attended.

46. Complimentary Programs/Demonstration Projects. Nutrition providers are encouraged to work together to provide programming at the congregate meal sites that include activities and meals. Nutrition providers may conduct a demonstration project to assess the feasibility of alternate delivery systems for congregate meals, such as but not limited to, providing a sack meal for persons that participate in an activity at the site that is not immediately before or after a scheduled meal time. Demonstration projects must be approved by Senior Resources prior to implementation.

Service Name: Home Delivered Meals

SERVICE CATEGORY	Nutrition Services
SERVICE DEFINITION	The provision of nutritious meals to homebound older persons.
UNIT OF SERVICE	One meal served to an eligible participant.

1. Each program shall have a written policy/procedure that covers integrating person centered planning into the home-delivered meals program. This may include, but is not limited to:
    a. Allowing HDM clients to attend congregate meals sites when they have transportation and/or help to the site; and,
    b. Providing diet modifications, as requested by the client, when nutrition provider is able to do so while following Older Americans Act guidelines.
2. Each program shall have written eligibility criteria which places emphasis on serving older persons in greatest need and includes, at a minimum:
    a. That to be eligible a person must be 60 years of age or older, or if indicated in the HDM assessment, that it is in the best interest of the eligible person, the following persons may also receive a meal:
        i. The spouse or partner of an HDM-eligible person, regardless of age.
        ii. The unpaid caregiver of an HDM-eligible person, including a family member under the age of 60 who provides full-time care for an eligible person.
        iii. An individual living with a disability who resides in a non-institutional household with a person who is eligible to receive home-delivered meals.
    b. That to be eligible a person must be homebound; i.e., normally is unable to leave the home unassisted, and for whom leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
    c. That to be eligible a person must be unable to participate in the congregate nutrition program because of physical or emotional difficulties.
    d. A person may also be eligible if they are unable to obtain food or prepare meals for themselves because of:
        i. A disabling condition, such as limited physical mobility, cognitive or psychological impairment, sight impairment, or
        ii. Lack of knowledge or skill to select and prepare nourishing and well balanced meals, or

iii. Lack of means to obtain or prepare nourishing meals, or
iv. Lack of incentive to prepare and eat a meal alone, or
v. Lack of an informal support system: has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed, or the informal support system needs to be supplemented.

e. That the person's special dietary needs can be appropriately met by the program, as defined by the most current version of the US Department of Agriculture "Dietary Guidelines for Healthy Americans."
f. That to be eligible a person must be able to feed himself/herself.
g. That to be eligible a person must agree to be home when meals are delivered and to contact the program when absence is unavoidable.
h. At the provider's discretion, persons not otherwise eligible may be provided meals if they pay the full cost of the meal. The full cost of the meal includes raw food, preparation costs, and any administrative and/or supportive services costs.
i. Documentation that full payment has been made shall be maintained. Eligibility criteria shall be distributed to all potential referring agencies or organizations and be available to the general public upon request.
j. Each program shall conduct an assessment of need for each participant within 14 days of initiating service. At a minimum, each participant shall receive two assessments per year, a yearly assessment and a six-month re-assessment. The initial assessment and yearly assessment must be conducted in-person. The six-month re-assessment may be either in-person or a telephone assessment.

3. A telephone re-assessment may be used if the participant meets the following criteria:
   a. is able to complete a telephone assessment by themselves, or with the assistance of a family member, caregiver or friend;
   b. has no significant HDM delivery issues;
   c. the HDM driver, delivery person, and family and/or caregivers have no significant concerns for the participant's well-being.

   The nutrition provider may deem a participant not eligible for the telephone re-assessment at any time during their participation in the program. In-person assessments will then replace the telephone re-assessment.

4. The program should avoid duplicating assessments of individual participants to the extent possible. HDM programs may accept assessments and re-assessments of the participant conducted by case coordination and support programs, care management programs, other in-home service providers, home and community based Medicaid programs, other aging network home-care programs, and Medicare certified home health providers. Participants with multiple needs should be referred to case management programs as may be appropriate.

5. If the HDM program is the only program the participant will be currently enrolled in, the assessment and re-assessments must, at a minimum, include:
   a. Basic Information
      i. Individual's name, address and phone number
      ii. Source of referral

iii. Name and phone number of emergency contact
iv. Name and phone numbers of caregivers
v. Gender
vi. Age, date of birth
vii. Living arrangements
viii. Whether or not the individual's income is below the poverty level and/or sources of income (particularly Supplemental Security Income).

b. Functional Status
i. Vision
ii. Hearing
iii. Speech
iv. Changes in oral health
v. Prostheses
vi. Current chronic illnesses or recent (within past 6 months) hospitalizations.

c. Support Resources
i. Services currently receiving
ii. Extent of family and/or informal support network.

d. Participant Satisfaction (re-assessment only)
i. Participant's satisfaction with services received
ii. Participant's satisfaction with program staff performance.

6. Each home delivered meal program shall demonstrate cooperation with other meal programs and providers and other community resources.

7. Each program may provide up to three meals per day to an eligible client based on need as determined by the assessment. Providers are expected to set the level of meal service for an individual with consideration given to the availability of support from family and friends and changes in the participant's status or condition. This process must include person-centered planning, which may include allowing the client to attend congregate meals when they have transportation and/or assistance to attend. It may also include meal choices such as vegetarian, as long as they meet the Meal Planning Guidelines.
    a. Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

8. Meals shall be available at least five days per week.
9. Nutrition providers may also make liquid meals available to program participants when ordered by a physician. The regional dietitian must approve all liquid meals products to be used by the program. The program shall provide instruction to the participant, and/or the participant's caregiver and participant's family in the proper care and handling of liquid meals. When liquid meals are used to supplement a participant's diet, the physician's order must be renewed every six months. When liquid meals are the participant's sole source of nutrition, the following requirements must also be met:
    a. Diet orders shall include client weight and be explicit as to required nutritional content;
    b. Diet orders must be renewed, by a physician, every three months; and,

c. The care plan for participants receiving liquid meals shall be developed in consultation with the participant's physician.

10. The program shall verify and maintain records that indicate each client can provide safe conditions for the storage, thawing, and reheating of frozen foods.

11. Frozen foods should be kept frozen until such time as it is to be thawed for use. Frozen food storage should be maintained at 0 degrees Fahrenheit. Each nutrition provider shall develop a system by which to verify and maintain these records.

12. Each program shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. Staff and volunteers shall be trained on procedures to be followed in the event of severe weather or natural disasters and the county emergency plan.

13. Each program must complete a prioritizing pre-screen for each individual placed on a waiting list for home delivered meals.

14. Each program must be able to document their criteria for prioritizing individuals being placed on a waiting list.

Service Name: Nutritional Education

SERVICE CATEGORY	Nutrition
SERVICE DEFINITION	An education program which promotes better health by providing culturally sensitive nutrition information (which may also address physical fitness and related health issues) and instruction to participants, and/or care givers, in group or individual settings.
UNIT OF SERVICE	One educational session.

1. In addition to the following standards, The General Requirements for All Service Programs are applicable to Nutrition Education.

2. Nutrition education services shall be provided, or be supervised by, a registered dietitian or an individual with comparable expertise.

3. Each program shall establish linkages with local sources of information that meet the standards for accuracy and reliability as set by the American Dietetic Association. Programs may incorporate the purchase of fresh produce as a component of nutrition education services. All programs must be approved in advance by SRWM.

4. Nutrition education sessions shall be conducted at senior centers and congregate meal sites, to the extent feasible.

Service Name: Senior Pantry

SERVICE CATEGORY	Nutrition Services
SERVICE DEFINITION	A pantry dedicated to older adults. A supply of nutritious foods selected by an individual on a walk-in basis. Nutrition Education will be provided on a monthly basis.
UNIT OF SERVICE	One distribution (package) of food.

Minimum Standards:

1. Eligibility:

   Clients must be physically or emotionally unable to leave their home to qualify for home delivery of pantry foods. Proxies may be used for individuals unable to leave their home to shop.

2. Income eligibility will be based on the annual publicized poverty guidelines by the U.S. Department of Health and Human Services.

3. Level of Service:

   a. Clients must be allowed to access foods from the pantry at least once per month. Clients may access food from the pantry as often as once per week determined by need. Exception: the service provider may elect to make fresh produce available continuously.

4. Minimum Distribution for foods:

   Foods for the package should be selected by the client. The following foods must be offered to the client for each food package. Clients will receive 2 food packages per visit:

   a. Milk – 2 selections may include:
      i. Fresh or powdered milk (1 quart minimum per selection)
         Yogurt (24 oz. minimum per selection)
      ii. Cheese (8 oz. minimum per selection)

b. Meat / Protein – Minimum of 16 oz. or equivalent measure. Items which may be counted toward the meat requirement include: eggs, peanut butter, pinto beans, baked beans, navy beans, split peas, black eyed peas, etc.

   i. Examples of meat/protein items are: 1 dozen eggs,
   ii. 18oz. jar peanut butter

c. Vegetable – 5 selections may include: Canned (12 oz. of larger per selection) Fresh (1/2 lb. per election)
   i. Frozen (12 oz. or larger per selection)
   ii. 100% Vegetable Juice (12 oz. or larger per selection)
   iii. Starchy vegetables such as potatoes and corn are counted as vegetable selections.

d. Fruit – 5 selections may include:
   i. Canned (12 oz. or larger per selection) Fresh (1/2 lb. per selection)
   ii. Frozen (12 oz. or larger per selection)
   iii. 100% Fruit Juice (12 oz. or larger per selection)
   iv. Bread: 3 selections (1 lb. or more per section) may include: Pasta, bread, rolls, crackers, cereal or other breads.

e. Other – As available

5. Liquid Meal Supplements:
   a. Liquid meal supplements must be approved by SRWM and may be provided only with a doctor's order. Physician orders must be renewed monthly or if certified as long term-every six months. (See SRWM Home Delivered Meal standards for additional liquid meal regulations).

6. Food Handling and Facility Standards:
   a. Each program must have a minimum of one ServSafe certified person, who is responsible for overseeing food safety at all locations.

7. Storage:
   a. Storage areas for the pantry shall have sealed and easily cleanable floors, walls, and shelving. Storage areas shall be kept clean and free of debris. All food and non-food items must be stored at least six (6) inches above the floor. Cleaning supplies or toxic items shall not be stored on the same shelf or above any food or food contact items such as single service ware.

8. Food:
   a. Sources of foods
      i. Foods may be purchased from traditional food service vendors, food banks or local establishments.
   b. Donated Food:

i. The following donated food items may be accepted:
    1. Commercially canned (not home canned) foods.
    2. Dry foods.
    3. Baked goods from licensed facilities.
    4. Fresh produce
    5. Frozen meats from licensed facilities.
    6. Fresh meats may be accepted only from licensed facilities.
    7. Game may be accepted only if killed at a licensed game farm and processed within two hours by a licensed processor.

c. Food Holding:
    i. Foods which have exceeded the manufacturer's recommended shelf life for quality and /or safety shall not be used.
    ii. Meats must be distributed in the frozen state unless packaged by the manufacturer and stamped with a clear use by date.
    iii. Any food which is repackaged must be clearly labeled as to its contents and use by date.

d. Non-Food Items:
    i. Non-food items may be distributed in addition to the minimum food selections. Non-food items that are not allowed include:
        1. Vitamins or other dietary supplements (except approved liquid meal replacements such as Ensure).
        2. Medications, including over the counter or prescription drugs.

9. Nutrition Education
    a. Nutrition Education programs shall be held at least monthly. Areas of interest should be solicited from clients and topics should be designed around client interests. Written hand-outs are encouraged, but should not be the sole component to the program conducted at the pantry. See Nutritional Education service standard.

10. Relocation
    a. Approval must be received from SR staff and the MCSAC prior to the relocation of the pantry.

In-Home & ADC Service Standards

*In-Home service providers must adhere to General Standards for In-Home Service Providers

Service Name: Homemaker

SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Homemaking does not include provision of chore or personal care tasks. Allowable homemaking tasks are limited to one or more of the following: • laundry • ironing • meal preparation • shopping for necessities (including groceries) and errand running • light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe environment) • observing, reporting, and recording any change in client's condition and home environment
UNIT OF SERVICE	One hour spent performing allowable homemaking activities.

Minimum Standards

1. Each program must have written eligibility criteria.

2. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, meal preparation, good health practices, observation, reporting and recording information.

3. Required in-service training topics include safety, sanitation, household management, nutrition and meal preparation.

Service Name: Medication Management

SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program components include: • Face-to-face review of client's prescription and OTC medication regimen. • Regular set-up of medication regimen (Rx pills, Rx injectables, and OTC medications). • Monitoring compliance with medication regimen. • Cueing via home visit or telephone call. • Communicating with referral sources (physicians, family members, primary care givers, etc.) regarding compliance with medication regimen. • Family, caregiver and client education and training.
UNIT OF SERVICE	Each 15 minutes (.25 hours) of component activities performed.

Minimum Standards

1. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented, and supervised.

2. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and appropriate caregiver.

Each program shall implement a procedure for notifying the client's physician(s) of all medications being managed.

3. The program shall be operated within the three basic levels of service as follows:

Level 1: Telephone reminder call/cueing with maintenance of appropriate documentation.
Program staff performing Level 1 services shall be delegated by the supervising nurse.

Level 2: In home monitoring visit/cueing with maintenance of appropriate documentation.

Program staff performing Level 2 services shall be delegated by the supervising nurse.

Level 3: In home medication set up, instructions, and passing and/or assistance with medications (e.g., putting in eye drops, pills and giving injections). Program staff performing Level 3 services shall be delegated by the supervising nurse.

4. The program shall maintain an individual medication log, for each client that contains the following information:

- Each medication being taken;
- The dosage for each medication;
- Label instructions for use for each medication;
- Level of service provided and initials of person providing service; and,
- Date and time for each time services are provided.

5. The program shall report any change in a client's condition to the client's physician(s) immediately.

Service Name: Personal Emergency Response System

SERVICE CATEGORY	In-Home
SERVICE DEFINITION	A service system utilizing electronic devices designed to monitor client safety and provide access to emergency crisis intervention for medical or environmental emergencies through the provision of a
UNIT OF SERVICE	One month of monitoring a client and each occurrence of equipment installation.
SERVICE DESCRIPTION	Personal Emergency Response Systems (PERS) are electronic devices which enable certain high risk individuals to secure help in the event of an emergency. The system may involve a portable "help" button to allow for client mobility. The system is connected to a client's telephone and programmed to signal a response center once the "help" button is activated. PERS services are limited to individuals who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and/or would otherwise require extensive routine supervision.

Minimum Standards

1. Equipment used must be approved by the Federal Communication Commission and must meet UL® safety standards specifications for Home Health Signaling Equipment.

2. Response center must be staffed 24 hours/day, 365 days/year with trained personnel. Response center will provide accommodations for persons with limited English proficiency.

3. Response center must maintain the monitoring capacity to respond to all incoming emergency signals.

4. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first serve basis.

5. Provider will furnish each responder with written instructions and provide training as appropriate.

6. Provider will verify responder and contact names semi-annually to assure current and continued participation.

7. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.

8. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct clients and caregivers in the use of the devices, as well as to provide for performance checks.

9. Provider will maintain individual client records that include the following:
    a. Service order.
    b. Record of service delivery, including documentation of delivery and installation of equipment, client/caregiver orientation, and monthly testing.
    c. List of emergency responders.
    d. Case log documenting client and responder contacts.

Service Name: Personal Care

SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Provision of in-home assistance with activities of daily living (ADL) for an individual including assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Personal care does not include health oriented services as specified for Home Health Aide Services.
UNIT OF SERVICE	One hour spent performing personal care activities.

Minimum Standards

1. Each program must have written eligibility criteria.

2. All workers performing personal care services must be directly supervised by a professionally qualified person. Each worker must be trained for each task to be performed. The supervisor must approve tasks to be performed by each worker. Completion of a recognized nurse aide training course by each worker is recommended.

Service Name: Respite Care

SERVICE CATEGORY	In-Home
SERVICE DEFINITION	Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail elder persons in the absence of the primary care giver(s). Respite care may be provided at locations other than the client's residence.
UNIT OF SERVICE	Each hour of respite care provided.

Minimum Standards

1. Each program must establish written eligibility criteria that includes at a minimum:
    a. That clients must require continual supervision in order to live in their own homes or the home of a primary care giver, or require a substitute care giver while their primary care giver is in need of relief or otherwise unavailable; and/or
    b. That clients may have difficulty performing or be unable to perform activities of daily living (ADLs) without assistance as a result of physical or cognitive impairment.

    1. Respite care services include:
        a. Attendant care (client is not bed-bound) - companionship, supervision and/or assistance with toileting, eating and ambulation; and,
        b. Basic care (client may or may not be bed-bound) - assistance with ADLs, routine exercise regimen, and assistance with self-medication.

    2. Respite care may also include chore, homemaking, home care assistance, home health aide, meal preparation and personal care services. When provided as a form of respite care, these services must also meet the requirements of that respective service category.

    3. Each program shall ensure that the skills and training of the respite care worker to be assigned coincides with the service plan of the client, client needs, and client preferences. Client needs may include, though are not limited to, cultural sensitivity, cognitive impairment, mental illness, and physical limitation.

    4. An emergency notification plan shall be developed for each client, in conjunction with the client's primary care giver.

    5. Each program shall establish written procedures to govern the assistance to be given participants in taking medications which includes at a minimum:
        a. Who is authorized to assist participants in taking either prescription or over the counter medications and under what conditions such assistance may take place. This must include a review of the type of medication to be taken and its impact upon the client.
        b. Verification of prescriptions and dosages. All medications shall be maintained in their original, labeled containers.

c. Instructions for entering medications information in client files, including times and frequency of assistance.
d. A clear statement of the client's and client's family responsibility regarding medications to be taken by the client while participating in the program and provision for informing the client and client's family of the program's procedures an responsibilities regarding assisted self-administration of medications.

Service Name: Adult Day Care Services

SERVICE CATEGORY	Community Care for In-Home
SERVICE DEFINITION	Daytime care of any part of a day, but less than 24 hour care, for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the client's home.
UNIT OF SERVICE	One hour of care provided per client.

Minimum Standard

1. Each program shall establish written eligibility criteria, which will include at a minimum:
    a. That participants must require regular supervision in order to live in their own home or the home of a relative.
    b. Participants must require a substitute caregiver while their regular caregiver is in need of relief, or otherwise unavailable.
    c. That participants must have difficulty or be unable to perform activities of daily living (ADLs) without assistance.
    d. That participants must be capable of leaving their residence, with assistance, in order to receive service.
    e. That participants would benefit from intervention in the form of enrichment and opportunities for social activities in order to prevent and/or postpone deterioration that would likely lead to institutionalization.

2. Each program shall have uniform preliminary screening procedures and maintain consistent records.
    a. Such screening may be conducted over the telephone. Records for each potential client shall include at a minimum:
        i. The individual's name, address and telephone number.
        ii. The individual's age or birth date.
        iii. Physician's name, address and telephone number.
        iv. The name, address and telephone number of the person to contact in case of emergency.
        v. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems.
        vi. Perceived supportive service needs as expressed by the individual.
        vii. Race and gender (Optional)
        viii. An estimate of whether or not the individual has an income at or below the poverty level.

Intake is not required for individuals referred by a case coordination and support, care management or HCBS/ED waiver program

If preliminary screening indicates an individual may be eligible for Adult Day Services, a comprehensive individual assessment of need shall be performed before admission to the program. All assessments shall be conducted face to face. Assessors must attempt to acquire each item of information listed below, but must also recognize, and accept, the client's right to refuse to provide requested items.

a. Basic Information

- Individual's name, address and telephone number
- Age, date and place of birth
- Gender
- Marital status
- Race and/or ethnicity
- Living arrangements
- Condition of environment
- Income and other financial resources, by source
- Expenses
- Previous occupation(s), special interests and hobbies
- Religious affiliation

b. Functional Status

- Vision
- Hearing
- Speech
- Oral status (condition of teeth, gums, mouth and tongue)
- Prostheses
- Psychosocial functioning
- Cognitive functioning
- Difficulties in activities of daily living
- History of chronic and acute illnesses
- Medication regimen (Rx, OTC, supplements, herbal remedies) and other physician orders
- Eating patterns (diet history) and special dietary needs

c. Supporting Resources

- Physician's name, address and telephone number
- Pharmacist's name, address and telephone number
- Services currently receiving or received in the past
- Extent of family and/or informal support network
- Hospitalization history
- Medical/health insurance information
- Long-term care insurance information

- Clergy name, address and telephone number

d. Need Identification

- Client perceived
- Caregiver perceived
- Assessor perceived
- Determination of whether individual is eligible for program

An initial assessment is not required for individuals referred by a case coordination and support, care management, or HCBS/ED waiver program. Admission to the program may be based on the referral.

4. A service plan shall be developed for each individual admitted to an Adult Day Service program. The service plan must be developed in cooperation with and be approved by the client, the client's guardian or designated representative. The service plan shall contain at a minimum:

a. A statement of the client's problems, needs, strengths, and resources.
b. A statement of the goals and objectives for meeting identified needs.
c. A description of methods and/or approaches to be used in addressing needs.
d. Identification of basic and optional program services to be provided.
e. Treatment orders of qualified health professionals, when applicable.
f. A statement of medications being taken while in the program.

Each program shall have a written policy/procedure to govern the development, implementation and management of service plans. Each client is to be reassessed every three months to determine the results of implementation of the service plan. If observation indicates a change in client status, a reassessment may be necessary before three months have passed.

5. Each program shall maintain comprehensive and complete client files which include at a minimum:

a. Details of client's referral to adult day service program.
b. Intake records.
c. Assessment of individual need or copy of assessment (and reassessments) from referring program.
d. Service plan (with notation of any revisions).
e. Listing of client contacts and attendance.
f. Progress notes in response to observations (at least monthly).
g. Notation of all medications taken on premises including
1. the medication,
2. the dosage,
3. the date and time,

4. initials of staff person who assisted, and,

5. comments.

h. Notation of basic and optional services provided to the client

i. Notation of any and all release of information about the client, signed release of information form, and all client files shall be kept confidential in controlled access files. Each program shall use a standard release of information form that is time-limited and specific as to the information being released

6. Each adult day service program shall provide directly or make arrangements for the provision of the following services. If arrangements are made for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

a. Transportation.

b. Personal care.

c. Nutrition: one hot meal per eight-hour day that provides one-third of recommended daily allowances and follows the meal pattern of the General Requirements for Nutrition Service Programs. Participants in attendance from eight to fourteen hours shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided, where feasible and appropriate, which take into consideration client choice, health, religious, and ethnic diet preferences. Meals shall be acquired from a congregate meal provider where possible and feasible.

d. Recreation: consisting of planned activities suited to the needs of the client and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction.

7. Each adult day service program may provide directly or make arrangements for the provision of the following optional services. If arrangements are made for provision of any service at a place other than program operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

a. Rehabilitative: physical, occupational, speech and hearing therapies, provided under order from a physician, by licensed practitioners.

b. Medical support: laboratory, x-ray, pharmaceutical services, provided under order from a physician, by licensed professionals.

c. Services within the scope of the Nursing Practice Act.

d. Dental: under the direction of a dentist.

e. Podiatric: provided or arranged for under the direction of a physician.

f. Ophthalmologic: provided or arranged for under the direction of an ophthalmologist.

g. Health counseling.

h. Shopping assistance/escort.

8. Each program shall establish written procedures to govern the assistance to be given participants in taking medications while participating in the program. The policies and procedures must address:

a. Written consent from the client, or client's representative, to assist in taking medications. b. Verification of medication regimen, including prescriptions and dosages.
c. Training and authority of staff to assist clients in taking medications.
d. Procedures for medication set up.
e. Secure storage of medications belonging to and brought in by participants.
f. Disposal of unused medications.
g. Instructions for entering medication information in client files, including times and frequency of assistance.

9. Each provider shall establish a written policy/procedure for discharging individuals from the program that includes, at a minimum, one or more of the following:

a. The participant's desire to discontinue attendance.
b. Improvement in the participant's status so that they no longer meet eligibility requirements.
c. An increase in the availability of caregiver support from family and/or friends.
d. Permanent institutionalization of client.
e. When the program becomes unable to continue to serve the client and referral to another provider is not possible.

10. Each program shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The program shall continually provide support staff at a ratio of no less than one staff person for each ten participants. Health support services may be provided only under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, it shall be accomplished thought a written agreement that clearly specifies the terms of the arrangement.

11. Program staff shall be provided with an orientation training that includes, in addition to the topics specified in the General Requirements for All Service Programs, assessment/observation skills and basic first-aid.

Program staff shall be provided in-service training at least twice each year, which is specifically designed to increase their knowledge and understanding of the program, aging process issues, and to improve their skills at tasks performed in the provision of service. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation. Records shall be maintained which identify the dates of training, topics covered and persons attending.

12. If the program operates its own vehicles for transporting clients to and from the service center the following transportation minimum standards shall be met:

a. All drivers and vehicles shall be appropriately licensed, and all vehicles used shall be appropriately insured.
b. All drivers shall be required to assist persons to get in and out of vehicles. Such assistance shall be available unless expressly prohibited by either a labor contract or an insurance policy.
c. All paid drivers shall be trained to respond to medical emergencies.

13. Each program shall have first-aid supplies available at the service center. A staff person knowledgeable in first-aid procedures, including CPR, shall be present at all times participants are in the service center.

14. Procedures to be followed in emergency situations (fire, severe weather, etc.) shall be posted in each room of the service center. Practice drills of emergency procedures shall be conducted once every six months. The program shall maintain a record of all practice drills.

15. Each service center shall have the following furnishings:

a. At least one straight back or sturdy folding chair for each participant and staff person.
b. Lounge chairs and/or day beds as needed for naps and rest periods.
c. Storage space for participants' personal belongings.
d. Tables for both ambulatory and non-ambulatory participants.
e. A telephone that is accessible to all participants.
f. Special equipment as needed to assist persons with disabilities.

All equipment and furnishings in use shall be maintained in a safe and functional condition.

16. Each service center shall demonstrate that it is in compliance with fire safety standards and the Michigan Food Code.