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SECTION 1 BACKGROUND OREGON PROJECT INDEPENDENCE

The official objectives of the Older Americans Act (OAA) were formulated in the mid-1960s as part of President Lyndon B. Johnson’s administration’s War on Poverty. While the Older Americans Act continues to evolve, all OAA funds come with a federal requirement called Maintenance of Effort (MOE), requiring the state to maintain a certain level of state or local fiscal effort in order to be eligible for full participation in the OAA grant. This is sometimes referred to as the ‘match’ and it means that the federal government provides 90% of the operating budget for Older Americans Act programs; each state is required to match those funds for the additional 10%. Oregon satisfies this MOE requirement with OPI services, a state funded in home services program for people who are not receiving public assistance.

Section 1.1 Declaration of Objectives for Older Americans Act

Section. 101.
The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States, of the several States and their political subdivisions, and of Indian tribes to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives:

(1) An adequate income in retirement in accordance with the American standard of living.

(2) The best possible physical and mental health which science can make available and without regard to economic status.

(3) Obtaining and maintaining suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.

(4) Full restorative services for those who require institutional care, and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes,
including support to family members and other persons providing voluntary care to older individuals needing long-term care services.

(5) Opportunity for employment with no discriminatory personnel practices because of age.

(6) Retirement in health, honor, dignity—after years of contribution to the economy.

(7) Participating in and contributing to meaningful activity within the widest range of civic, cultural, educational and training and recreational opportunities.

(8) Efficient community services, including access to low cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed, with emphasis on maintaining a continuum of care for vulnerable older individuals.

(9) Immediate benefit from proven research knowledge which can sustain and improve health and happiness.

(10) Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community based services and programs provided for their benefit, and protection against abuse, neglect, and exploitation.

(42 U.S.C. 3001)

**Section 1.2 History of OPI**

The 1975 Oregon Legislature passed HB 2163, which directed the Department of Human Resources to develop and place in effect a program of supportive services for persons age 60 or older, which required a fee for service based on ability to pay. This general language established OPI in response to two very specific concerns expressed by Oregon’s senior advocates, including Older Americans Act funded Area Agencies on Aging (AAA) Advisory Council advocates.

The first concern was that persons needing some kind of in-home service and who were not Medicaid eligible, were falling through the cracks. Their second concern was that minimal in-home services could sometimes prevent people from going into long term care institutions like nursing homes. There were no other services available for these people at that time; there were no Adult Foster Homes or Assisted Living Facilities in Oregon in the 1970's.
The official OPI Program was started in 1976 after initial consultation with the Governor’s Committee on Aging. (Predecessor to the Governor’s Commission on Senior Services.) Eleven specific services were initially authorized: Screening and Evaluation (Case Management), Chore, Homemaker, Home Health, Counseling, Escort, Outreach, Home-Related issues, Friendly Visiting, Telephone Reassurance and Home Delivered Meals. These services have been modified slightly over the ensuing years.

Funds for the new OPI program were distributed to the local Area Agencies on Aging (AAAs) throughout Oregon in a manner similar to that used for distributing Older Americans Act funds. This practice continues today.

There have been other minor program changes over the years, which included, in the early 1980’s, better accountability for both program and financial data. Additional services have been added like Adult Day Service, Respite Service and Personal Service. Funding for the program has fluctuated throughout the history of OPI, from the initial $1 million to the current $12 million dollars as of the 2007-2009 biennium.

In 1987, the Oregon Legislature added funds to the OPI program specifically for younger persons with Alzheimer’s or related disorders. The money for this specific population wasn’t used and the Legislature later (1991) allowed the funds to be used for any OPI eligible person, including those under 60 with a diagnosis of Alzheimer’s or one of several related dementia disorders.

During the legislative session 2005 House Bill 870 was passed, referred to informally as the OPI Modernization Act or the OPI Expansion Act. This bill has now been codified in statute as ORS 410.410 – 410.480. This act provided for OPI funding to be moved from the General Fund to the Senior Property Tax Deferral fund and for services to be expanded to younger persons with physical disabilities. It also offered a provision for the Area Agencies on Aging (AAAs) to begin charging services for case management services.

OPI served about 3,600 individuals from July 1, 2007 through June 30, 2008 with approximately $6,000,000 (six million dollars). Translated into a monthly figure the average monthly cost to the state to maintain an individual in his or her own home is about $140 per month under the OPI program. It is no small wonder that OPI remains on the radar, so to speak, every legislative session. As the trend to seeking cost cutting measures increases, we can only anticipate further revisions.
and enhancements to this valuable program adding incalculable value to the citizens of Oregon.
Section 1.3  OPI Statutes

All statutes can be accessed on the web at the following:
http://www.leg.state.or.us/ors/

OREGON PROJECT INDEPENDENCE

410.410 Definitions for ORS 410.410 to 410.480. As used in ORS 410.410 to 410.480:

(1) “Authorized agency” means any organization designated by the Department of Human Services as an area agency on aging.

(2) “Authorized service” means any service designated by the department pursuant to rule to be eligible for Oregon Project Independence funding.

(3) “Department” means the Department of Human Services.

(4) “Home health service” means items and services furnished to an individual by a home health agency, or by others under arrangement with such agency, on a visiting basis in a place of temporary or permanent residence used as the individual’s home for the purpose of maintaining that individual at home.

(5) “Service provider” means any agency or program that provides one or more authorized services under Oregon Project Independence. [1981 c.186 §1; 1983 c.740 §133]

410.420 Use of funds; rules. (1) Funds appropriated for Oregon Project Independence shall only be expended for the following authorized services:

(a) Homemaker;
(b) Housekeeper;
(c) Chore;
(d) Escort;
(e) Home health;
(f) Personal care service;
(g) Elderly day care; and
(h) Other services authorized by the Department of Human Services.

(2) The department shall adopt rules to implement ORS 410.410 to 410.480. [1981 c.186 §2; 1983 c.740 §134; 2001 c.900 §83]

**410.422 Oregon Project Independence Fund.** (1) The Oregon Project Independence Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Oregon Project Independence Fund shall be credited to the Oregon Project Independence Fund. Moneys in the Oregon Project Independence Fund at the end of a biennium are retained in the Oregon Project Independence Fund and do not revert to the General Fund.

(2) The Oregon Project Independence Fund consists of moneys appropriated to the fund by the Legislative Assembly, interest earned by the fund, moneys contributed to the fund by donors and moneys transferred to the fund under ORS 311.701.

(3) Moneys in the Oregon Project Independence Fund are continuously appropriated to the Department of Human Services for the purpose of funding Oregon Project Independence as provided in ORS 410.410 to 410.480. [2005 c.749 §1]

**410.425 Separate accounts for persons age 60 and over and for persons with Alzheimer’s disease or related disorders.** Except as provided in ORS 410.422, the funds available for purposes of ORS 410.410 to 410.480 shall be kept in separate accounts in the General Fund. One account shall be used for funds appropriated for persons otherwise eligible who are 60 years of age or older. The other account shall be used for funds appropriated for persons otherwise eligible who have Alzheimer’s disease or a related disorder. [1987 c.692 §3; 2005 c.749 §2]

**410.430 Eligibility for services under ORS 410.410 to 410.480.**
(1) In order to qualify for services from an authorized agency or service provider, each client or recipient must:

   (a) Be 60 years old or older or have been diagnosed as having Alzheimer’s disease or a related disorder;

   (b) Not be receiving financial assistance from the Department of Human Services, except food stamp benefits and limited medicare reimbursement benefits administered by the department; and

   (c) Be assessed to be at the risk of entering an institution.

(2) Eligibility determination shall be required before any client may receive services from an authorized agency or service provider. [1981 c.186 §3; 1987 c.692 §1; 1997 c.581 §3; 1999 c.59 §105; 2001 c.900 §84]

410.435 Expansion of Oregon Project Independence; rules. (1) Notwithstanding ORS 410.430 and subject to the conditions described in subsection (2) of this section, the Department of Human Services shall adopt rules:

   (a) Expanding the eligibility requirements of Oregon Project Independence to cover persons 19 years of age or older with physical disabilities; and

   (b) Expanding authorized services under Oregon Project Independence to include:

      (A) Public education on long term care planning and resources;

      (B) Establishment and maintenance of a website on long term care planning and resources; and

      (C) Long term care case management and case planning services offered for a fee to persons who are not eligible for services from Oregon Project Independence.

   ► (2) The department may not adopt the rules expanding Oregon Project Independence described in subsection (1) of this section unless the amount of moneys in the Oregon Project Independence Fund established in ORS 410.422 is sufficient to provide services to eligible clients under ORS 410.410 to 410.480 and is sufficient to fund the expansion of the program to persons with physical disabilities and the additional authorized services described in subsection (1) of this section.
(3) Rules adopted under subsection (1) of this section are valid only for the biennium in which the rules are adopted. [2005 c.749 §9]

410.440 Priorities for services. (1) Eligible clients shall receive authorized services on a priority basis, with highest priorities receiving services first.

(2) Priority for receipt of authorized services shall be:

(a) Clients already receiving authorized service as long as their condition indicates services are needed.

(b) Clients who are to be placed immediately in an institution if needed authorized services are not provided.

(c) Clients who are probably to be placed in an institution if needed authorized services are not provided. [1981 c.186 §4]

410.450 Determinations of eligibility. (1) Eligibility determinations and determinations of services for Oregon Project Independence shall be made in accordance with rules of the Department of Human Services.

(2) Determination of services shall be based on each client’s financial, physical, functional, medical and social need for such services.

(3) Clients who appear eligible for services provided by the department because of disability or age and income shall be encouraged to apply to the department for service. [1981 c.186 §5; 1983 c.740 §135; 2005 c.22 §278]

410.460 Computation of allowable costs. Allowable costs by authorized agencies are those associated with the direct provision of services to clients and such administrative costs as may be required to assure adequate services and to provide information to the Department of Human Services. [1981 c.186 §6; 1983 c.740 §136]

410.470 Fees; collection; records; use. (1) The Department of Human Services shall establish fees for services provided under ORS 410.410 to 410.480 after consultation with area agencies on aging. The fees may differ for different areas and for different income levels.
(2) Fees established under subsection (1) of this section shall be charged to all clients.

(3) A record of all fees collected shall be kept by each authorized agency and made available upon request to the department.

(4) Nothing prevents any client of Oregon Project Independence from making a contribution.

(5) Fees and any contribution must be used to expand services. [1981 c.186 §7; 1983 c.740 §137; 2005 c.749 §10]

**410.480 Required record keeping; audit.** (1) Each authorized agency and service provider shall maintain books, records, documents and accounting procedures which reflect costs and such other activities as the Department of Human Services may require. The books, records and documents shall be made available to the department upon request.

(2) Each authorized agency shall submit to the department an audit of its financial records annually. Such audits shall be conducted by an individual holding a permit issued by the Oregon Board of Accountancy under ORS 673.010 to 673.457.

(3) Fiscal and program reports shall be completed on forms provided by the department and be submitted to the department by the specified due dates.

(4) The use or disclosure by any party of any information concerning a recipient or client of authorized services described in ORS 410.410 to 410.480 for any purpose not directly connected with the administration of the responsibilities of the department, or an authorized agency or a service provider is prohibited except with written consent of the recipient, or the legal representative thereof. [1981 c.186 §8; 1983 c.740 §138; 1999 c.322 §39]
DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES DIVISION
OREGON ADMINISTRATIVE RULES
CHAPTER 411, DIVISION 32
OREGON PROJECT INDEPENDENCE

411-032-0000 Definitions  (Effective 11/1/2006)

For purposes of these rules:

(1) "Activities of Daily Living" (ADL) means those personal functional activities required by an individual for continued well being, health and safety. For the purposes of these rules, ADLs consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (bowel and bladder management) and cognition/behavior.

(2) "Adjusted Income" means the income for all household members after deductions for household medical expenses as defined in OAR 411-032-0044(1)(b)(D)(i).

(3) "Administrative Costs" means those expenses associated with the overall operation of the Oregon Project Independence (OPI) Program that are not directly attributed to a service. These costs can include, but are not limited to, costs associated with accounting services, indirect program costs, facility expenses, etc.

(4) "Adult Day Service" means a structured comprehensive program designed to meet the needs of functionally and/or adults with cognitive impairments. Adult day service provides individually planned service, supervision, social and related support services, and health monitoring in a protective setting during any part of a day, but less than 24-hour care.
(5) "Advisory Council" means an advisory council of the authorized Agencies on Aging.

(6) "Alzheimer's Disease and Other Related Disorders" means a progressive and degenerative neurological disease that is characterized by dementia including the insidious onset of symptoms of short-term memory loss, confusion, behavior changes and personality changes. It includes dementia caused from any one of the following disorders:

(a) Multi-Infarct Dementia (MID);
(b) Normal Pressure Hydrocephalus (NPH);
(c) Inoperable Tumors of the Brain;
(d) Parkinson's Disease;
(e) Creutzfeldt-Jakob Disease;
(f) Huntington's Disease;
(g) Multiple Sclerosis;
(h) Uncommon Dementia such as Pick's Disease, Wilson's Disease, and Progressive Supranuclear Palsy; or
(i) All other related disorders recognized by the National Alzheimer's Association.

(7) "Area Agency" means the agency designated by the Department as an Area Agency on Aging that is charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and those individuals with disabilities in a planning and service area. For purposes of these rules, the term "Area Agency" (AAA) is inclusive of both Type A and B Area Agencies on Aging as defined in ORS 410.040 to 410.350.

(8) "Area Plan" means the approved plan for providing authorized services under Oregon Project Independence.

(9) "Assisted Transportation" means escort services that provide assistance to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

(10) "Authorized Service" means any service designated by the Department and these rules to be eligible for Oregon Project Independence funding.
(11) "Case Management" means a service designed to individualize and integrate social and health care options for or with a person being served. Its goal is to provide access to an array of service options to assure appropriate levels of service and to maximize coordination in the service delivery system. Case management must include four general components: access, assessment, service implementation, and monitoring.

(12) "Case Management Costs" means those expenses associated with individualizing and integrating social and health care options for or with a person receiving a service. Cost elements should include time spent with the individual, travel to and from an individual's home, mandated training time, case recording, reporting, time spent arranging for and coordinating services for the individual, supervision and staffing time related to an individual, and time spent in the initial assessment of a person who does not become an OPI individual.

(13) "Case Manager" means an SPD/AAA employee who assesses the service needs on an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The Case Manager authorizes and implements the service plan and monitors the services delivered.

(14) "Chore Service" means assistance with heavy housework, yard work or sidewalk maintenance for persons who need assistance with these activities to assure safety.

(15) "Client-Employed Provider Program" (CEP) refers to the program wherein the provider is directly employed by the eligible individual and provides hourly services. In some aspects of the employer/employee relationship, the Department of Human Services acts as an agent for the client-employer. These functions are clearly described in OAR chapter 411, division 031.

(16) "Community Support Resources", "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Services provided by natural supports are resources not paid for by the Department or AAA.

(17) "Contracted In-Home Service" means a service provided through a contractor that consists of assistance with activities of daily living and self-management tasks.

(18) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR 333-536-0000 through 333-536-
0095 that provides hourly contracted in-home service to individuals of the Department or Area Agency on Aging.

(19) "Department of Administrative Services" means the Department of Administrative Services for the State of Oregon.

(20) "Department" means the Oregon Department of Human Services, Seniors and People with Disabilities, unless otherwise specifically defined.

(21) "Department of Revenue" means the Oregon Department of Revenue.

(22) "Diagnosed" means, for purposes of these rules, that the individual's physician has reason to believe and indicates that the individual has Alzheimer's Disease or a Related Disorder.

(23) "Direct Service Costs" means those expenses for direct labor that are attributable to an eligible individual-related service. For example, the direct service cost of home care is the cost of time actually spent providing home care services in the home. Other direct service costs are those that are directly attributable to an individual-related function.

(24) "Eligibility Determination" means the process of deciding if a prospective individual meets the requirements necessary to receive authorized services under Oregon Project Independence.

(25) "Exception or Variances" means that an agency or individual contractor or subcontractor is not required to meet one or more specific requirements of these rules.

(26) "Fee-based case management" means a service for which a fee is assessed for case management for an individual who would otherwise be ineligible for OPI services. Fee-based case management services include service planning and coordination, service plan implementation, service plan monitoring and reassessment.

(27) "Fiscal Records and Data" means all information pertaining to the financial operation of an agency or program.

(28) "Gross Income" means household income from salaries, interest and dividends, pensions, Social Security, railroad retirement benefits, and any other income prior to any deductions.

(29) "Health Services" means the Department of Human Services, Health Services.
(30) "Home Care or Homemaker Services" means all those ADL or IADL in-home services necessary to help individuals achieve the greatest degree of independent functioning.

(31) "Homecare Worker" means a provider, as described in OAR 411-030-0020 and 411-031-0040, who is directly employed by the eligible individual via the Client Employed Provider Program, and who provides hourly services to eligible individuals. Homecare Workers also include providers in the Spousal Pay Program.

(32) "Home Delivered Meal" means a meal paid from OPI funds and delivered to an eligible individual who is receiving at least case management services.

(33) "Home Health Agency" means a licensed (in accordance with OAR 333-027-0000 through 0170), public or private agency providing coordinated home health services on a home visiting basis. Home health agencies provide skilled nursing services in at least one of the following therapeutic services: Physical therapy; Occupational therapy; Speech Therapy; or Home health aide services.

(34) "Home Health Service" means items and services furnished to an individual by a home health agency, or by others under arrangement with such agency, on a visiting basis in a place of temporary or permanent residence used as the individual's home for the purpose of maintaining that individual at home.

(35) "Household" means the individual, spouse and any dependents as defined by the Internal Revenue Service.

(36) "Hourly Services" means the in-home services, including activities of daily living and self-management tasks, that are provided at regularly scheduled times. None of these hours are exempt from federal or state minimum wage or overtime laws.

(37) "Information and Assistance" means a service that provides current information on opportunities and services available within their communities; assesses the problems and capacities of the individuals; links individuals to the opportunities and services and, to the maximum extent feasible, ensures the individual receives the services needed and is aware of the opportunities available by establishing adequate follow-up procedures.

(38) "In-Direct Cost" means:

   (a) Incurred for a common or joint purpose benefiting more than one cost objective, and
(b) Not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. The term "indirect cost," as used herein, applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities. To facilitate equitable distribution of indirect expenses, to the cost objectives served, it may be necessary to establish a number of pools of indirect costs. Indirect cost pools should be distributed to benefited cost objectives on bases that will produce an equitable result in consideration of relative benefits derived.

(39) "In-Home Services" means those services that assist an individual to stay in his or her own home.

(40) "Institution" means any state, community or private hospital and any nursing facility.

(41) "Instrumental Activities of Daily Living (IADL)" or "Self Management Tasks" consist of housekeeping, including laundry, shopping, transportation, medication management and meal preparation as described in OAR 411-015-0007.

(42) "Personal Care Service" means in-home services provided to maintain, strengthen, or restore an individual's functioning in their own home when an individual is dependent in one or more ADLs, or when an individual requires assistance for ADL needs. Assistance can be provided either by a contracted agency or by a Homecare worker paid in accordance with the collectively bargained rate.

(43) "Program Records and Data" means any information of a non-fiscal nature.

(44) "Program Support Costs" means those expenses associated with managing the services provided either through contract or directly by the Area Agency on Aging, that are attributable to a specific service.

(45) "Provider" means the individual who actually renders the service.

(46) "Registered Nurse Services" mean services provided by a registered nurse on a short-term or intermittent basis that include but are not limited to: interviewing the individual and, when appropriate, other relevant parties; assessing the individual's ability to perform tasks; preparing a service plan that includes treatment needed by the individual; monitoring medication; training and educating providers around the provisions of the service plan.
(47) "Respite" means paid temporary services to provide relief for families or other caregivers who are unpaid. In-home and out-of-home respite may be provided on an hourly or daily basis, including 24-hour respite service for several consecutive days. Range of tasks to be provided may include: supervision, companionship and personal services usually provided by the primary caregiver.

(48) "Seniors and People with Disabilities Division" means the Seniors and People with Disabilities Division of the Department of Human Services.

(49) "Service Provider" means any agency or program that provides one or more authorized services under Oregon Project Independence.

(50) "Service Determination" means the process of determining the proper authorized service for each eligible individual.

(51) "Service Need" means those functions or activities for which the individual requires the support of the Department or Area Agency on Aging.

(52) "Service Priority" means the order in which the Department determines individuals to be eligible for the Oregon Project Independence program.


Interpretive Guidelines 411-032-0000 (35) IRS Publication 501 (2007) provides a member of household test for determining when an income should be included for OPI fee determination. Generally, to be included a household resident would have to be (A) a member of the household for the year; (B) not a qualifying child (19 or younger or under 24 by the end of the year and a student) (C) have a gross income of less than $3,400, (D) 50% or more of support would have to be provided for the year.

411-032-0001 Goals (Effective 11/1/2006)

The goals of Oregon Project Independence are to:

(1) Promote quality of life and independent living among seniors and people with physical disabilities;

(2) Provide preventive and long-term care services to eligible individuals to reduce the risk for institutionalization and promote self-determination;
(3) Provide services to frail and vulnerable adults who are lacking or have limited access to other long-term care services; and

(4) Optimize eligible individuals' personal and community support resources.


411-032-0005    Administration    (Effective 11/1/2006)

(1) Advisory Council: Each area agency will show evidence that the advisory council of the area agency, and the community were involved in the identification of need, selection of services to be offered, and the development of the Area Plan.

(2) Area Plan:

(a) Each area agency will submit an Area Plan by a date specified and on forms provided by the Department.

(b) The Area Plan must, at a minimum, contain:

(A) The types and amounts of authorized services to be offered;

(B) The costs of these services;

(C) How the agency will ensure timely response to inquiries for service;

(D) How individuals will receive initial and ongoing periodic screening for other community services, including Medicaid;

(E) How eligibility will be determined;

(F) How the services will be provided;

(G) The agency policy for prioritizing OPI service delivery;

(H) The agency policy for denial, reduction or termination of services;

(I) The agency policy for informing individuals of their right to grieve adverse eligibility, service determination decisions, and consumer complaints;

(J) How fees for services will be developed, billed, collected and utilized;
(K) The agency policy for addressing individual non-payment of fees, including when exceptions will be made for repayment and when fees will be waived;

(L) How service providers will be monitored and evaluated; and

(M) Conflict of interest policy for any direct provision of services for which a fee is set.

(3) Contracts:

(a) Contracts between the Department and Area Agencies on Aging for Oregon Project Independence will be effective each year on July 1, unless otherwise agreed to by the Department. These contracts will be based on the Area Plan and must, at a minimum, contain:

(A) A budget showing the amounts of Oregon Project Independence funds;

(B) The types of authorized services to be offered;

(C) The stipulation that contracted authorized services will be in accordance with the standards and requirements provided in these rules, and in accordance with the In-Home Services Rules (OAR chapter 411, divisions 030 and 031 and the Service Priority Rules OAR 411 division 015), and, if applicable, in accordance with the Home Health Agencies Rules (OAR chapter 333, division 027);

(D) The stipulation that required data will be gathered, reported and monitored in accordance with these rules and the Department;

(E) A section pertaining to general provisions as required by the Department of Administrative Services;

(F) A provision that area agencies will submit service provider contracts and amendments to the department upon request from the Department; and

(G) Fee for service schedules developed in accordance with these rules, including fee-based case management when this service is offered

(b) Contracts between Area Agencies on Aging and service providers will be signed and kept on file by the area agencies for not less than three years
for all services funded through Oregon Project Independence. The contracts must, at a minimum, contain:

(A) A budget or a maximum amount of Oregon Project Independence funds, as well as all other resources devoted to Oregon Project Independence under the contract;

(B) The types and amounts of authorized services to be offered and the rate per unit for each authorized service;

(C) The stipulation that authorized services will be offered in accordance with the standards and requirements provided in these rules, and in accordance with the In-Home Services Rules, OAR chapter 411, divisions 030 and 31 and the Service Priority Rules, OAR chapter 411 division 015, and, if applicable, in accordance with the Home Health Agencies Rules, OAR chapter 333, division 027;

(D) The stipulation that required data will be gathered and reported in accordance with these rules and the Department; and

(E) A section pertaining to general provisions as required by the Department of Administrative Services.

(c) All contracts as described in this rule can be amended with the consent of both parties.

(d) All contracts as described in this rule will contain provisions for cancellation of the contract for non-performance and violation of the terms of the contract.

(4) Personnel Practices and Procedures:

(a) Each area agency and service provider will maintain written personnel policies.

(b) The personnel policies will contain all items required by state and federal laws and regulations, including such items as:

   (A) An affirmative action plan; and

   (B) Evidence that the area agency and service provider are equal opportunity employers.

   (C) Each area agency and service provider will maintain a personnel record on each employee.

(5) Non-Compliance:
(a) Non-compliance to these rules, except in those cases where an exception or variance has been granted by the Department may result in a reduction or termination of Oregon Project Independence funding;

(b) The determination of the amount of reduced funding will be made by the administrator of the Department;

(c) Any funds that are either reduced or terminated from a funding grant will be reserved by the Department for redistribution at its discretion. At the end of the biennium, unexpended funds will be returned to the OPI Fund.


411-032-0010  Authorized Services and Allowable Costs  
(Effective 11/1/2006)

(1) Authorized Services:

(a) Oregon Project Independence funds will only be expended for administration and direct service for the following authorized services:

(A) Homemaker (Home Care);
(B) Chore Service;
(C) Assisted Transportation (Escort);
(D) Home Health;
(E) Personal Services;
(F) Adult Day Services;
(G) Respite;
(H) Information and Assistance;
(I) Registered Nurses;
(J) Home Delivered Meals;
(K) Other services authorized by the administrator of the Department or his or her designee;
(L) Planning for long term care services; and
(M) Public education on long term care planning and resources.
(b) Home health services will meet the standards and requirements of the Home Health Agencies Rules (OAR chapter 333, division 027) and can only be offered through a home health agency licensed by the Department of Human Services, Health Services.

(c) Services provided by an In-Home care agency will meet the standards and requirements of In-Home Care Agencies under ORS 443.305 to 443.350 and OAR chapter 333 division 536, and can only be offered through a home care agency licensed by the Department of Human Services, Health Services.

(d) Services provided by a Homecare Worker will meet the standards and requirements of the Home Care Commission under ORS 410.600 to 410.614 and OAR chapter 411, division 031.

(e) Services provided using the Client Employed Provider Program should meet the standards and requirements of chapter 411, division 030.

(2) Authorized Administrative Functions -- If the state agency or Area Agency on Aging is already providing case management services (as of the date of submission of the plan) under a state program, the plan may specify that such agency be allowed to continue to provide the following case management services:

(a) Intake;
(b) Eligibility;
(c) Assessment;
(d) Service Planning/Service Coordination;
(e) Implementation of plan services;
(f) Monitoring the service plan; and
(g) Reassessment.

(3) Computation of Allowable Costs -- Allowable costs by area agencies are those associated with the direct provision of services to individuals and such administrative costs as may be required to assure adequate services and to provide information to the Department.

(4) Administrative Costs -- Administrative costs will not exceed ten percent of Oregon Project Independence funds.
Interpretive Guidelines 411-032-0010
This rule provides the list of authorized services, authorized administrative functions and computation of allowable costs. Along with the list of services is guidance for selecting an appropriate (authorized) provider. Please note that your agency is allowed to choose which services it offers and the means of providing these services according to this rule. Additional services may be approved by DHS Central office when included in your area plan. Administrative costs to run the program may not exceed 10% of your OPI allocation.

411-032-0013 Fee-Based Services (Effective 11/1/2006)
(1) When service limitations have been established at the local level and an individual would otherwise be eligible to receive OPI services under this rule, fee-based case management may be authorized for administration and direct service provided for the following:

(a) Service planning and coordination;
(b) Service plan implementation;
(c) Service plan monitoring; and
(d) Reassessment.

(2) A separate fee schedule will be established by each area agency and will be applied to those individuals receiving fee-based case management services.


Interpretive Guidelines 411-032-0013
OPI now allows an area plan to offer fee based case management services to those individuals who would qualify for OPI services under state rule when services at the local level have been limited due to budget constraints or local decision. For example, if an agency determines that it will provide services for home care, personal care and escort services only and an individual’s needs are such that Adult Day Service is the appropriate service plan that agency could choose to establish the eligible individual as a fee based case managed client and then provide that service. If an agency is providing services for SPL levels 4-18 and an individual is an SPL 1,2 or 3, fee based case management services could apply.
411-032-0015  Data Collection, Records, and Reporting
(Effective 11/1/2006)

(1) Data Collection:

(a) The collection of required program and fiscal data associated with Oregon Project Independence will be on forms and data systems as approved by the Department.

(b) Each area agency and service provider will collect data as required by the Department on eligible individuals receiving authorized service.

(c) All authorized service data collected on eligible individuals, supported by Oregon Project Independence, will contain the individual's Social Security Number and date of birth.

(d) For individuals under the age of 60, documentation will be placed in the individual's file that the person has been diagnosed as having Alzheimer's Disease or other related disorder. Documentation must come verbally or in writing from the individual's physician. The type of "other related disorder" will also be specified in this documentation.

(2) Records:

(a) Each area agency and service provider will maintain all books, records, documents and accounting procedures that reflect all administrative costs, program support costs, direct service costs, and case management costs expended on Oregon Project Independence. These records will be retained for not less than three years.

(b) These records will be made available upon request to representatives from the Department, or to those duly authorized by them.

(3) Fiscal and Program Reporting:

(a) Fiscal and program reports will be completed on forms provided by the Department.

(b) Fiscal and program reports will be submitted to the Department by the specified due dates.

(c) Fiscal/Program reports must, at a minimum, include:

   (A) Current cumulative expenditures;

   (B) Cost per unit of authorized service;
(C) Administrative costs;
(D) Program support costs;
(E) Case management costs;
(F) Direct service costs;
(G) The amount of fee for service assessed, billed, expended and collected and other funds received;
(H) Number of unduplicated clients year to date served for each authorized service year to date, and unduplicated case count year to date;
(I) Number of units of service for each authorized service; and
(J) Demographic, social, medical, physical, functional, and financial data, including a breakdown of the income levels of OPI eligible individuals, as required by the Department on the SPD Client Assessment/Planning System (CA/PS) and in Oregon ACCESS database.

(4) Confidentiality. The use or disclosure by any party of any information concerning a recipient of authorized services described in these rules, for any purpose not directly connected with the administration of the responsibilities of the Department, Area Agency or service provider is prohibited except with written consent of the recipient, or their legal representative. Disclosure of recipient information will meet Department requirements.


**Interpretive Guidelines 411-032-0015**

The rule specifies information that the AAA is required to collect for purposes of reporting to the legislature and to the Administration on Aging. This information is needed, and either the State Unit on Aging will create data pulls from Oregon ACCESS in order to obtain it or requests will be honored via personal contact agency by agency. Please note that 411-032-0015 (1)(c) Data Collection: requires Social Security Number, something not normally required for an OAA client. This is due to Oregon ACCESS data entry requirements and is not necessary for receiving any other Older American Act services.

At this time the rule 411-032-0015 (1)(d) requires that there is documentation of condition on file for Alzheimer's or related disorder. This can be as simple as a conversation with the doctor confirming diagnosis as long as this is narrated as such.
411-032-0015 (2) Record retention relates to the program and not to the client files but SPD Worker Guide G5 provides guidance on records for client files and states that client files need to be maintained for 3 years after the last activity. This will very probably be included in the next rule update.

411-032-0015(3)

411-032-0015(4) Confidentiality. AAAs are contracted with the state to adhere to all DHS confidentiality rules. These rules are included in the Addenda section of the manual and can be accessed on the web at: http://www.dhs.state.or.us/spd/tools/additional/workergd/index.htm. While the rules seem cumbersome and lengthy, it is also true that once learned, like driving, with practice it is readily incorporated into your daily process.

411-032-0020 Eligibility and Determination of Services

(Effective 11/1/2006)

(1) Eligibility:

(a) In order to qualify for services from an area agency or service provider, each eligible individual must:

(A) Be 60 years old or older; or be under 60 years of age and be diagnosed as having Alzheimer's Disease or a related disorder;

(B) Not be receiving financial assistance or Medicaid, except Food Stamps, Qualified Medicare Beneficiary or Supplemental Low Income Medicare Beneficiary Programs; and

(C) Meet the requirements of the Long-Term Care Services Priority Rule, OAR 411, division 015.

(b) Eligibility determination will be required before any individual may receive services from an area agency or service provider. The documentation required by OAR 411-032-0015(1)(d) must be obtained before an individual under the age of 60 may be determined to be eligible.

(c) Eligibility determination will be the responsibility of the area agency. In those instances when eligibility determination is performed by an agency other than the area agency, the area agency will have in place a system for evaluating the eligibility determination process, including an independent review by the area agency of a representative sample of cases.

(d) Any person residing in a nursing facility, assisted living facility, residential care facility, or adult foster care setting will not be eligible for
authorized services. This will not restrict the ability to move an eligible individual from such institutions to their home to receive services, when judged more appropriate, based on medical, financial, physical, functional, and social considerations.

(e) Any person residing in a living setting that offers any services authorized under OAR 411-032-0010 will be limited to receiving OPI services that are not available in that setting.

(f) The Department will determine the factors that constitute an individual being at risk of institutionalization. These factors are currently defined in the Long-Term Care Services Priority Rules, OAR chapter 411, division 015. These factors will be utilized by each area agency and service provider.

(g) Applicants will receive written notification of eligibility determination.

(2) Determination of Services:

(a) Determination of services will rest with the area agency. In those instances when determination of services is performed by an agency other than the area agency, the area agency will have in place a system for evaluating the determination of service process, including an independent review by the area agency of a representative sample of cases.

(b) The determination of services will be based on each individual's financial, physical, functional, medical, and social need for such services and in accordance with OAR chapter 411, division 015.

(c) Determination of services provided under Oregon Project Independence will be limited to the authorized services allowed by these rules.

(d) The determination of services will be made:

    (A) After eligibility determination; and

    (B) At regular intervals but not less than once every twelve months.

(e) Individuals will receive written notification of determination of services:

    (A) Notice will include the maximum monthly hours of service authorized, the hourly and maximum monthly fee, the service rate, and provider contact information.
(B) Written service notification will be provided to the individual upon initial determination of services, at annual reassessment and when there are changes to the determination of services.

(3) Priority of Services:

(a) Area Agencies on Aging may establish local priorities for service authorization but will not conflict with this rule. In event of a grievance, this rule will take precedence over local priorities.

(b) Priority for authorized services will be:

(A) Maintaining eligible individuals already receiving authorized service as long as their condition indicates the service is needed.

(B) Individuals who will immediately be placed in an institution if needed authorized services are not provided and meet the Long-Term Care Services Priority Rules, OAR chapter 411, division 015.

(C) Individuals who are probably to be placed in an institution if needed authorized services are not provided.

(4) Appeals: Persons for whom services are denied, disallowed, or reduced through eligibility determination or service determination will be entitled to request review of the decision through the Area Agency on Aging grievance review procedure, set forth in agency policy.

(a) Individuals will continue to receive services until the disposition of the local agency grievance review.

(b) The Area Agency will provide the applicant with written notification of the grievance review determination decision.

(c) Applicants that disagree with the results of the Area Agency grievance review have a right to an Administrative Review with the Department of Human Services, Seniors and People with Disabilities Division, pursuant to ORS Chapter 183. This information will be provided to the applicant in a written notification at the time of the grievance review decision.

(d) Applicants requesting an Administrative Review from the Department will not be eligible for continued services through Oregon Project Independence.
(e) All persons, including those who may have previously been terminated from Oregon Project Independence, have the right to apply for OPI services at any time.


**Interpretive Guidelines 411-032-0020**

411-032-0020(1) Eligibility for the OPI program at the statewide level includes just three factors: 60 or over, (or under 60 with an Alzheimer’s related illness), NOT receiving Medicaid and meeting Service Priority level 1-18. Some AAAs serve only some of the service priorities and some of the AAAs serve all SPL needs.

411-032-0020(2) Priorities for receiving services at the state level are set by statute and they include just 3 factors: already receiving services, at risk of institutionalization without services or probably at risk of institutionalization without services. Since this program is never fully funded some AAAs necessarily must create waiting lists for services. When this happens it is incumbent that local policy adheres to the service priorities established by the legislature. It is never okay to limit services by income or by resources since the intent of the OPI program from the onset was to provide additional options for Oregonians who might not qualify for Medicaid services and would fall through the cracks without some services.

411-032-0020(4) addresses the grievance process that has two levels of review. The first level is at the local agency level where clients have a right to continued services pending results of the review process. If a client requests a hearing at SPD the client’s benefits may be terminated pending results of the administrative review process.

**411-032-0044 Fees for Service and Fees for Service Schedule**

*Effective 11/1/2006*

(1) Fee for Services:

(a) A $5 annual minimum fee will be applied to all individuals receiving OPI services who have adjusted income levels at or below federal poverty level. The fee is due at the time eligibility for OPI service has been determined and for each 12 month subsequent reassessment. This fee does not apply to home-delivered meals.

(b) Fees for service will be charged based on a sliding fee schedule to all eligible individuals whose annual income exceeds the minimum, as established by the Department. No fees for service will be charged for Home Delivered Meals or case management services. For purposes of these rules, an individual’s gross annual income will include:
(A) Salaries from the household;
(B) Interest and dividends from the household;
(C) Pensions, annuities, Social Security and railroad retirement benefits from the household; and
(D) Any other income from the household.
   (i) All medical costs, including prescription drugs that are the responsibility of the household, may be deducted from the individual's gross annual income.
   (ii) All child support paid by a non-custodial parent may be deducted from the individual's gross annual income.

(c) A recommended donation will be established for OPI-funded Home Delivered Meals and implemented in the same manner as for the Older Americans Act meal programs.

(d) Individuals will receive written notification of the hourly and maximum monthly fee for service upon initial service determination and whenever there is a change.

(e) Area agencies will develop procedures for assessing, billing, collecting, and expending fees.
   
   (A) The Area Agency will establish a written policy addressing individual non-payment of fees to be reviewed and approved in the agency area plan.

   (B) Individuals will be given a copy of the agency policy pertaining to individual non-payment of fees upon initial eligibility determination.

   (C) The decision to terminate Oregon Project Independence services for non-payment of assessed fees for service will be the responsibility of the local area agency.

(f) A record of surcharges and all fees for service will be kept by each area agency and reported monthly to the Department.

   (A) Annual minimum fees and fee for service determination forms will be a part of each individual's case record. Fee for service...
determination forms will meet minimum requirements for
documentation, as established by the Department.

(B) The maximum monthly authorized fee for services will be
recorded on each individual's Oregon ACCESS record upon initial
service determination and at least annually thereafter, at time of
reassessment.

(g) Nothing in these rules will prevent Oregon Project Independence
individuals, or his or her family, from making a donation or contribution.
Such donations will also be used to expand services under Oregon Project
Independence. Expansion of services will be limited to services authorized
in OAR 411-032-0010(1)(a) as identified in the agency's area plan.

(h) The minimum annual fee and all fees for service will be used to expand
services under Oregon Project Independence. Expansion of services will be
limited to services authorized in OAR 411-032-0010(1)(a) as identified in
the agency's area plan.

(i) Area agencies and providers will not be required to make a second
attempt to collect Oregon Project Independence fees of $5.00 or less.

(2) Fee for Service Schedule.

(a) The Department, after consultation with the Area Agencies, will develop
and publish a fee schedule for services based on the federal poverty level
and distribute the schedule to the area agencies annually.

(b) The fee for service schedule will be applied to the local rate specific to
the service and the type of provider for the individual.

(c) Fees for OPI services start at the federal poverty level net monthly
income and increase by approximately $25 income increments up to 200%
of the federal poverty level. Families with net monthly incomes over 200%
of the federal poverty level will pay the full hourly rate of services
provided.


Interpretive Guidelines 411-032-0044
All OPI clients must now pay a fee, including those who will not be required to pay on the
sliding fee scale.
Fees are determined by sliding fee based on household income and no fees will be assessed for case management or home delivered meals. (Exception here would be if an agency is providing fee based case management services.)

“Household” means the individual, spouse and any dependents as defined by the Internal Revenue Service.

Deductions can be made from income for health related/medical costs and supplies.

Deductions can be made from income for child support.

Donations can be made.

AAAs are required to develop a written policy regarding non-payment of fees and that is to be given to a client when determined eligible.

HDM – recommended donation established and

Agencies are not required to make a second collection attempt on fees of $5 or less.
Oregon Administrative Rule (OAR) Chapter 41, division 002 states that an Area Agency on Aging (AAA), also referred to as an Area Agency on Aging & Disabilities is a designated entity with which the Department of Human Services (DHS) contracts to provide social services to older and disabled Oregonians residing within designated planning and service area's (PSA). Two models of AAA exist, both of which are briefly described below.

**Type A AAA model**

A public or private non-profit agency or unit of local government that administers the Older Americans Act (OAA) and Oregon Project Independence (OPI) programs for a planning and service area.

Type A agencies do not administer Medicaid, financial services, adult protective services, or regulatory programs for the elderly and disabled. These programs are administered by a DHS Senior & People with Disabilities local office within each PSA. **Oregon has eleven AAAs:**

1. Columbia Action Team (serving Columbia County)
2. South Coast Business Employment Corp. (serving Coos and Curry Counties)
3. Mid-Columbia Council of Governments (serving Hood River, Wasco, Sherman, Gilliam and Wheeler Counties)
4. Central Oregon Council on Aging (serving Jefferson, Crook and Deschutes Counties)
5. Klamath Basin Senior Citizens Council (serving Klamath and Lake Counties)
6. Community Action Program of East Central Oregon (serving Morrow and Umatilla Counties)
7. Community Connection of NE Oregon (serving Grant, Union, Wallowa and Baker Counties)
8. Harney County Senior & Community Services Center (serving Harney County)
9. Malheur Council on Aging & Community Services (serving Malheur County)
10. Clackamas County Social Services (serving Clackamas County)

11. Washington County Disability Aging & Veterans Services (serving Washington County)

**Type B AAA model** is a local government administering the OAA and OPI programs, in addition to Medicaid, financial services, adult protective services, and regulatory programs for the elderly and disabled.

Type B agencies may choose to have DHS employees transferred to AAA employment through a transfer agreement or contract with DHS for the services of state employees to administer Medicaid, and all other services mentioned above. Accordingly, there are Type B Contract agencies and Type B Transfer agencies. Oregon has two (2) Type B Contract and four (4) Type B Transfer AAA’s (see attached map):

1. Northwest Senior & Disability Services (serving Clatsop, Tillamook, Yamhill, Polk and Marion Counties) - Transfer

2. Multnomah County Aging & Disability Services (serving Multnomah County) - Transfer

3. Oregon Cascades West Council of Governments Senior & Disability Services (serving Linn, Benton and Lincoln Counties) - Transfer

4. Lane Council of Governments Senior & Disabled Services (serving Lane County) - Transfer

5. Douglas County Senior & Disability Services Division (serving Douglas County) - Contract

6. Rogue Valley Council of Governments Senior & Disability Services (serving Josephine and Jackson Counties) - Contract
Section 1.6  Local Control

OPI is a state program with State Unit on Aging oversight designed to maximize local control. Since OPI is not an entitlement program services are limited based on local resources. At the state level minimum requirements are set per Oregon Revised Statute (ORS) and Oregon Administrative Rule (OAR) and each local community manages the program based on local capacity. Authorized services under OAR 411-032 include other services that are not listed as long as approval has been given by DHS. As a general rule, no formal waiver process is necessary. The AAA reports provision of a service in their area plan and it is approved when the state approves the area plan. If an office chooses to change the services they provide at the local level it is important to notify the SUA through an update their area plan.

Local control of the OPI program is not limited to choosing particular services provided in your area but includes broad discretion to determine the number of care hours an OPI eligible individual will receive. Most offices currently allow between 20 and 30 hours a month for service per recipient but the state recognizes that other factors such as local donations and recipient contributions will impact that determination.

As a result of these local decisions an eligible individual might see a significant difference between services they are receiving in Gold Beach from those which a sister is receiving in Lakeview and in each of these cases the program might be in complete compliance with state rule. For example, services that can be economically delivered in Portland might be cost prohibitive in Burns; Wallowa contributions might be substantially higher than those in Lincoln City and services that are available in Roseburg may simply not be an option for LaGrande. A true strength of the OPI program is the recognition that a “one-size-fits-all” approach to delivering services does not meet local need and honors what is unique in each community.
SECTION 2 COMPONENTS OF OPI CASE MANAGEMENT

Section 2.1 Eligibility Requirements

To be eligible, the applicant must be: (OAR 411-032-0020)

- Age 60 or older; OR under 60 with a medically documented diagnosis of Alzheimer’s or related disorder; AND
- The applicant must not be receiving Medicaid (Note: they can be eligible for Food Stamps, Qualified Medicare Beneficiary (QMB) and Supplemental Income Beneficiary (SMB) Programs and still get OPI); and
- Meet the requirements of the Long Term Service Priority Rule OAR chapter 411, division 015.

Section 2.2 Priority for Services

Oregon revised statute clearly states that priority for receiving OPI services is as follows:

(a) Clients already receiving authorized service as long as their condition indicates services are needed.

(b) Clients who are to be placed immediately in an institution if needed authorized services are not provided.

(c) Clients who are probably to be placed in an institution if needed authorized services are not provided.

Section 2.3 The Assessment

The initial purpose of assessing clients is for the case manager to evaluate the functionality of the individual and how well they can survive in their living situation, then determine what service needs are required that will allow the person to safely remain in the least restrictive environment. Clients must meet the requirements in Rule 411-015-0000 through 411-015-0100. To determine this eligibility requirement, you must do a CAPS assessment.

It is important to attend the CAPS2 class for a full understanding of how the tool works even when you’ve had limited hands-on exposure in your local office. There are two assessment wizards in the CAPS2 program one for general
assessment and one for State Plan Personal Care. General Assessment allows for selecting a wizard function according to the program for which the client is being assessed. Options include Title XIX, OPI, APS and PAS assessments. The OPI case manager must choose the general assessment wizard and must designate OPI as the assessment type.

What is a Wizard? A Wizard is a tool to guide you through the steps of a process or task by asking a series of questions or presenting options.

This computerized assessment tool is a comprehensive, holistic evaluation system of an individual’s mental, social, and physical health and is used for determining the service levels met. If the level of service priority verifies the individual’s eligibility for services, a service plan is then developed.

Use the definitions in OAR 411-015-0005 to guide you through a step by step assessment of the clients physical limitations in the areas of Activities of Daily Living (ADL’s) and Self Management Tasks (IADL’s).

All ADL questions that are asked in the CAPS2 conform to the definitions in Oregon Administrative Rule Chapter 411, Division 015 so it is not necessary to reference the rule each time you do an assessment, in order to accurately record the response. Because of this strict correspondence, however, it is critical to spend time thinking about both the question and the possible answers before entering your response.

Remember: A hastily recorded response will result in an inaccurate Service Priority Level determination and precious OPI dollars may be misspent.
The following elements are observed, verified, and documented in the CA/PS:

<table>
<thead>
<tr>
<th>Activities of Daily Living (ADLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
</tr>
<tr>
<td>Eating</td>
</tr>
<tr>
<td>Elimination</td>
</tr>
<tr>
<td>Cognition</td>
</tr>
<tr>
<td>Bathing</td>
</tr>
<tr>
<td>Hygiene</td>
</tr>
<tr>
<td>Dressing</td>
</tr>
<tr>
<td>Grooming</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instrumental Activities of Daily Living (IADLs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housekeeping</td>
</tr>
<tr>
<td>Laundry</td>
</tr>
<tr>
<td>Breakfast</td>
</tr>
<tr>
<td>Lunch</td>
</tr>
<tr>
<td>Dinner</td>
</tr>
<tr>
<td>Med Management</td>
</tr>
<tr>
<td>Shopping</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
</tbody>
</table>

Please be sure to include comments that support or substantiate your responses.

In addition, you will find a Synopsis screen allowing free entry for personal elements such as drug, alcohol or tobacco use. It is appropriate to narrate this information within the CAPS2 assessment rather than the narrative.

It is recommended that assessments are completing using a laptop computer. A hardcopy of Laptop Basics instruction has been included in the Appendix of this
OPI Desk Manual - 2008

manual and is also available online in the Oregon ACCESS system. If you do not have a laptop, you will need to use a paper tool and then later do the computer entry portion back in the office at your desk. Both the abbreviated form and a complete paper tool are available on the Staff Tools Case Management website at http://www.dhs.state.or.us/spd/tools/cm/capstools/index.htm. You will wait to notify the client whether they are eligible for OPI until after you have done the online data entry.

Once you have completed the data entry into the CAPS2 assessment wizard, a service priority number will be generated. Compare this number with the list of service priorities in OAR 411-015-0010; this is the service priority level. If this number is listed as levels 1-18, they are eligible for OPI services. The cut off number may be higher or lower in your local area; for instance you may not be able to offer OPI services to people who have a survival priority level between 15-18, so consult the management team in your area to find out which numbers you serve.

If the survival priority number is not one of which your office serves, prepare a denial notice explaining why they are not eligible, citing the rules listed above, and also include the OPI grievance procedure. (Note: The grievance procedure is developed locally so contact your local manager for details on your grievance procedure.) Keep a copy of the denial notice in your file.

Section 2.4 Client Details

This section of CAPS II is designed for entering items such as Medications and Diagnoses. These are items that do not affect the individual’s service eligibility or provider payment and hours but they are required to complete a holistic assessment and many of these are a CMS waiver requirement.

In order for your assessment to be complete, Client Details should be filled out as completely as possible.

Section 2.5 Develop a Service Plan

The service plan must be cost effective in management of the AAA’s limited resources in order to serve the greatest number of individuals with high priority service needs.
Determine what areas the client needs help in and discuss what type of help the client thinks they need.

Determine whether the client has any unmet needs; i.e., is the spouse, child, or other family member providing the care already? If they are currently providing for this care need, why can they no longer do this? (See Natural Supports)

Determine the least costly means of providing their service.

Work with your client to develop a service plan that includes only services for those items that are considered unmet needs (i.e., they have no other way of getting care for this task).

OPI’s complete list of authorized services appears in OAR 411-032-0010 and includes:

<table>
<thead>
<tr>
<th>Authorized Services for OPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker (Home Care)</td>
</tr>
<tr>
<td>Chore Service</td>
</tr>
<tr>
<td>Home Health</td>
</tr>
<tr>
<td>Personal Services;</td>
</tr>
<tr>
<td>Adult Day Services</td>
</tr>
<tr>
<td>Assisted Transportation (Escort);</td>
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<td></td>
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</tbody>
</table>

In CAPS2, in order to complete a service plan, the Assessment Wizard must be complete and you must assign yourself as the OPI, Service and Eligibility worker on the Benefits tab/Case Overview screen. You will go back to the CAPS2 menu and select the Service Plan wizard. Remember that once you’ve completed the
assessment you can no longer change it, so be certain you have created an accurate and complete record prior to proceeding with a service plan.

There are two sections to the Service Planning page: Service Category/Benefits and Service Plan. When the Service Category/Benefits section is in “approved” status a connection is made with the mainframe that will approve payments to the provider within that given date range. There is an auto-default date ending approved payments one year from the date the plan begins.

The wizard allows you to assign a provider, assign specific tasks to a provider and to assign the number of hours allocated to a specific task in the Service Plan section. In most cases the number of hours you can assign for an OPI case will be less than the number of hours that are recommended and you will be asked to provide a reason for assigning fewer hours. You will be asked for a reason why you are not assigning the same hours as recommended by the CAPS2 wizard but Reason Options include “CM Determination” a choice designed to bypass the recommended maximum allowable hour rule.

This section also allows you to generate a plan summary that is reflective of the needs identified through the assessment process, a service plan listing all services needs and specifies how those needs will be met, and also a task list for any given provider. After completing the service planning section, forms can be accessed for print by simply requesting “print” from the main menu and selecting the form, as appropriate.

Please plan to mail copies of the task list to the client. Three copies should be made: One copy for the client to keep, one copy for the care provider to keep, and one copy to be returned to you for your file (the client and the care provider should sign one copy and return it to you.)

In addition to the Service Planning section this wizard also allows for documenting any local resource referrals that were made and provides the individual with written contact information for follow up. All necessary referrals are charted by type, service provider to whom client is referred, time lines for services, and outcome.

Section 2.6 Authorized Hours

Authorized hours for OPI individuals are subject to the extent of client need and the availability of funds. Remember that the intent of the OPI Program to authorize paid in-home services only to the extent necessary to supplement
potential or existing resources within the client’s personal support system. Case Managers must assess and utilize available friends and family members as appropriate, [See Natural Supports section], cost-effective assistive devices, durable medical equipment and/or housing accommodations which could reduce the client's reliance on paid in-home service hours.

Actual hours authorized for OPI clients will be based on availability of local funds and local policy to be established by the local AAA. The following page provides an example of such a policy, courtesy of Columbia Action Team. This tool is used for case managers to determine the service plan number of hours allowable under their Area Plan.
As you can see the chart allows for some flexibility in assigning hours. In the example above CAT does not assign fewer than 4 hours per month and allows up to and including 15 hours per month, per client. Under administrative rules chapter 411, division 032, your agency has the option of limiting number of hours and service priority levels, in addition to the types of services that are authorized by OPI.
OPI Desk Manual - 2008

Remember that the intent of the OPI Program is to authorize paid in-home services only to the extent necessary to supplement potential or existing resources within the client’s personal support system.

Section 2.7 Select a Service Provider

Working with your client, help them select a service provider. The following options are available to OPI clients but subject to local availability.

1. Contracted In-home Services:

This option may be used when this method of service proves to be the most cost efficient in meeting the needs of the client or necessary to meet interim or emergency service needs while more cost-effective solutions are sought and procured or in meeting the needs of clients who are more difficult to serve.

2. Client-Employed Provider (CEP) Program:

The CEP program can be described as an interconnected and cooperative relationship involving the employer/client, the agency/case manager, the Home Care Worker Program and the Department (SPD). Each of these entities performs a clear and distinct function in the provision of services to the OPI client.

The CEP program was designed for the client to have primary responsibility for locating; interviewing; screening; and hiring his/her own employees. The relationship between the provider and the client is that of employee and employer. As such, both terms of dismissal and resignation notice requirements are the sole responsibility of the employer to establish at the time of employment. As case manager you will likely assist your OPI clients by locating and screening homecare workers (HCW) through the Registry Referral System. [https://www.or-hcc.org/SelectUserRole.aspx?PageID=118](https://www.or-hcc.org/SelectUserRole.aspx?PageID=118). This is also the time to talk with your client about the STEPS program, when it is appropriate to do so.

STEPS to Success with Your Homecare Worker provides free training for employers. STEPS is a state-wide training program that teaches employer skills to people who receive in-home services through the Client-Employed Provider Program. STEPS offers free training through workshops, one-on-one trainings, and “Guide on the Side” services (mentoring once you’re taken the trainings). STEPS provides information about:

- Role, rights, and responsibilities as the employer of a Homecare Worker;
- Identifying what services are needed and writing a job description;
- Screening, interviewing, and hiring a Homecare Worker;
• Putting together a Homecare Worker back-up plan to stay safe;
• Managing the employee;
• Training the Homecare Worker;
• Communicating more effectively and solving problems;
• Keeping records;
• Terminating the Homecare Worker when necessary;
• Being safe in your home and planning for emergencies.

For more information about STEPS, call toll free at 1-877-277-0513 or visit the STEPS website at www.orsteps.org.

Payment for CEP services will be made by the Division after all acceptable employee standards have been verified and both the employer and employee have been formally notified in writing that payment by DHS – SPD is authorized to do so. Acting on behalf of the Client-Employer, the Department will withhold the Homecare Worker-employee FICA (Federal Insurance Contributions Act) contribution and submit it to the Social Security Administration in accordance with applicable regulations.

Payment for such services will depend on the presence of certain employee standards. Payment may be suspended or terminated when:

• Violations of protective service and abuse laws occur;
• Fiscal improprieties occur;
• Services are not provided as required;
• Employee does not have the skills to adequately or safely provide services;
• The employer requests termination; or
• New criminal convictions come to the attention of the local AAA.

For additional resources regarding the HCW program see: The Homecare Worker Procedures Manual at http://www.dhs.state.or.us/spd/tools/cm/homecare/manual/index.htm

3. Self-Provider of In-home Services:
OPI Desk Manual - 2008

Formerly an Area Agency on Aging could Self-Provide for In-home services as long as they had issued an RFQ/RFP and there were no proposals submitted for the service OR if the AAA also submitted a proposal and was selected as the provider. This option no longer exists since we now have the Home Care Worker collectively bargained contract but Oregon still has one remaining AAA that has been grandfathered as a Self Provider of In-Home services.

Section 2.8 Determine Gross Income

Request gross household income amounts (this should include salaries from client, spouse and any dependents as defined by the IRS, interests and dividends, pensions, annuities, social security, railroad retirements, and any other income from household).

Request information on out of pocket medical expenses including prescription drugs that are the responsibility of the household. (i.e., those things not covered by health insurance or paid through another type of system). Note: If you count the income for a person in the household you also count the medical deductions for that person.

- Non-prescription drugs
- Medical supplies
- Nutritional supplements
- Herbal remedies recommended by a licensed health professional
- Medicare premiums or other health care premiums
- Doctor visits (full cost or co-pays)
- Hospital costs
- In-home nursing care
- Health care equipment

Total household income. Total any authorized medical deductions. Take the total gross income and subtract the authorized medical expenses. This is your net income for OPI.

"Household" means the individual, spouse and any dependents as defined by the Internal Revenue Service. OAR 411-032-0000
Section 2.9  Calculate OPI Client Fee:

STEP ONE: Using the net income you calculated in 2.7 and the number of people in the household, compare this with the OPI Client Fee Schedule. This will help you determine the exact client cost for OPI services.

STEP TWO: Multiply the number in the HCW Rate Column of the OPI Client Fee Schedule by the number of hours authorized in the service plan to determine the monthly client fee. See Sample Fee Determination Form on the next page.

STEP THREE: Notify the client in writing of their client fee.

Example: Mr. Smith’s gross income from Social Security is $1,500.00. He is the only one in the household group, so his Family Size is one. He pays $50.00/month for a Medicare supplement and $50.00/month for a prescription for a total medical deduction of $100.00/month. He receives 10 hours of service through OPI for mobility and bathing assistance. His net income is figured as $1500.00 - $100.00 = $1400.00/month. Using the OPI Client Fee Schedule for a Family of One, Mr. Smith’s net income falls between the $1,390 - $1,415 range. This corresponds to a Home Care Worker Rate of $5.67/hour*. *2009 OPI Fee Schedule

The service plan includes 10 hours per month. Multiply the number of hours in the service plan (10 hours) by the HCW Rate ($5.67/hour) to calculate the Client Fee. (10 hours/month x $5.67/hour = $56.70.) This is the client fee.

The federal poverty guidelines are revised annually by the Department of Health and Human Services. Because the OPI Fee Schedule for services is based on the federal poverty guidelines, the fee schedule must be revised to reflect the new income levels annually. The fee always starts at $0.00 with hourly rates increasing incrementally until the full cost of services is reached. A sample fee schedule is included in the Appendix section of this manual. What is important to know is that this is a schedule that changes at least annually. Questions should be directed to the State Unit on Aging’s OPI program coordinator at (503) 373-1750.

The 2005 Legislature established that all individuals receiving OPI services will pay something for those services. OAR 411-032-0044 requires those individuals who are not paying a fee will be charged $5.00 upon approval.

Please Note: For two-client households, each person is considered separately.
Section 2.10  Redeterminations

Review the client’s eligibility for OPI and service plan at least yearly, or when a change in circumstances takes place for instance, more or less income or change in care needs that requires a reduction or an increase to the service plan.

*SPECIAL NOTE: Any time you deny or terminate (close) eligibility for OPI or reduce a service plan, you must notify the client in writing and provide at least 10 days notice before taking action. The notice to reduce, to deny, or to close must be in writing and it must include a written statement on the OPI grievance procedure (the grievance procedure is developed locally, so contact your local manager to find out how your OPI grievance procedure works).*
Section 2.11 Case Closure Process

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<th>Notices</th>
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| "OPI closure due to ...", if death, narrate how you were informed) "Effective...xx/xx/xxxx" "Sent...": | **Service Needs** (Smiley Face)  - OAA Sumry  - OAA Svc/FCGS  (Service date should end on last day of the month)  **Benefits** (Circling Arrows)  - Case Overview  - Uncheck OPI box  - Assigned Worker  - Service Tab  **CAPS2**: Service Date and Plan Date end date  **CAPS** – move to history  *Inactivate case if no other services will be provided in your branch | * Decision Notice to client (agency or SPD 540)  
* 4105 or written notice to HCW or Home Health Agency |
|  | *HCW  *SPD  *MOW  *Other? | |

| Notes: Depending on reasons for closing the OPI case the following may apply: | Review case for any and all other program eligibility  Program Options: if client will probably transition to Medicaid, invite SPD Case Manager for joint visit or staff over phone  Transfer case to other branch as appropriate | |
Section 2.12 Service Provider Payments:

When the benefit plan has been approved in the CAPS2 Service Planning section, a connection between the Service Plan and the DHS payment screens is established. A 546 is generated by accessing the Print button on the main menu, which is given to the voucher clerk, who generates the voucher for HCW provider payment. The voucher clerk enters the dates, the types of services and the number of hours and requests that the voucher is mailed to the provider. If your client’s regular HCW takes paid time off, you will need to fill out a 546sf so that the voucher clerk can adjust the regular worker’s schedule, reissue a voucher that reflects the adjusted time accurately and ensure that the relief HCW also receives a voucher for payment.

When the voucher comes in each month, verify that the care provider and client have both signed the form and that the care provider has not exceeded the authorized hours for the month.

If the voucher is complete and is correct, process the payment within 3 working days. Then issue the next month’s voucher.

If the voucher is not correct, return to care provider for correcting.

Issue the next month’s voucher within 5 calendar days of the payment processing date.
Section 3 Forms and Signatures

Many forms required for the OPI client file are forms that have been designed at the local AAA level in order to accommodate local business needs. The following is a list of documentation that would be reviewed in a site monitoring for the OPI program. From time to time the OPI Advisory group reviews the merits of standardizing forms for statewide uniformity; at this time universal forms do not exist.

**Application** – No universal application form is needed for OPI. Request for assessment, whether agency referral or telephone request is assumed to be a request for services and the CAPS2 assessment suffices as documentation of application.

**Verifications** – OPI requires name, age, address and social security number are entered into Oregon ACCESS. No income or resource verification is required but, in some cases, it is useful to review income documents with the client to determine possible OPI sliding fee scale amount. An optional local form can be designed for this purpose.

**Denial Notice** – SPD offers several “Denial for Services” notices, none of which has been tailored to meet OPI needs. A sample form in Grievance Procedure Section 4 of this manual has been included and can be modeled if need be.

**Grievance:** local office or see sample in Section 4.

**Fee for Service Determination (fee calculation worksheet):** Local office or see sample.

**Notice of Privacy Practices** - DHS 2090 DHS (signed by client)

**Authorization for Use & Disclosure of Information** - DHS 2099

**Worker’s Compensation Release** (if using a HCW) SDS 354 – (signed by client)

**NAPIS form** – DHS 0001 (updated annually)

**In-Home Service Plan** with OPI % of costs - SDS 546 or 546N

**Task List** (sent to HCW) - SDS 598

**SDS 4105** (or local equivalent) – whenever reducing/ending HCW hours

Any service referrals

A complete list of forms relating to CAPS and to CAPS2 are listed in OREGON ACCESS under the File/Print tab. All forms can also be accessed on the DHS website.
Section 4  OPI GRIEVANCE PROCEDURES

All AAA Offices who provide OPI services should have a written, OPI Grievance Procedure. This grievance procedure should be given to the client when any adverse action is taken in their case. For instance, if you deny an OPI application or reduce OPI benefits.

The OPI grievance procedure should include:

➢ A formal process that allows the client the opportunity to meet with a management level staff person to discuss the issue.
➢ Specific time frames for the grievance procedure (this should be included in both the optional informal process as well).
➢ A written outcome that explains the result of the formal grievance meeting.
➢ The option for an administrative review with the Department of Human Services, Seniors and People with Disabilities, State Unit on Aging, should the formal grievance process not meet the satisfaction of the client.

It is recommended, but not required, that an informal process be included in the grievance procedure. This allows the client an opportunity to meet with the case manager to discuss concerns and hopefully reconcile the issue without the need to progress to a more formalized process.

The Lane Council of Governments (LCOG) Procedural Manual provides us with good examples of the OPI Grievance Procedure on the pages that follow:
SAMPLE OPI GRIEVANCE PROCEDURE

LOG NUMBER: 000x AAA PROCEDURE MANUAL

EFFECTIVE DATE: 09-25-06

TOPIC: Oregon Project Independence (OPI) Grievance Procedure

INTRODUCTION:

The Area Plan Contract between the Department of Human Services (DHS) and AAA/name of organization here requires AAA/NAME to establish and maintain a system through which a client or client representative may present grievances about the operation of name services. To this end, AAA/name has established a system, which involves four components, each tailored to a specific aspect of the AAA/name operations. These components are as follows:

Customer Comments and Complaints Procedure: This process is designed to obtain feedback from applicants for and recipients of services administered by AAA/name. Its use is appropriate for individuals who wish to provide positive comments to AAA/NAME, or to lodge complaints about service provision, including issues such as timeliness of service, the accuracy of information provided, and treatment by AAA/name staff. See Log #15 for more information on AAA/name Customer Services Report process.

Contested Case/Administrative Hearings: The Oregon Department of Human Services has created an extensive system for addressing public assistance benefits issuance decisions. AAA/name will utilize these procedures when applicants for and clients of AAA/name wish to challenge or grieve decisions concerning their receipt of public assistance benefits and services. See Log #16 for additional information on administrative hearings.

Older Americans Act (OAA) Grievance Procedure: This procedure is designed to address and resolve client grievances regarding the provision of OAA services by AAA/name. Information on this component of AAA/name grievance system is contained in Log # 39.
SAMPLE OPI GRIEVANCE PROCEDURE

OPI Grievance Procedure: This procedure is designed to address and resolve client grievances with the provision of OPI services by AAA/name. Its use is most appropriate for clients who wish to grieve AAA/name decisions which result in a reduction, termination or denial of OPI services. Information on this component of AAA/name grievance system is set forth below.

AAA/name OPI GRIEVANCE PROCEDURE: The following process will be used to resolve differences of opinion between an OPI client and AAA/name.

1. Guidelines and Definitions:
   a. Representation: The client may be represented at any stage in the grievance process by a representative of the client’s choosing, including legal counsel. (Free legal counsel may be available from Lane County Legal Aid or Lane County Law and Advocacy Center, 376 E. 11th, Eugene, 541-485-1017.)
   b. Written Decision: A decision, rendered at any level, shall be in writing, setting forth the decision and the reason for it. The decision shall be promptly mailed to the aggrieved client or representative.
   c. Time Limits: It is important that a grievance be processed as rapidly as possible. Specified time limits may, however, be extended by mutual agreement between the aggrieved person and AAA/NAME. If a grievance is not submitted by the client or his/her representative within the time limit established by this procedure, the grievance shall become void. If AAA/NAME fails to respond to a procedural step within the established time line, the client or his/her representative may proceed to the next step of the process within the specified time line for it.
   d. Definition of the term “a day”: A day shall mean a business day. If a due date falls on a weekend or holiday, the due date shall be the next business day.
   e. Notices of grievance and other written correspondence regarding grievances are to be mailed or delivered to AAA/NAME at the following address:
SAMPLE OPI GRIEVANCE PROCEDURE

AAA/NAME Director
1025 Willamette Street, Suite 200
Eugene, Oregon 97401

2. Notice to Applicant or Client of Decision to Deny, Reduce or Terminate OPI Service:
   a. Denial of Service: When an AAA/NAME worker determines that an applicant for OPI service will not be provided a requested service, the worker shall provide to the applicant, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the applicant’s grievance rights, including the deadline for submitting a grievance. (Sample letter attached.)
   b. Reduction or Termination of Service:
      (1) Involuntary Reduction or Termination: When an AAA/NAME worker determines that service to an OPI client is to be reduced or terminated, the worker shall provide to the client, by mail, a written notice of this decision. This notice shall state the specific reason(s) for this decision and shall describe the client’s grievance rights, including the deadline for submitting a grievance. (Sample letter attached.)
      (2) Voluntary Reduction or Termination: When a client and AAA/NAME worker mutually agree that service for the client is to be reduced or terminated, this agreement shall be confirmed in the following manner: The worker shall provide to the client, by mail, a written notice of agreement. This notice shall list the reason(s) for this decision and, in the event that the client has second thoughts about this action, shall describe the client’s grievance rights, including the deadline for submitting a grievance. (Sample letter attached.)
SAMPLE OPI GRIEVANCE PROCEDURE

3. Informal Problem Resolution Process (Optional): Ideally, differences of opinion between a client and AAA/NAME should be resolved at the lowest level possible. If the client or his/her representative wishes to avail himself/herself of this step in AAA/NAME OPI Grievance Procedure, the client or representative should contact AAA/NAME’s worker involved in the client’s case within ten (10) days of date of mailing of notice of contemplated action which is the subject of the grievance. Within five (5) days of this contact, AAA/NAME’s worker shall schedule a meeting with the client and representative (if any) to attempt to reach a mutually acceptable resolution of the matter. The worker and his/her supervisor shall attend this meeting. Within five (5) days of the conclusion of this meeting, the worker shall inform the client or representative, as appropriate, of a decision regarding this matter.

4. Formal Grievance Process:
   a. Filing a Grievance:
      (1) A client or representative may file a formal grievance with AAA/NAME without taking advantage of the informal process described in Paragraph 3 above. If the informal process is omitted, the client or his/her representative must file a written notice of grievance with AAA/NAME at the address set forth in Paragraph 1.e above within ten (10) days of date of mailing of notice of contemplated action which is the subject of the grievance.
      (2) If the client or representative participated in the informal grievance process described in Paragraph 3 above, he/she or representative must file a written notice of grievance with AAA/NAME at the address set forth in Paragraph 1.e above within ten (10) days of date of mailing of notice of the outcome of the informal process.
      (3) Assistance in filing a written notice of grievance may be obtained from AAA/NAME. Contact AAA/NAME’s Contract Manager in the Eugene Office (541-682-4137) for assistance.
b. Upon the receipt of a written notice of grievance, **AAA/NAME** shall schedule a grievance review meeting. This meeting shall be scheduled within ten (10) days of the receipt of the grievance. The client and his/her representative (if any) shall be notified by mail of the date, time and location of the meeting. This notice shall contain the following additional information:

1. The name and phone number of the **AAA/NAME** staff member to contact for additional information about the contents of the notification letter.
2. Notification of the client’s right to continue receiving OPI service while he/she is awaiting the outcome of **AAA/NAME** grievance review.
3. Information on the client’s rights at the grievance review, including the right to representation and the right to have witnesses testify on his/her behalf.
4. Information on the client’s right to seek an administrative review by DHS of the outcome of **AAA/NAME**’s grievance review.

c. The grievance review meeting shall be held at the date, time and location specified in the grievance meeting notification letter. To assure impartiality, the review shall be conducted by a **AAA/NAME**’s Supervisor or Manager who does not directly supervise the **AAA/NAME** employee who routinely works with the aggrieved individual.

d. Within five (5) days of the conclusion of this meeting, the **AAA/NAME** Supervisor or Manager who conducted the meeting shall inform the client or representative, as appropriate, of a decision regarding this matter. This decision shall be binding unless the aggrieved client or his/her representative wishes to pursue this matter with the Oregon Department of Human Services (see A[e] below). Regardless of whether an administrative review with the Department of Human Services is pursued, if the decision of the grievance review meeting upholds **AAA/NAME**’s plan to reduce or terminate OPI services, these services shall be reduced or terminated immediately.
SAMPLE OPI GRIEVANCE PROCEDURE (cont.)

e. A client or his/her representative who wishes to request an administrative review hearing with the Oregon Department of Human Services may do so following the conclusion of AAA/NAME’s grievance review process. The hearing request should be sent to the Department of Human Services, Senior and People with Disabilities, State Unit on Aging, 676 Church St. NE, Salem, Oregon, 97301. A copy of the hearing request should also be sent to the Department’s Seniors and People with Disabilities office.
Section 4.1 Sample Notices

The pages that follow feature sample notices, also from LCOG, for those clients for whom services have been denied, reduced or terminated or who agree with the decision to reduce or terminate. These samples are to be used as a model only and can be adapted to your agency’s use.

SAMPLE NOTICE LETTER TO APPLICANT DENIED OPI SERVICE:

Date
Applicant’s Name and Address

On (insert date) you applied to Senior & Disabled Services, a division of Lane Council of Governments, for (insert name of service). I have determined that your request for service is denied for the following reasons: (insert reasons for denial, including reference to AAA/NAME policy, state or federal rule)

If you feel that this decision has been made in error, you may appeal this decision in one of the following ways:

1. Informal Approach (optional): You may contact me within ten (10) business days of the date of this notice. If you use this approach, within five business days of your call to me, I will schedule a meeting with you to discuss this decision and to try to resolve it in a way that is agreeable to both of us. (If you choose to use this approach, you will still be able to file a formal grievance under #2 below.)

2. Formal Approach: You may file a written grievance within ten (10) business days of the date of this notice. Your grievance is to be submitted to: AAA/NAME Director, 1025 Willamette St, #200, Eugene, OR 97401. If you use this approach, AAA/NAME will schedule a grievance review meeting within ten business days of receiving your grievance. You and your representative, if any, will be notified in writing of the date, time and location of this meeting. Your rights at this meeting will be set forth in the meeting notice.

If you have questions regarding this notice of service denial, please contact me.

Sincerely,

(Worker Name)    (Phone #)
SAMPLE OPI NOTICES

Sample Notice Letter to Client whose Service is to be Reduced or Terminated:

Date
Client’s Name and Address
You are currently receiving (insert name of service) from Senior & Disabled Services, a division of Lane Council of Governments. I have determined that your service will be: (check appropriate line)

  ____ Reduced from (current level of service) to (new level of service) on (date).

  ____ Terminated on (date).

The reason for this decision is as follows: (insert reason(s) for service reduction or termination, including reference to AAA/NAME policy, state or federal rule)

If you feel that this decision has been made in error, you may appeal this decision in one of the following ways:

1. Informal Approach (optional): You may contact me within ten (10) business days of the date of this notice. If you use this approach, within five business days of your call to me, I will schedule a meeting with you to discuss this decision and to try to resolve it in a way that is agreeable to both of us. (If you choose to use this approach, you will still be able to file a formal grievance under #2 below.)

2. Formal Approach: You may file a written grievance within ten (10) business days of the date of this notice. Your grievance is to be submitted to: AAA/NAME Director, 1025 Willamette St, #200, Eugene, OR 97401. If you use this approach, AAA/NAME will schedule a grievance review meeting within ten business days of receiving your grievance. You and your representative, if any, will be notified in writing of the date, time and location of this meeting. Your rights at this meeting will be set forth in the meeting notice.

If you grieve the decision to reduce or terminate your service, you will continue to receive this service until the outcome of your formal grievance is known.
If you have questions regarding this notice of service denial, please contact me.

Sincerely,

(Worker Name)              (Phone #)
SAMPLE OPI NOTICES

Sample Notice Letter to Client who Agrees with the Decision to be Reduce or Terminate Service:

Date
Name, Address

This is to confirm that you and I recently agreed that the (insert name of service) service which you are currently receiving from Senior & Disabled Services, a division of Lane Council of Governments, will be reduced or terminated, as follows: (check appropriate line)

___ Reduced from (current level of service) to (new level of service) on (date).
___ Terminated on (date).

The reason for this agreement is as follows: (insert reason(s) for service reduction or termination, including reference to AAA/NAME policy, state or federal rule). If you feel that this agreement was made in error, you may appeal this decision in one of the following ways:

1. Informal Approach (optional): You may contact me within ten (10) business days of the date of this notice. If you use this approach, within five business days of your call to me, I will schedule a meeting with you to discuss this decision and to try to resolve it in a way that is agreeable to both of us. (If you choose to use this approach, you will still be able to file a formal grievance under #2 below.)

2. Formal Approach: You may file a written grievance within ten (10) business days of the date of this notice. Your grievance is to be submitted to: AAA/NAME Director, 1025 Willamette St, #200, Eugene, OR 97401. If you use this approach, AAA/NAME will schedule a grievance review meeting within ten business days of receiving your grievance. You and your representative, if any, will be notified in writing of the date, time and location of this meeting. Your rights at this meeting will be set forth in the meeting notice.

If you grieve the agreement to reduce or terminate your service, you will continue to receive this service until the outcome of your formal grievance is known.

If you have questions regarding this notice of service denial, please contact me.

Sincerely,

(Worker Name) (Phone #)
Section 5  Home Care Workers

Ballot Measure 99, passed by Oregon voters in 2000 created the State of Oregon’s Home Care Commission (OHCC). The OHCC is required to ensure the quality of in-home care services. In order to do this OHCC provides for the following:

- Establishes qualifications for homecare workers (HCWs);
- Provides training opportunities for HCWs and for seniors and individuals with physical disabilities who employ HCWs;
- Establishes and maintains a registry of qualified HCWs to provide routine, emergency and respite referrals to individuals who employ HCWs; and
- Serves as the "employer of record" for purposes of collective bargaining for HCW who are paid from public funds.

Section 5.1  Registry Referral System

The OHCC Registry and Referral System (RRS) was developed in partnership with the Service Employees International Union (SEIU), Local 503, and the State of Oregon, Department of Human Services (DHS), through Seniors and People with Disabilities (SPD). The RRS is intended to provide employers with a list of HCWs who meet the Minimum Qualifications established by the HCC. It is a web-based system that provides:

- Employers, their representatives, and SPD and Area Agency on Aging and Disability (AAAD) staff with access to qualified HCWs;
- A list matching employers with qualified HCWs;
- Emergency and respite referrals; and
- Twenty-four hour online access.

In Oregon, nearly 11,000 individual HCWs provide in-home services to people receiving services paid with Medicaid or OPI funds. The HCW’s role is a crucial one, because in many instances, the employer’s quality of life diminishes without the services provided. Services which are commonly needed include assistance with Activities of Daily Living (ADLs), Self Management Tasks also known as Instrumental Activities of Daily Living (IADLs) and other Health-Related Procedures.
Section 5.2 Provider Pay System

Please refer to DHS Staff tools for additional information regarding the Provider pay system. Information in Section 5.2 (1-9) can be accessed on the Case Management Tools page under Support Staff Assistance Manual at: http://www.dhs.state.or.us/spd/tools/cm/index.htm

III.B Client Employed Provider Payment System 7/1/06

1. Overview

The Client Employed Provider (CEP) Payment System is a computer-based information system that allows for the issuance of vouchers and payment of vouchers enabling homecare workers (HCW) to be paid for the care they have provided to SPD clients. Access to the System is limited to authorized individuals in each local office, per DHS prescribed security policies. When Oregon ACCESS entry is completed for an OPI client a record is created on the DHS mainframe allowing for generation of a voucher once or twice a month, according to the wishes of the assigned Home Care Worker.

2. Frequently Used Computer Screens

PROVIDER NUMBER SCREENS

- SVDM - The voluntary union deduction menu accesses several screens related to union deductions, paid leave and health insurance
- SSNX,SOCIAL SECURITY NUMBER - Used to look up provider number by Social Security Number
- SPVF,SOCIAL SECURITY NUMBER - Used to look up provider by Social Security Number
- SPVF,PROVIDER NUMBER - Used to look up provider by provider number.
- SPVF,PROVIDER NAME - Used to look up provider by provider name.
OPI Program Manual 2008

- PRVX,LAST NAME,FIRST 3 INITIALS,Y,P - Used to search for a HCW’s provider number
- PRV8, PROVIDER NUMBER - Provider information detail

HOUSEKEEPER PAYMENT SCREENS

- HATH, PRIME #, PROVIDER NUMBER - Online entry of authorization to generate a voucher.
- HPAY, VOUCHER NUMBER - To pay a provider.
- HATH, VOUCHER NUMBER - To inquire about a particular voucher.
- HINV, P, PROVIDER NUMBER - History payment file for the provider.
- HINV, V, VOUCHER NUMBER - Information regarding a particular voucher.
- HINV, R, CASE NUMBER - All vouchers for a particular recipient.
- HINV - Displays basic voucher detail. To access, select voucher from HINV.
- HDTL - Displays service dates, hours, gross wages, mileage and deduction detail for the selected voucher. To access, [F10] from HINV.
- HSVC - Displays the summary of services and detail for each service. To access, [F10] from HINV or [F11] from HDTL.
- HRAT - Screen to calculate rates.
- HADV, VOUCHER NUMBER - Shows adjustments made to a voucher.
- HRSP, PROVIDER NUMBER - Respite hours earned for OC112 respite providers.

MISCELLANEOUS

- HFIQ, PROVIDER NUMBER - Tax information by quarter and year
- SLIA, P, Number - Shows if a provider has had recoupments, garnishments, etc.
- HRDY, BRANCH# - All vouchers paid for the day
- SVDM - Voluntary union deduction menu. Accesses several screens related to union deductions, 8 hour leave and health insurance
3. Application Process for Homecare Workers

Individuals seeking employment as a homecare worker complete the following forms:

- Home Care Worker Application Form (SDS 355)
- Employment Eligibility Verification (I-9), Section 1
- DHS Criminal History Request Form with instructions (DHS 301).

Local office staff complete the following procedure:

- Complete Section 2 of the I-9 and sign only after verifying the documents and copying them for the provider’s file. The following are acceptable verifications:
  - 1. Valid drivers license or Oregon I.D. card
  - 2. Social Security Card or birth certificate
    - Any other combination of identification listed in Section 2 of the I-9 form
- Review the SDS 303 for completeness.

- Request a criminal history check from the Provider Payment Unit by completing the DHS 301CP. Fax the form to the Criminal Records Unit.

- Local office reviews LEDS and makes a fitness determination.

- If only a provider number is necessary, request it from the Provider Payment Unit through Oregon ACCESS.

- Maintain provider files for each provider. At a minimum, the file should contain the I-9, DHS 301, SDS 736, driver's license and Social Security card.

Once the application process is complete, the provider may be added to Oregon ACCESS (worker must have the proper authority). See ACCESS on-line help titled "Maintain Provider".

4. Status Codes

There is an action request SPD-AR-03-044 that defines the status codes for providers used on PRV1. This action request should be reviewed by anyone working with homecare workers. The codes provide a better history and description of what is happening with a particular provider. Available status codes can be viewed by going into PRV1 and placing the cursor on the Status CD field on the lower left hand side of the screen and pressing [F1].
5. Set-up and maintenance of HCW Provider Files on Oregon ACCESS
Refer to the Oregon ACCESS Provider Guides for detailed instructions.

6. Data Entry of Vouchers
If payment requires an adjustment, a late payment or a recoupment contact the Provider Payment Unit using the CHX application or SYSM. For CHX instructions, see III.D.

7. Forced Vouchers
To issue a HCW payment voucher that exceeds the authorized hourly payment limit, contact the Provider Payment Unit of SPD using the CHX application. Staff from that unit will complete the data entry to issue the voucher. The voucher can then be paid by the local office for up to six months providing the information does not change. If changes are required, contact the Provider Payment Unit.

Edits that can be forced:

- **Hourly Wage Must Be Reviewed By (date)** - Up to (dollar amount) Hourly Without Approved Exception
- **Hourly Wage Not Minimum Wage** - OC112 Wage is Less Than Minimum
- **Hours Authorized Must Be Reviewed By** - Up to 400 Hours Per Client
- **Hours Over the Level 3 Maximum** - Up to 400 Hours Per Client
- **Recipient is on Review** - “R” Code on ELGR, Must Be Forced Every Time
- **Suspected Duplicate Voucher** - Service Date Overlap or Multiple Providers
- **Terminal Not in Originating Branch** - Branch Doing Entry is Not Where Client is On ELGR, or CAF Client
- **Voucher Past 12 Month Filing Limit** - Voucher is Over 1 Year Old
- **Wage Over Level 3 Maximum** - OK Up to Client’s Corresponding ALF Level

Normally edits about client file(s) cannot be forced; the file should be updated/corrected by case manager. Examples: No Valid Client Assessment record, Service Category not Found, Client on Long Term Care.
8. FICA Refunds

SPD withholds FICA tax which is a combination of both social security and medicare tax from the client employed provider's check. At the end of the year some individuals may receive a tax refund.

The FICA refund is based on the total gross wages earned by the provider in an entire year. If the provider earns less than the Federal Standard set by the IRS/SSA then the provider will be sent a FICA refund check along with an explanation. The refunds are mailed in early January.

When a provider receives a FICA refund their W-2 will show "0" under both the "Social Security Tax Withheld" and under "Medicare Tax Withheld" boxes.

If a check is undeliverable, it will be returned to the Provider Payment Unit. It can be released to the provider once a correct mailing address is obtained.

9. Unemployment Claims

Refer to SPD-PT-04-011 of March 10, 2004 or the Homecare Workers' Guide for information.
Section 6  

OPI and the Computer

The following is an abbreviated overview of some basic computer information that includes functions common to the OPI Case Manager. This is neither comprehensive training nor a complete overview but should provide general information to supplement formal training that can be supplied through the DHS Learning Center. DHS offers training in mainframe (Hummingbird) navigation and coding, and SPD offers Case Management Basics, Oregon ACCESS Basics and CAPS2.

Section 6.1  

Security

Information systems and security rights within the Department of Human Services (DHS) are an integral part of DHS daily activities. The confidentiality and integrity of information assets stored within those systems are to be protected so only authorized users have access to specified information assets.

AAA offices should use the OAA/OPI Identification & Individual User Profile Form to assign and/or alter security rights for employees. Each employee who works with OAA/OPI programs should be assigned security rights using this form, including AAA directors, case managers, supervisors, office managers, support staff/office assistants, and other OAA workers. This form should be completed by the program manager or supervisor, not by the employee themselves. The employee should sign the form as well as the manager authorizing security rights for the employee. Once the form is completed, fax or email to your sub-administrator; Sub-administrator will then review the security rights request and authorize appropriate rights. Type A AAAs will contact the sub-administrator the State Unit on Aging for security rights. Type B AAAs generally have sub-administrators designated locally. This form will need to be updated on a yearly basis per policy number AS-090-003.

Information, including security rights to information contained in Oregon Access and the Mainframe System, will be disclosed only to those people who have a legitimate business need for the information. Reasonable efforts will be made to limit the amount of information released to an employee of DHS or a AAA partner to the
minimum necessary to accomplish related work requirements. To help determine the specific work related need for information, the NAPIS/OPI RACF Identification Code & Oregon Access Security Clearance form has been updated to include the individual’s job title. This will assist sub-administrator in determining what types of rights are appropriate, given the individuals specific job duties.

Section 6.2 Introduction to Oregon ACCESS

Case management duties require the worker to master a number of different, sometimes disparate, functions and skills. While many workers are attracted to the social worker aspect of their position it is critical that mastery of the computer support systems is achieved, as well. The HELP screens in Oregon ACCESS are more up to date than ever and will provide invaluable information when the machine just doesn’t do what you want. Improved availability for classes and support at Central Office should ease the sense of being overwhelmed by the machine. Do not hesitate to call if you have questions.
Case Managers should be sufficiently familiar with Oregon Access to enter basic client information on the following data entry screens:

<table>
<thead>
<tr>
<th>Screen</th>
<th>Tabs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Case</td>
<td>Person, Address and Contacts</td>
</tr>
<tr>
<td>Financial</td>
<td>Income <em>(Note: do not change Financial or medical amounts if the client has an SPD eligibility worker attached to the case. By entering a different amount it may affect Food Stamps or QMB benefits. Instead, note in the narrative page the amounts you have been given and notify the eligibility worker of any discrepancy)</em></td>
</tr>
<tr>
<td>Medical</td>
<td>Health Insurance, Medical Services, Medical cost <em>(see note above)</em></td>
</tr>
<tr>
<td>Service Needs (Smiley Face)</td>
<td>OAA Sumry, (update NAPIS review date annually as you update the form)</td>
</tr>
<tr>
<td></td>
<td>Nutrition Risk</td>
</tr>
<tr>
<td></td>
<td>OAA Svc/FGCS – enter Authorized Units annually</td>
</tr>
<tr>
<td>Benefits</td>
<td>Case Overview: Assign Worker + OPI check + Svc PA + Date of Request</td>
</tr>
<tr>
<td></td>
<td>Service Tab: Service Request Date + WC Consent (354) + Case Action + Admin Rule (411-032) + OPI Fee + OPI Monthly %</td>
</tr>
<tr>
<td>CAPS/CAPS2</td>
<td>Assessment, Client Details, Service Plan</td>
</tr>
</tbody>
</table>
OPI Program Manual 2008

OPI Case Manager’s Oregon ACCESS Checklist

• Person Details
  □ Fill in as completely as possible

• OAA Sumry Tab
  □ NAPIS Info
  □ Last Review Date
  □ Months to review
  □ # in HH
  □ Income level
  □ Start date
  □ Race, Ethnicity

• OAA Svc Tab
  □ All services on Svc Plan
  □ Start Date

• Case Details
  □ Fill in as completely as possible
  □ Contacts and Roles

• Case Overview/Benefits
  □ Date of Request
  □ OPI Box Checked
  □ Assign Worker, Roles

• Service Tab
  □ Case Action
  □ Start Date
  □ OAR Citation
  □ Monthly Fee
Section 6.3 Remote ACCESS

Oregon ACCESS now includes procedures for using a laptop remotely in its HELP screens. Printable instructions have been included in the Addenda section of this manual, as well. Please note that at initial log-in some screens do not provide the option of Remote Access. To add “Remote Access (out of office)” to your default log-in screen, do the following:

Choose Select from the menu bar, choose Housekeeping, Show Connection screen. Vice-versa – deselect when “Consolidated Access (in office)” is the only choice you want presented on the screen.
Section 6.4  Reassigning A Caseload In Oregon Access:

The ability to reassign a caseload from one worker in your office to another is based on the worker assigned to the case. When setting up a case, resource assessment, or screening a worker needs to be assigned. If no worker is assigned, or it is the wrong worker, this function will not work for that case.

To Reassign your entire caseload, or part thereof, to another worker in your office you need to go through Select, Housekeeping, Reassign Caseload. You will need to do this from the Main Menu. (Please note that Security may be restricted and if you do not see the Reassign Caseload option you may need to check with your supervisor.)

When you are in the Reassign Caseload section of Oregon ACCESS there will be three tabs. Choose Case, RA, or Screening, whichever is applicable. Go into each tab separately to transfer all cases assigned to you.

The Reassign Caseload screen will give you fields to enter appropriate criteria to choose the part of the caseload you wish to transfer to another worker. It will default to you as the worker for the Reassign From and give you a drop-down list of the other staff in your office so you can choose the worker you need to Reassign To.

For a Case you will need to indicate which worker role(s) you represent in the cases you wish to reassign. You may choose ALL cases you are on, regardless of role, or you may choose a specific role by selecting a role from the Worker Role drop-down list. For example, if you are the eligibility and service worker, but you only want to reassign the eligibility part of the case, select eligibility from the Worker Role list and click the Show Selected Cases button. If you want to reassign all of your cases, click the Show All Cases button to bring up a list of all cases you are assigned to. You may then choose various other search criteria to choose what part of the caseload needs to be transferred.

After you have the list of appropriate cases, use the buttons at the bottom of the screen to select those you wish to reassign. If you only need to reassign 10 from the list, highlight those to be reassigned and click the Reassign button. If all are to be reassigned, click the Select All button, then the Reassign button.

For Resource Assessments and Screenings you will just need to identify the worker to whom you wish to transfer the cases to.

Once you have entered the appropriate worker and caseload criteria click on the Show Caseload button. This will bring up a list of your cases that meet the selection criteria. From this list you may select all by clicking on the Select All button (or by
individually clicking on the appropriate names from the list). If you click on a name you do not want you may click on it again to "deselect" it. If you have selected the entire list and this is incorrect you may click on the **Deselect All** button. When the cases in the list are Selected they will become "highlighted"; when Deselected the "highlighted" case(s) will no longer be highlighted. If the entire list is incorrect just change your selection criteria and click on the **Show Caseload** button again. This will bring up a new list.

Once the correct list has been selected you may print this list by clicking on the **Print** button at the bottom of the screen. To transfer this list to the selected worker click on the **Reassign** button at the bottom of the screen. *(If you want to Print the list be sure to do so prior to reassigning)*. These cases are now assigned to the new worker.

**Remember:** This functionality is only to be used when transferring caseloads in bulk. For example, this could be used when a new staff person is hired, when reorganizing, when adjusting caseloads, etc. If you are just giving a case to another worker do it as you do now by just assigning it to the other worker on the Case Overview screen of the case.
Section 6.5  Transferring a case to another branch office:

Select Transfer from menu row, select Transfer Out

8.3 Closing a Case
Section 7  OPI Reporting Requirements

National Aging Program Information System (NAPIS)

All OPI clients who receive any of the NAPIS registered services funded entirely or partially with OPI dollars must be registered in the Oregon ACCESS NAPIS system.

The registered NAPIS services are: Home Care, Personal Care, Chore, Adult Day Care, Home Delivered Meals, Case Management, Congregate Meals, Nutrition Counseling, or Assisted Transportation (Escort).

Client information is collected in the Oregon ACCESS NAPIS program through the OAA Sumry page. Authorized Units in any given service provide an unduplicated client count. When service units are recorded on this tab, a service unit computation is recorded in the NAPIS system.

If an Authorized Unit is not recorded on the OAA Sumry tab annually, you will be asked for an unduplicated client count in your caseload so that the annual report can be completed.

If Service units are not entered monthly in the OAA Sumry tab, you may be asked to provide the number of units of service you have provided to your clients.

(Note: A second option exists to manipulate units of service in the OAA Batch as long as an authorized unit of service has been approved on the OAA Sumry page – this action is generally performed by someone performing fiscal duties in each office. It is important that you familiarize yourself with local procedures for reporting this information.)

If the local AAA chooses not to track units of service by client through the Oregon ACCESS program, another system has to be in place in order to accurately track client counts and the units of service so they can be reported annually in the State Program (sometimes referred to as “RAIN”) report. At this time most units of service by client should be tracked through the Oregon ACCESS program.

When you do track units of service by clients in Oregon ACCESS, you can use the optional Client Billing Program to bill clients monthly for their percentage of the hourly rate for services.
Section 8  OPI and Your Area Plan

All OPI services shall be described in the Area Plan submitted every four years to the State Unit on Aging and updated annually. Please refer to your local Area Plan for questions about what services your office provides and the framework under which your local OPI program operates.