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**I.** **Statement of Purpose and Goal**

Information and Options Counseling is a service designed to link persons with resources available to meet their needs and/or interests.

The primary goal of the service is to provide a continuum of access services (information, assistance and options counseling) to facilitate informed decision-making about the range of long-term services and supports (LTSS) and serve a key role in the streamlined access to supports. Access to information and options counseling helps to prevent or delay premature institutionalization by offering options to help individuals spend resources wisely in the community.

Any references to the service name “Information and Assistance” within APA rules herein should be read as “Information and Options Counseling”.

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**II. Legal Base**

##### *Federal or State Statutory Requirement*

Older Americans Act of 1965 as Amended. 42 U.S.C. 3001, {Public Law

100-175, Section 321 (a)(1)}

<http://www.aoa.gov/aoaroot/aoa_programs/oaa/oaa_full.asp>

North Carolina G.S. 143B-181.1(c)

http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=143B-181.1

North Carolina G.S. 143B-181.1(a)(11)

http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=143B-181.1

# *B.* *Federal Regulation or State APA Rule*

 (none)

###### Division of Aging and Adult Services Administrative Requirement

 The above referenced legal bases also give the Division of Aging and Adult Services

 the authority to establish broad procedures that address the Administration of Aging

 services. These are covered in the **North Carolina Home and Community Care**

 **Block Grant Procedures Manual for Community Service Providers**. This

 document should be used routinely by providers in administering their programs for

 topics such as: Confidentiality Policies and Procedures, Applicant/Client Appeals,

 Reporting Requirements, Reimbursement Procedures, etc.

 Options Counseling is seen as a critical service. All programs receiving funding for

 Information and Assistance are required to offer Options Counseling. Any references

 to Information and Assistance within this document should be read to include

 Options Counseling.

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##### III. Definition of the Service

# *Federal or State Statutory Requirement*

Older Americans Act of 1965 as Amended. 42 U.S.C. 3001, {Public Law 100-175,

Section 102 (a) (28)}

<http://www.aoa.gov/aoaroot/aoa_programs/oaa/oaa_full.asp>

# *Federal Regulation or State APA Rule*

# NCAC 22L .0101 Definitions and Scope of Information and Assistance

(A) SCOPE

Information and Assistance is identified as a critical service which assists older adults, their families and others acting on behalf of older adults, in their efforts to acquire information about programs and services and to obtain appropriate services to meet their needs.

 (B) DEFINITIONS

The following definitions shall apply throughout this section:

1. "Agency" is any agency who receives Home and Community Care

 Block Grant Funds for the provision of Information and Assistance Services.

(2) “Information” includes informing people about programs and services,

 identifying the types of assistance they need and connecting them to

 appropriate service providers.

(3) “Assistance” is a more intensive service for those persons who require additional help with negotiating the service delivery system. Assistance includes the provision of planning, referral, coordination of services, follow-up and advocacy activities on behalf of the older adult or their family, or both, in an effort to ensure that needed assistance is received and that the assistance provided meets identified needs. Assistance may also include a home visit to more clearly identify a client’s needs for the purpose of initiating the development of a care plan.

###### Division of Aging and Adult Services Administrative Requirement

Definition of Options Counseling

Options Counseling is seen as a critical service. All programs receiving funding for Information and Assistance are required to offer Options Counseling. Any references to Information and Assistance within this document should be read to include Options Counseling.

Options Counseling is an interactive process where individuals receive guidance as they make informed choices about long-term services and supports. The process is directed by the individual or person acting on behalf of the individual but may include others the individual chooses to be present for the discussions. Regardless of representation, the individual to be served through Options Counseling shall be involved in the process to the greatest extent possible. Options Counseling includes the following steps:

(1) conduct a personal interview to discover strengths, values, and

 preferences of the individual and screen for eligibility for private pay and

 publicly funded programs;

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(2) facilitate the decision-support process which explores resources and

 service options, and support the individual in weighing pros and cons;

(3) develop an Action Plan, unless the individual elects not to create a plan, and provide assistance in applying for and accessing support options when requested;

(4) provide quality assurance and follow-up to ensure that decisions and

 supports are working for the individual.

1. *Practice Guidance*

Information, Assistance & Options Counseling are seen as single components of the continuum of access services. For a person needing services, the specific service to be provided may not be immediately clear. The agency may initially provide “Information” and through conversations with the individual, realize that the person could also benefit from “Assistance” or “Options Counseling”. The service is meant to have this kind of flexibility to meet the needs of the individual. The expectation is that the agency staff receiving the contact should use a person-centered approach to make sure the individual’s needs have been fully addressed.

Using person-centered concepts (what is “important to” and “important for” an individual) throughout the process, adopting a holistic approach, and empowering individuals needing services and supports to self-advocate, are basic tenets of Options Counseling.

1. *Suggestions for Excellence (or QI)*

(none)

##### Page 6

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##### IV. Client Eligibility and Target Population

# *Federal or State Statutory Requirement*

[OAA, Sec. 102 (Definitions), (35)]

The term “older individual” means a person who is 60 years of age or older.

# *Federal Regulation or State APA Rule*

NCAC 22L .0201 Eligibility for Information and Assistance

Those eligible for Information and Assistance services are persons 60 years of age and older or persons acting on behalf of persons age 60 and older and who are in need of information or services.

## *Division of Aging and Adult Services Administrative Requirement*

This service shall be available to persons of all incomes and assets.

1. *Practice Guidance*

Often the provider of Information and/or Assistance has no way of knowing the age of the person needing help unless and until full documentation is pursued. Providers do not need to learn the person’s age until it becomes relevant for the longer-term services or opportunities he/she is seeking. However, obtaining age (and income) information is often critical to making a good referral. If the person is under 60, he/she should be given the needed information and be referred (including assistance with referral) to the agency or organization that can provide additional service. He/she should also be informed if age is a criteria for any of the services he/she is interested in receiving in order to avoid inappropriate referrals.

Options Counseling is a more intensive service requiring greater commitment of staff time. The provider agency may choose to target this service to particular groups. In particular, the service is recommended for individuals whose changing health, support system, or life circumstances place them at increased risk for institutionalization. The service is also very appropriate for people who are transitioning from hospital and institutional settings back to community settings.

Options Counseling can also be offered to caregivers who meet client eligibility per NCAC 22L .0201 to assist them in making choices about the level of care they can offer, finding support for their caregiving efforts, and communicating with the care recipient. In this situation, the person-centered, decision-support process is focused on the caregiver’s needs. A separate Options Counseling process may take place with a focus on the care recipient’s needs. These would be documented as two separate Options Counseling events.

1. *Suggestions for Excellence (or QI)*

 (none)

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# V. Marketing and Service Promotion

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

(none)

## *Division of Aging and Adult Services Administrative Requirement*

Implementing a variety of methods, the agency must promote the Information & Options Counseling service to individuals, service providers, community groups, employers, and public officials to create awareness about and promote appropriate utilization of the service.

1. *Practice Guidance*

Agencies are encouraged to develop a written marketing plan to promote awareness of the service with a priority given to people experiencing care transition or those at high risk of institutionalization.

 An agency is encouraged to consider offering and publicizing a variety of methods for accessing the service, such as:

1. Availability by telephone, with the number listed in all appropriate directories and publications
2. Walk-in consultation, also advertised appropriately
3. Developing a Resource Directory (or making an existing one available) to community professionals, families, and seniors
4. Internet/e-mail connection so that consumer questions can be handled directly
5. Intermittent, scheduled and advertised community meetings/forums to provide basic information, to respond to questions, and to make the Information and Options Counseling service as accessible as possible.
6. Participate in a statewide human service resource database, if available.

*E. Suggestions for Excellence (or QI)*

1. Use staff to distribute appropriate aging literature and service information at appropriate sites; to make presentations for community groups or for other providers.
2. Develop a Speakers’ Bureau on aging and disability-related issues and services and coordinate community requests for resource persons.
3. Create a web site, with answers to frequently asked questions available; or automated resource directory.
4. Offer materials in alternate formats and language(s), and/or provide access to interpreters for individuals who have Limited English Proficiency, hearing loss, limited literacy or other communication barriers.

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##### VI. Service Provision

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

 NCAC 22L .0102 Service Provision

Any agency offering Information and Assistance shall have the capacity and capability to provide all of the following functions:

1. Assess/Evaluate: Determine the immediate problem or concern of the individual; probe for other problems or concerns.
2. Inform: Provide individuals with information related to the assessed problems or concerns on services and opportunities available within the community.
3. Refer: Link the individual with the service or provide information on how to access or connect with available services.
4. Research: Locate information requested, but not immediately available, relevant to meeting the individual’s needs.
5. Plan: Assist individual in identifying the desired outcome(s) and method(s) for obtaining what the individual needs.
6. Coordinate: Directly connect the individual to the service desired; monitor on a short-term basis the person’s success in making the connection to needed services.
7. Follow-up: Re-contact the individual or service provider to determine the outcome of the situation and provide additional services if requested.
8. Advocate: Intervene on behalf of an individual or a group of individuals in an effort to obtain a positive change in the availability or delivery of one or more essential services.

## *Division of Aging and Adult Services Administrative Requirement*

By including “Information", “Assistance” and “Options Counseling” in the same service, all components must be made available by the agency in order to be funded for the service.

Each agency shall implement a process for receiving initial inquiries related to Options Counseling. All agencies must have the capacity to meet with individuals in a confidential setting.

Every attempt shall be made to deliver Options Counseling in the setting and by the method desired by the individual. Settings and methods of service delivery may include:

1. individual’s place of residence;
2. nursing home, hospital, or rehabilitation center;
3. office or satellite office;
4. phone;
5. e-mail;
6. video conferencing technology or other electronic method.

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Options Counseling components shall include:

1. a personal Interview to learn the individual’s values, strengths, preferences, concerns, and available resources for long-term services and supports. Accommodation shall be made for language and disability needs.
2. the decision-support process that assists the individual in evaluating various pathways, including the pros/cons of specific choices,
3. a written action plan unless the individual elects not to create the plan. Any decision not to develop a plan must be documented in the individual’s record, and
4. follow-up shall be provided and documented.

Options Counselors shall determine the capacity of the individual to 1) understand the information and 2) self-advocate.

Agencies providing Information and Options Counseling shall insure that Options Counselors disclose in writing and oral discussion with the individual any personal or professional financial interests or organizational bias that might influence the services being considered during the decision-support process. A copy of the disclosure shall be maintained within the individual’s record.

1. *Practice Guidance*
2. Providing Information

Information requested can range from specific information about a service to a broad interest in the types of service or recreational opportunities that exist in the area. Requests can be focused on a specific family member, neighbor or friend or be a general concern about older adults in the community. The provider should be flexible in receiving the request and be able to think both broadly and specifically in response.

Responses to requests can range from limited information (such as an organization’s name, address and phone number) to detailed data about the community service system (such as explaining how the intake system works for a particular agency, or the specific eligibility requirements for a service).

Many callers or visitors requesting information are quite capable of following through and securing desired services on their own. In working with these individuals, the primary responsibilities of the provider staff include:

1. Listening to and sorting out brief or uncomplicated requests.
2. Using resources to overcome communication barriers (physical, language, cultural).
3. Discreetly probing to find out if the inquirer has stated his/her information needs completely. This could include exploring the problem or need he/she is experiencing. See Appendix 2 for sample Intake tools.
4. Identifying and referring more complicated or longer-term requests/needs to staff skilled in Assistance or Options Counseling.
5. Giving accurate and pertinent information to meet these needs, using the resource file effectively.
6. Offering to make referrals if assistance is needed (transition to Assistance or Options Counseling).

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1. Encouraging the inquirer to call back if the information proves incorrect, inappropriate, or insufficient to link with the needed services.
2. Maintaining confidentiality of persons requesting information.
3. Collecting and documenting information needed for the Information Log; tabulating statistical information from the Log. See Appendix 1 for sample Information Log.

2. Providing Assistance and/or Options Counseling

Some callers or visitors need more help than just Information, as described above. These situations generally require more time and skill than straight information requests. In agencies where there is a division of responsibilities, these requests would be handled by or referred to a person with the appropriate skills. In agencies where this is not possible, assigned staff needs to be prepared to do both. Staff will need to distinguish between people needing Assistance and those needing Options Counseling based on the needs or desires of the person. Assistance and/or Options Counseling are meant to be “fluid” services that respond to the specific needs of the individual. Some individuals may need both services at different times.

**Assistance** typically responds to immediate, but complex need(s), often where the individual is unable to access services independently. By contrast, **Options Counseling** is a broader, more comprehensive approach to planning for long-term services and supports in which the individual (and/or informal support) takes the lead in carrying out their personalized Action Plan. Typically, the Options Counseling process takes 30 – 90 days. Options Counseling would typically not be indicated where immediate crisis management is needed. Options Counselors are encouraged to have at least one in-person meeting because it helps establish rapport and trust. It can provide a more complete picture of the individual and his/her situation. However, when there is a major disaster declaration or state of emergency such as a pandemic or hurricane, this guidance may not be applicable.

Both Assistanceand Options Counseling include, but are not limited to, the following activities:

1. Conducting a personal interview to learn about the person’s preferences, needs, values and concerns.
2. Carrying out a screening or more in-depth assessment of difficult or multiple problems or longer-term needs.
3. Connecting with other persons or service providers to gain insight into the situation (with the permission of the individual).
4. Researching requests for information not immediately available.
5. Providing appropriate options for the resolution of problems.
6. Developing mutually agreed upon Action Plans with the person(s) involved, unless declined by the individual. See Appendix 7 for sample Action Plan form.
7. Assisting persons in approaching or connecting with resources, as necessary.
8. Providing direct assistance in referring or connecting to other service providers for agreed upon options. See Appendix 3B for sample Consent forms.
9. Following up with the individual and/or service provider to make sure the appropriate connections have been made; making additional efforts to obtain services when first efforts have not worked out.

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1. Maintaining confidential, accurate and up-to-date client records. See all sample tools in Appendix 3.

Specific features of Options Counseling include:

a. A focus on long-term planning, using an interactive, decision-support process to weigh the pros and cons of options. The decision-support process is the component that distinguishes Options Counseling from Assistance.

1. In-depth exploration of private and informal resources.
2. The individual or person acting on behalf of the individual takes the lead in creating and carrying out the Action Plan.
3. Follow-up takes place at an agreed upon time with the individual, typically within 1 month but no longer than 3 months after creation of the Action Plan.

See Appendix 10 for further clarification of screening process

As a reminder:

When an individual and the Options Counselor communicate via email, reasonable safeguards should be used such as never sending highly confidential or sensitive information. The Options Counselor should use professional judgement about whether another form of communication is more appropriate.

When using email, it is recommended that the Options Counselor include the following points in the initial email to the individual and get consent before sharing additional information.

* This agency’s email system is not encrypted, and therefore the information is not secured when sent via email. (Delete this point if it is not applicable)
* Due to the risk that electronic messages can be misdirected or intercepted by unintended parties, this agency cannot and does not guarantee the confidentiality of messages sent over the Internet.
* If you share an email account with family members, others may access your information.
* If you use your employer’s email system, you should determine the security/ownership/privacy policy at your workplace. Your employer may have a legal right to your email.
* Do not use email for discussion of sensitive or highly confidential issues.
* Please notify me, via email, if your email address changes.

3. Individual Closure/Discharge

Staff should recognize when the needs of the individual/family have gone beyond the intent and capacity of the Information and Options Counseling service. If the individual/family is capable of pursuing their own resources, they should be empowered with information and encouragement to do so. When the identified needs indicate the provision of a specific or primary service, the individual should be referred to that service program (either within the same agency or to another community agency) as quickly as possible. If the individual needs long-term coordination of services, he/she should be offered Care Management (or a similar service), if available. If the individual’s needs cannot be met with private, informal or existing community resources, he/she should be informed, and the Information and Options Counseling process ends (with the individual given the option to re-contact for other needs).

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4. Advocacy

All advocacy efforts should include, to the extent possible, the involvement of those individuals and/or groups concerned with the need or issue.

a. The first effort should be to empower persons to self-advocate.

b. Advocacy on behalf of individuals when they cannot represent themselves

 effectively in order to assist in: establishing eligibility for service, obtaining a

 needed service or retaining a needed service when problems have arisen.

c. Group advocacy includes actions on behalf of a group of persons to seek a

 change in the availability of certain essential services or in the method of delivery of these services. It can also include encouragement to agencies or others when the services they offer or their interactions with clients have been received positively.

*E. Suggestions for Excellence (or QI)*

1. Conduct assessments in the home setting, as needed, to understand the situation and offer assistance acceptable to the individual/family.
2. Provide services similar to Information and Options Counseling under a variety of funding arrangements to meet the special needs of the community.
3. Develop and implement follow-up procedures.
4. Measure the quality of information provided. For example, do follow-up calls or a survey asking about:
5. appropriateness of referrals,
6. promptness of receipt of information,
7. currency and accurateness of information, and
8. whether expectations for the service were met.
9. Where a CRC exists, participate as a collaborating partner. If no CRC exists, coordinate with service providers to use standardized tools (e.g., assessment), forms, and computer programs to make information easily transferable.
10. Develop a complaint procedure for unsatisfied callers/individuals.

7. Make staff and the community aware of current issues, concerns and events that

 would affect older adults and persons who have disabilities. Page 13

##### VII. Community Partnerships and Service Coordination

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

(none)

## *Division of Aging and Adult Services Administrative Requirement*

1. Cooperative working relationships with key service provider agencies serving older adults must be established and maintained.
2. Activities on behalf of individuals must show efforts to coordinate services with provider agencies.
3. Educational opportunities shall be provided to staff of community partners who might make referrals for Options Counseling. Education shall include defining the Options Counseling service, recognizing when an individual might utilize Options Counseling, and how to make appropriate referrals. Documentation of education provided shall be on file.
4. *Practice Guidance*

Having key informal and workable personal linkages between agencies is critical to any system. Information and Options Counseling staff needs to initiate interactions with key community service providers to older adults in order to familiarize providers with information, assistance and options counseling services, including what these services are, when it is appropriate to make a referral and the referral process.

It is also important to establish and maintain formal and informal cooperative arrangements with other information service providers to improve service delivery and minimize duplication. Information and Options Counseling staff are encouraged to initiate meetings or less formal interactions with all other agencies or organizations that provide information, assistance, and options counseling in order to:

1. sort out primary target populations each serves,
2. identify areas of strength and expertise,
3. identify areas where cross referrals are needed to deal with specific situations, and
4. develop technical and personal strategies for information sharing re: resources.

Activities that promote community partnerships and service coordination among community providers include:

1. Staff visitation to provider agencies.
2. In-service sessions with community providers on a regular basis.
3. Participation in community networking opportunities (health fairs, information

fairs, focus groups, etc.).

1. Information sharing/work sessions with providers interested in aging issues.
2. Initiation of joint activities to expand existing services or advocate for new services on behalf of clients.

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1. *Suggestions for Excellence (or QI)*

 Initiation of written interagency working agreements with service providers which

 define:

1. responsibilities of each party,
2. how content of the agreement will be communicated at all levels of agencies,
3. method for evaluating the effectiveness of the agreement, and
4. annual review /modification of the agreement.

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##### VIII. Resource File Development and Maintenance

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

 NCAC 22L .0202 Resource File

The agency providing Information and Assistance shall develop, maintain, and use an accurate, up-to-date resource file that contains information on available community resources. The Information and Assistance provider shall update the resource file annually.

1. A profile shall be developed on each service organization and agency that shall include, but is not limited to: the legal name, common name, or acronym; address; telephone number; hours and days of service; services provided; area served; branch offices; known barriers to accessibility and restrictions on facility use.
2. The resource file shall be accessible to all staff providing Information and Assistance.

## *Division of Aging and Adult Services Administrative Requirement*

The resource file shall include both public and private resources.

Options Counselors shall have access to the resource file.

1. *Practice Guidance*
2. All staff providing the service should have Internet and e-mail easily available.
3. The resource file should be set up to accept additional information, such as the

 following fields:

* Directions to physical location
* E-mail address
* FAX number
* Eligibility requirements
* Intake procedure
* Cost of service(s)
* Funding used or accepted
* Acceptable payment
* Contact person
* Web address

3. The resource file should be maintained and updated on a regular basis (at a

 minimum annually).

*E. Suggestions for Excellence (or QI)*

1. Information and Options Counseling providers are encouraged to acquire and make use of available statewide, automated systems that will assist them in developing, maintaining, and using the resource file. The system to maintain the resource file should include:
* Keyword and taxonomy search capabilities
* All items in Practice Guidance

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1. The Information and Options Counseling service and/or its provider agencies should put community resource information on their website and keep it updated.
2. Develop and implement a protocol for assuring the quality of the information in the resource data base. Measurements could address the extent to which the data is:
* current
* complete
* comprehensive

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## IX. Service Documentation

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

#  NCAC 22L .0204 Documentation

1. Each agency providing Information and Assistance shall maintain a daily log or tracking system indicating contacts made during the course of the day.
2. For those persons who receive Information and Assistance, as defined in 10 NCAC 22L. 0101, the log shall include the date, nature of theconcern and action taken.
3. For those persons who receive Assistance, as defined in 10 NCAC 22L .0101, a client record or file shall be maintained by the agency and shall include: client identification information; identification of client needs; a client plan showing anticipated outcomes and methods to be used and action taken or agencies to whom the client was referred and dates; necessary coordination of services; and follow-up contacts made to or on behalf of the client and the dates.
4. The provider agency shall have written procedures in place to keep client information confidential. (Refer to the **NC Home and Community Care Block Grant Procedures Manual for Community Service Providers**,Section 6, Confidentiality Policies and Procedures.)

## *Division of Aging and Adult Services Administrative Requirement*

Documenting Options Counseling

Agencies shall maintain a system to document individual Options Counseling contacts. Documentation may be in a paper and/or electronic format.

Documentation shall include at a minimum:

 1) name of individual(s) receiving Options Counseling;

 2) contact setting and/or method;

 3) a summary of each contact that includes a clear picture of the individual’s

 situation, what was discussed, and what was decided. At some point within the

 entire body of documented contacts the following are addressed:

1. the individual’s preferences and needs with ongoing notation on how they are addressed;
2. options/information discussed, and
3. options selected

 4) date, time spent with or on behalf of the individual;

 5) counselor’s initials or signature and date;

 6) a summary, or electronic attachment, or a written copy of the Action Plan

 (Appendix 7 - sample Action Plan) resulting from the contact(s), that identifies

 and weighs options and available resources or a notation that the individual

 declined to develop an Action Plan; and

 7) a record of follow-up activities, unless declined by the individual. Follow-up

 documentation shall include:

1. an outline of the individual’s current situation
2. outcomes since last contact
3. whether steps in the Action Plan occurred, if not, why
4. any next steps needed; and

 8) a notation and date when Options Counseling ends.

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At a minimum, the Action Plan shall include the following components:

1. identification of specific needs;
2. clear outline of action steps;
3. responsible party designated for each action step and target date set;
4. potential resources are identified and listed;
5. identification of any unresolved issues;
6. designation of an agreed upon date for follow-up by the Options Counselor;
7. counselor contact information; and
8. date of plan

The Options Counselor shall give the individual a copy of the Action Plan upon its completion unless the individual declines to develop a plan.

1. *Practice Guidance*

1. Documenting Information

Most information contacts are brief; the individual’s needs can be immediately satisfied, and the required data entered on the log. However the provider agency may wish to document and maintain more information than that entered on the log, if the agency will potentially need it later (e.g., if a follow-up contact will be made with the caller or the agency anticipates further requests from this person). Appendix 1 provides an example for keeping basic log data. The tools in Appendix 2 can be used to record more extensive intake data.

### 2. Documenting Assistance and/or Options Counseling

Individuals needing Assistance and/or Options Counseling usually share more information and often need follow-up contacts. Therefore, it makes sense, both in serving the individual and in tracking community service needs, to keep more complete information. The agency may choose to use already developed

tools, such as the examples in Appendices 3A, 3C, 4, and 7; or the agency may develop its own instrument(s) to capture the required data and other desired information. If an agency develops its own forms, those forms must include all required documentation elements.

*E. Suggestions for Excellence (or QI)*

1. The provider has developed and carried out a system for tallying the type and number of service requests made (met and unmet). Types of information gathered may include:
2. contacts by type (consumer, caregiver, professional, agency)
3. reason for contact
4. whether need is met or not.

2. The Information and Options Counseling agency routinely reviews and evaluates:

a. the services/opportunities available in the community

b. individual needs in comparison to services/opportunities

c. service utilization.

3. The Information and Options Counseling agency develops and distributes reports

 to local and other appropriate decision makers on:

 a. services/opportunities currently available

b. potential service needs

c. service usage

d. unmet needs.

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## X. Reporting and Reimbursement

# *Federal or State Statutory Requirement*

(none)

# *Federal Regulation or State APA Rule*

(none)

## *Division of Aging and Adult Services Administrative Requirement*

1) Reporting

Information and Assistance Reporting

At the end of the month the provider must total the number of duplicated Information and Assistance contacts and enter the total into the ARMS System (see ARMS reporting instructions). This must be taken from the individual tracking system or call log (see sample in Appendix 1).

This reporting system will be used for all individuals receiving Information and Assistance even though more extensive or individual specific information may be documented locally.

Options Counseling Reporting

All providers shall register individuals receiving Options Counseling using the DAAS 101 Client Registration Form and enter 1 unit per client for each month, regardless of the method (email, telephone, face-to-face) or number of contacts during the month Options Counseling service is provided.

#### 2) Reimbursement

Reimbursement for Information and Options Counseling is not unit based.

 Specific procedures for reporting client data and service reimbursement information

 are outlined in the Division of Aging and Adult Services’ Home and Community Care

 Block Grant Procedures Manual for Community Service Providers.

 <http://www.ncdhhs.gov/aging/manual/hccbg/bgmanual.htm>

1. *Practice Guidance*

1. Definition of a Contact

Information and Options Counseling contacts refer to individual one-on-one contacts between a service provider and a client or someone on their behalf. Follow-up calls may be counted as contacts. An activity that involves a contact with several clients or potential clients (group activities) should not be counted as a contact of Information and Options Counseling. Hang up calls, wrong numbers, and calls made to other agencies should not be counted as a "contact" for reporting purposes.

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**XI. Options Counseling Certification and Recertification**

* 1. *Federal or State Statutory Requirement*

(none)

#  *Federal Regulation or State APA Rule*

(none)

## *C.*  *Division of Aging and Adult Services Administrative Requirement*

 Certification

The certification process is as follows:

a**.** Individuals who meet the criteria outlined in XII, Staff Competence and

 Supervision, shall complete an Initial Application for Options Counseling

 Certification.

b**.** An applicant who is an Executive Director of an organization shall provide a letter

 from a Board member that addresses:

 1) the individual’s suitability as an applicant for Options Counseling

 certification,

 2) the agency’s commitment to provide Options Counseling as

 outlined in these standards, and

 3) the supervisor’s commitment to participate in Options Counseling

 Concepts and Standards training.

c. The applicant and his/her supervisor shall read the Information and Options

Counseling Standards prior to submission of the initial application. If the applicant is an Executive Director, a copy of the Information and Options Counseling Standards shall be provided to his/her Board of Directors.

d. The initial application (See Appendix 8) shall be submitted to the Division of Aging

 and Adult Services’ (DAAS) Options Counseling Coordinator and reviewed by the

 Coordinator.

 e**.** For approved applications, an email shall be generated by *The Middle Space*, a

 Learning Management System (LMS), and sent to the individual with all training

 information and instructions. Applicants not meeting criteria shall receive written

notification.

 f. Completion date of initial certification training shall be six months from the date of

 receiving the email. Should all required training not be completed within the six

 month period, the applicant may make a written request to the DAAS Options

 Counseling Coordinator to extend the deadline. This request shall be submitted at

 least 30 days prior to the end of the six-month period. The amount of time

 approved for an extension shall be based upon the circumstance for making the

 request and the amount of work to be completed. Maximum extension of the

 deadline is an additional six months.

 g. Upon successful completion of all required training components, the LMS shall

 generate and send a “notification of training completion” email to the applicant and

 to the DAAS Options Counseling Coordinator.

h. Upon receipt of the “notification of training completion” by the DAAS Options

 Counseling Coordinator, a certificate shall be awarded to the individual that ~~is~~ valid

 for two years provided that the individual is affiliated with a CRC, a AAA or other

 agency as designated by the Division of Aging and Adult Services.

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i. The Options Counselor and/or agency shall notify the DAAS Options

 Counseling Coordinator within 30 days of any change in employment and/or

 contact information, or if the individual chooses to relinquish certification.

 Recertification

a. To maintain certification, Options Counselors, prior to certification expiration date

 shall:

1. conduct Options Counseling within the two-year certification period as evidenced

 on the annual Documentation Checklist.

2. complete 20 hours of ongoing training related to Options Counseling during the

 two-year certification period. A maximum of 10 Senior Health Insurance Information Program (SHIIP) quarterly meeting hours can be counted toward meeting the 20-hours of ongoing training. (see Guidance for other training topic examples).

 3. complete any required training that has been added or updated since the

 individual’s prior certification.

 4. submit the recertification form (See Appendix 9), validation of the 20 hours of

 ongoing training and completed annual Documentation Checklists (See Appendix 13) (one for each year of the two-year certification period) to the DAAS Options Counseling Coordinator.

 Submitted documentation shall be reviewed and if approved, a new two-year

certificate shall be awarded to the Options Counselor.

b. An individual seeking recertification following the lapse of Options Counseling

 certification shall complete the respective requirements based upon the following

 lapsed time periods:

**Less than one year:**

1) Complete 20 hours of continuing education for the most recent two-year

 certification period plus one additional hour of continuing education for each month

 beyond the expired certification period.

2) Complete any required training that has been added or updated since the

 individual’s prior certification.

3) Conduct Options Counseling during the most recent two-year certification period.

4) Submit the recertification form (See Appendix 9), validation of all continuing education training, completed annual Documentation Checklists (See Appendix 13) (one for each year of the two-year certification period) to the DAAS Options Counseling Coordinator.

**More than one year:**

Apply for a new certification (See Appendix 11), complete the online training and any required training that has been added or updated

*D. Practice Guidance*

 1. Executive Director certified as an Option Counselor

 a. An Executive Director is in a unique position by reporting to a Board of Directors

 rather than a supervisor. A letter from a Board member submitted with the Initial

 Application for Certification will suffice in lieu of signature on Initial and

Page 22

Recertification applications.

b. Providing a copy of the Standards to the Board of Directors insures an

 opportunity for the Board to review them and allows for full disclosure of Options

 Counseling and its service delivery.

2. Training topic areas for on-going training:

 Examples include:

1. Issues related to aging and disabilities
2. Options Counseling philosophy and protocols
3. Person-centered planning
4. SHIIP quarterly updates
5. Ethics
6. End of Life
7. Communication skills

Acceptable forms of training validation include a certificate, note of verification from instructor, or a copy of training registration and agenda with supervisor’s signature.

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## XII. Staff Competence and Supervision

# *Federal or State Statutory Requirement*

 (none)

# *Federal Regulation or State APA Rule*

 NCAC 22L .0203 Staff Competence

The agency providing Information and Assistance shall make orientation and training available to paid and volunteer staff.

 (1) Staff shall participate in an orientation program which, at a minimum, reviews

 the role, purpose, and function of Information and Assistance; the role of the

 agency; and the administrative structure and policies for providing the service.

 (2) Agencies shall also provide education and to enable staff to perform the

 functions defined in 10 NCAC 22L. 0102. At a minimum, this shall include the

 development of interviewing techniques and communication skills.

## *Division of Aging and Adult Services Administrative Requirement*

1. Agencies shall create staffing and supervision/managerial structures to support a

 seamless Information, Assistance and Options Counseling process.

 a. The provider must have the full-time, part-time and/or volunteer staff to

 provide Information, Assistance, and Options Counseling promptly and

 completely.

* Each agency must have at least one certified Options Counselor.
* If an agency loses its capacity to provide Options Counseling, it must identify a candidate for Options Counseling certification and begin certification training within six months of the vacancy.

. The provider agency must have office space, phone, and record

 keeping/reporting systems to support provision of the service.

c. Staff providing the service shall receive at least 10 annual training hours that

 focus on acquiring knowledge or building skills related to any aspect of the

 service.

1. Staff, whether paid or volunteer, shall receive comparable training and

supervision and have the same degree of competence, based on the tasks assigned and performed.

1. Requirements specific to Options Counseling

a. Options Counselors shall have a:

* BSW with 2 years’ work-related experience or
* MSW with 1-year work-related experience or
* bachelor’s degree in a relevant Human Services field with 3 years’ experience in providing support to individuals needing Long Term Services and Supports (LTSS) or
* master’s degree in a relevant Human Services field with 2 years’ experience in providing support to individuals needing LTSS or
* bachelor’s or master’s degree in a non-Human Services field with 4 years

 experience in providing support to individuals needing LTSS

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An individual who does not meet the above education and/or work experience

criteria can request a waiver.

The process for making the request is as follows:

Submit to the Area Agency on Aging (AAA):

* a letter from the applicant requesting a waiver to the above education and/or experience requirements that offers rationale and justification for the request. Supporting documentation may be attached to the letter.
* a letter of recommendation from the applicant’s supervisor that addresses the individual’s suitability for Options Counseling certification.
* a completed Options Counseling Initial Application for Certification

The Area Agency on Aging reviews the waiver documentation and informs the individual of the decision. Waivers shall be considered on a case-by-case basis.

* If the waiver is approved, the AAA shall forward all the documentation to

 the DAAS Options Counseling Coordinator for final review and

 approval or denial of the initial application (as outlined in Section XI

 Certification and Recertification).

* If the waiver request is for a staff member of the AAA, then the request

 shall be sent directly to the DAAS Options Counseling Coordinator.

* If the waiver is denied, the decision is final and includes a letter to the

 applicant outlining the reason(s) for denial. Should the circumstance

 change for the applicant, he/she may reapply.

b. Applicants pursuing Options Counseling certification shall successfully

 complete training and other requirements as listed below

* Options Counseling Concepts and Standards (on-line)
* Person-centered Thinking
* Senior Health Insurance Information Program (SHIIP) online training plus ongoing participation in SHIIP quarterly update meetings
* Options Counseling On-line training that includes:
	+ Interviewing Skills
	+ Resource Basics
	+ Health Literacy and Cultural Competency
* Disability Rights and Systems Advocacy
* Medicaid webinars that include:
	+ Medicaid Foundations: What You Need to Know
	+ Medicaid for Long Term Services and Supports

 c. Supervisors of Options Counselors shall:

* complete the Options Counseling Concepts and Standards training. This training must be completed before an Options Counselor can receive his/her certificate;
* complete any required supervisor training that is added or updated;
* be responsible for recommending individuals for initial certification training and recertification based on ongoing evaluation of Options Counselor’s qualifications and skills);
* keep a copy of each Options Counselor’s certificate on file;

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* review, at least annually, a maximum of five Options Counseling client records. If there are fewer than five records, the supervisor shall review all;
* use the required Documentation Checklist (See Appendix 13) to review Options Counseling records.
* submit copies of the completed annual Documentation Checklists (one for each year of the two-year certification period) with the Options Counselor’s recertification packet.
1. *Practice Guidance*

 1. General considerations in providing Information, Assistance and Options

 Counseling

a. Agency leadership should determine what staffing structure will work best

 based upon their agency and organizational capacity.

b. Rapport-building is a critical component of Information, Assistance and

 Options Counseling. For individuals who receive Options Counseling, it is

 preferable that Options Counseling is provided by one Counselor who

 supports the individual through the entire decision-making process and follows

 up with the individual to see what decisions are working.

c. Orientation to the service and basic skills should be provided by agency staff

 (or other appropriate resources when the service is new to the agency).

 Additional in-service and on-the-job training may be provided by experienced

 agency staff, agency staff with similar skills, by appropriate community college

 or other academic programs, or the service system, including the NC Division

 of Aging and Adult Services. Types of training appropriate for Information,

 Assistance and Options Counseling staff include, but are not limited to:

1. Interviewing techniques and listening skills
2. Short term assessment skills
3. Information giving and referral procedures
4. Techniques for handling crisis calls
5. Techniques for dealing positively with demanding callers
6. Public benefits
7. Long-term services and supports
8. Topic areas listed in Guidance Section XII Certification and Recertification for Options Counseling

 2. Considerations specific to Options Counseling

a. Options Counseling requires a commitment of time and effort to provide

 individualized decision support.

b. Options Counselor specific requirements include competencies in the

 domains of decision support, person-centered planning, cultural

 competency, communication, participant direction, and quality. Experience

 with these competency domains should be strongly considered.

c. Ongoing participation in quarterly SHIIP update meetings is required, 10 hours of which can be counted toward the

 20 hours of required continuing education training. If an Options Counselor chooses to do this, validation of those 10 hours can be attained by submitting copies of quarterly meeting sign-in sheets or obtaining verification from SHIIP.

 d. Supervisors are encouraged to increase their knowledge about Options

 Counseling in order to support the Counselor(s) on their staffs, as well as

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to enhance their own skills regarding the program’s management, planning

 and evaluation.

Training considerations for supervisors of Options

Counselors can include, but is not limited to:

* Person-Centered Thinking
* Disability Rights and Systems Advocacy

 e. Documentation review is linked to the Options Counselor’s recertification

 and quality assurance of the service. In addition to completing the required

 Documentation Checklist, supervisors may elect to also use the Options

 Counseling Performance Validation Checklist (See Appendix 12) to assist

 in evaluation of the Options Counselor. If a training need is identified, contact your AAA.

 f. When there is a change in an Options Counselor’s supervisor, the provider

 agency should notify the DAAS Options Counseling Coordinator and

 provide the name and contact information for the new supervisor.

*E. Suggestions for Excellence (or QI)*

1. Staff pursue certification by the National Alliance of I and R Specialists.

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**XIII. Continuous Quality Improvement**

# *A. Federal or State Statutory Requirement*

 (none)

# *B. Federal Regulation or State APA Rule*

 (none)

## *C. Division of Aging and Adult Services Administrative Requirement*

Provider agencies shall use and submit the Documentation Checklist to the DAAS Options Counseling Coordinator as outlined in Standard XII.C.2.c.

DAAS Options Counseling Coordinator shall offer training, as needed, that relates to:

1. the basic principles and protocols of Options Counseling;
2. any changes or updates to the Options Counseling Standards; or
3. any expansion of the Options Counseling service.

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**APPENDICES**

**Appendices 8, 9, 11 and 13 are required forms.**

All other appendices are a collection of tools that Information and Options Counseling staff and/or supervisors may find helpful. They are designed to assist with or provide guidance for this service.

Information Log Appendix 1

Information Documentation: Sample Tools Appendix 2

1. Intake Form and Progress Notes
2. Adult Services Intake/Inquiry Information and Face Sheet

Assistance Documentation: Sample Tools Appendix 3

1. Service and Service Outcome Screen (SOS)
2. Consent Forms
3. General Release of Information Form
4. Specific Release of Information Form
5. Assistance Plan Template

Options Counseling Documentation & Follow-up Sheets Appendix 4

Client Satisfaction Tool Appendix 5

Tools for Soliciting Voluntary Contributions Appendix 6

Options Counseling Action Plan Template Appendix 7

Initial Application for Options Counseling Certification **(Required)** Appendix 8

Options Counseling Recertification Form **(Required)** Appendix 9

Initiating the Options Counseling Process Appendix 10

Options Counseling Certification Reapplication **(Required)** Appendix 11

Options Counseling Performance Validation Checklist Appendix 12

Documentation Checklist **(Required)** Appendix 13

Appendix 1

**INFORMATION LOG**

**MONTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- |
| **Date** | **Name** | **Need** | **Information Provided** | **Follow up Needed?** | **Contact Information** |
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INTAKE FORM

Intake Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROBLEM STATED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Caller’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSON REFERRED**:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB or Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Arrangement: Alone With Spouse Family Friends LTC facility

Income Source: Employed at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired Unemployed

 Pension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (amount) Other Assets \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(amount) Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(amount)

 Income: Single \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Combined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Does Not Know Income

Health Insurance: Medicare\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplementary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Private Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medicaid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Long Term Care Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 None \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Status:

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 Does Not Need 24 Hour Care  Can Function Independently if Alone

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Agencies/Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ACTION TAKEN**  General Information Only Options Discussed/Referrals Made To: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Call Back Required Assistance Required No Further Assistance Required

 Caller Informed That the Information Provided Is Not the Recommendation of This Agency

Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completion Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendix 2-A, p.2

# PROGRESS NOTES

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Appendix 2-B, p. 1

#  Adult Services Intake/Inquiry Information

## Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If Assigned*: Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Contact Persons other than client involved in initial referral/contact:

 (check all that apply)

🞎 Office Visit 🞎 Family member (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Phone Call 🞎 Neighbor(s)/Friend(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Home Intake 🞎 Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s level of involvement in referral/contact:

🞎 Client was present and participating 🞎 Client unaware of contact (explain)\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Client was not present, but desires referral/contact 🞎 Uncertain (e.g. telephone contact)

🞎 Client not present, but aware of referral/contact

🞎 Client was present but did not participate (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Presenting Problem(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional history (duration/efforts/outcomes): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Expectation of person(s) at intake interview, including services requested:

 Urgent? 🞎 Yes 🞎 No

Preliminary Information in Functional Domains

Social: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Environmental:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mental Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physical Health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ADL/IADL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Economic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DISPOSITION (Check all that apply)

🞎 Opened case/accepted referral (specify) 🞎 Application for emergency financial assistance

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Application for senior nutrition/home-delivered 🞎 Wrote/phoned referral to other agency (specify) meals

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Family planning information

🞎 Advised of food stamp program 🞎 Explained other DSS services (specify)

🞎 Advised of Medicaid application procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 FL-2 given 🞎 Bus ticket provided

🞎 Application for eye exam 🞎 Closed/handled intake

🞎 Application for transportation 🞎 Unable to assist client (reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Application for fuel assistance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did anything during the initial interview suggest that the client may live in an environment dangerous to the social worker visiting? (Check all that apply and explain below.) Be sure to note changes in the directions to home section of the face sheet.

🞎 Dangerous neighborhood 🞎 Guns/weapons in home 🞎 Drug use/transactions in home

🞎 Violence in home 🞎 Biting dog or other dangerous pets

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe (include source of information and impression of the seriousness of the danger):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments (if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Intake social worker’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form provided by the NC Division of Social Services

Appendix 3A, p. 1

#### **Duke Long Term Care Resources Program**

###### **The Service and Service Outcome Screen**

##### DUKE SOS PROFILE

***(page numbers refer to the 1st edition SOS User Manual)***

© 1991-97 Duke LTC **Duke Long Term Care Resources Program** Date      /    /

 **The Service and Service Outcome Screen**

(*page numbers refer to the 1st edition SOS User Manual*) **DUKE SOS PROFILE**

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First MI Agency Use

**Problem
Summary**

(*p. 31 & 52*) Health Cog/MH IADL ADL Help S. Support Housing Income Agency Referred **URGENT**

**1. Basic Information** (*p.6 & 31*) From:  Self  Other

 a. Client Phone j. Sex:  Female  Male

 b. Street Address k. Racial/Ethnic Identity

 c. City/Township  White  African Amer.  Amer. Indian

 d. County  Asian  Hispanic  Other \_\_\_\_\_\_\_\_

 e. Zip Code

 f. Date of Birth l. Mention of Unmet Skilled Need  Yes  No

 g. Mother’s Maiden Name (e.g. help with oxygen /sterile dressing

 h. Soc. Sec. Number electronic equipment /I.V. / monitoring)

 i. Client Needs/Preferences for Services Comment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  Appropriate for agency

  Perhaps appropriate for agency

  Not appropriate for agency

 Eligible for veteran’s benefits?  Yes  No If yes, VA Claim #

**2. Emergency Contact?** (*p. 11, 36*)

 Contact Doctor

 Phone: Days Nights Phone

**3. Complete *ONLY IF CALLER IS OTHER THAN CLIENT*** (*p. 12*)

 a. Caller’s Name d. Reason not to call client

 b. Caller’s Phone e. Caller sees situation as **urgent**:  Yes  No

 c. Relation to Client Problem

**4. Health Perceptions and Services** (*p. 14 & 36*) **5. Cognitive/Mental Health** (*p. 16 & 38*)

 a. Diagnosed or Perceived Health Problems Sense of Well-Being

 How much time in the past month?

 a. Nervous  All  Some  None

 b. Sad/nothing cheers  All  Some  None

 b. Would you say in general your/his/her health is: c. “In touch” If client answered Section 1, were

  Excellent  Very Good  Good  Fair  Poor answers a. through h.:

 c. How much bodily pain during past month?:  Appropriate

  None  Very Mild  Mild  Moderate  Severe  Questionably Appropriate

 d. Hospital (past year)  Yes  No  Clearly Inappropriate

 e. Doctor’s care (past month)  Yes  No d. In section 3, was reason not to call

 f. Nurse in home (past month)  Yes  No client given as confusion, Alzheimer’s

 g. Service agency involvement (past yr.)  Yes  No Disease, dementia or related disorders?

 h. If YES, agency(ies)?  Yes  No

 Problem Problem

 **Client’s Name**

 Last First MI

**Functional Activities**

 Able Has Enough

**6.** **IADL** (*p. 17 & 41*) To Help Help **9. Social Support** (*p. 24 & 48*)

a. Use transport y n y n y n a. Client lives alone  Yes  No

 b. Use phone y n y n y n b. If NO, with whom?

 c. Take medicine y n y n y n c. If YES, is client in regular contact

 d. Manage money y n y n y n with anyone other than caregivers

 e. Do shopping y n y n y n (listed in Section 8)?  Yes  No

 f. Do housework y n y n y n Contact’s name

 g. Do laundry y n y n y n Relationship

 h. Prepare meals y n y n y n Phone number (if known)

 Count the “no’s” in

 the “able to” column **Problem Problem**

**7.** **ADL** (*p. 20 & 44*) **10. Housing** (*p. 25 & 49*)

a. Bath y n y n y n a. Indoor plumbing  Yes  No

 b. Dress y n y n y n b. Heating okay  Yes  No

 c. Walk inside y n y n y n c. Cooling okay  Yes  No

 d. Transfer in/out bed y n y n y n Is toilet convenient:

 e. Use bathroom y n y n y n d. To bedroom  Yes  No

 f. Eat y n y n y n e. To living quarters  Yes  No

 Count the “no’s” in

 the “able to” column **Problem Problem**

**8.** **Help with ADL/IADL** (*p. 23 & 47*) **11. Income** (*p. 25 & 49*)

 a. Name of Caregiver a. Gets SSI check  Yes  No

 b. Phone Number b. Enough to pay for

 c. Relation to Client needs and extras  Yes  No

 d. Hrs/week e. Help:  Paid  Unpaid c. Estimated monthly income $

 f. **Other Helpers** d. Possible self-pay  Yes  No

 g. Relation to Client e. Receives Medicaid  Yes  No

 h. Hrs/week i. Help:  Paid  Unpaid (blue card)

 **Problem Problem**

 **Directions to Home**

**P**

**R**

**O**

**B**

**L**

**E**

**M**

 **Referred to** Date

 Completed by:

 **URGENT** **Agency** Assigned to: Date:

 **Follow-up** (*p.* *26 & 50*) © 1991-97 Duke LTC All Rights Reserved

Appendix 3-B, 1

General Release of Information Form

I, give the

 Client name Agency name

permission to share the information specified below with the agency(s) listed below.

1. Nature & amount of information to be disclosed:

 Purpose:

 Agency to which disclosure is made:

2. Nature & amount of information to be disclosed:

 Purpose:

 Agency to which disclosure is made:

3. Nature & amount of information to be disclosed:

 Purpose:

 Agency to which disclosure is made:

I understand that I or my legal representative may revoke this consent at any time except to the

extent that action has been taken in reliance on it, and that in any event this consent expires

automatically in one year. I have been provided a copy of this form.

 Signature of Individual (Client)/Legal Representative Date

 Witness Date

Appendix 3-B, 2

Specific Release of Confidential Information

 I, authorize,

 *NAME OF INDIVIDUAL (CLIENT)*

 to disclose to

 *NAME OF AGENCY MAKING DISCLOSURE*

 the following information:

 *NAME OF ENTITY TO WHICH DISCLOSURE IS TO BE MADE*

 *NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, AS LIMITED AS POSSIBLE*

The purpose of the disclosure authorized in this consent is to:

 *PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE*

 I understand that I may revoke this consent at any time except to the extent that action has been

 taken in reliance on it, and that in any event this consent expires automatically as follows:

 *SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES*

 I have been provided a copy of this form.

 Signature of Individual (Client)/Legal Representative Date

 Witness Date

Appendix 3-C

**ASSISTANCE PLAN**

## CLIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services will be discontinued when the goals listed below have been satisfactorily met and/or the Case Manager and client determine that termination is appropriate. If services are continued, goals will be revised as needed.

|  |  |  |  |
| --- | --- | --- | --- |
| PROBLEM/NEED | OUTCOME ORIENTED GOALS | SERVICES/SUPPORTS | PROGRESS NOTES |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

SIGNATURE OF CLIENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF STAFF PERSON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ORIGINAL: FILE COPY: CLIENT

Appendix 4

Options Counseling Documentation Sheet

**Individual’s Name**:

**Counselor’s Name**:

**Date of Contact: Time Spent with/on Behalf of Individual:**

**Contact was:** [ ] In Person [ ]  Phone [ ]  Email [ ]  Other:

**Individual’s Preferences and Needs:**

**How Preferences/Needs are Addressed:**

**Options/Information Discussed:**

**Options Selected:**

**Notation and Date Options Counseling Ends:**

 Counselor’s Initials or Signature

Appendix 4

Follow-up

**Individual’s Name**:

**Counselor’s Name**:

**Date of Follow-up: Time Spent with/on Behalf of Individual:**

**Contact was:** [ ] In Person [ ]  Phone [ ]  Email [ ]  Other:

**Individual’s Current Situation:**

**Outcomes Since Last Contact:**

**Action Plan Steps Occurred, if Not, Why:**

**Next Steps Needed:**

 Counselor’s Initials or Signature

Appendix 5

**CLIENT SATISFACTION TOOL**

# QUALITY ASSESSMENT SURVEY [May be administered by mail or phone.]

You recently contacted (agency) . Please answer the following questions by circling the answer (or “telling me the answer”) that comes closest to your experience with the Information and Assistance

 service:

 Definitely Not at all

1. Was the counselor you talked with 5 4 3 2 1

 helpful, polite and knowledgeable?

2. Did the counselor provide appropriate 5 4 3 2 1

 information and the assistance that you

 needed?

3. If the counselor sent you one or more 5 4 3 2 1

 publications related to your caregiving

 needs, did you find them helpful? or N/A

4. Did you actually choose a service program

 or facility from the referrals sent to or discussed Yes No

 with you?

5. If yes, are you satisfied with the service chosen? Yes No

 If no, please indicate why you did not choose among those options?

6. If you are a family member or caregiver, please give the response that best describes how helpful the service has been in terms of your own job performance or other responsibilities. The help provided:

A. Reduced need to arrive late, leave early, 5 4 3 2 1

or take time off for dependent care.

B. Reduced amount of time spent on phone 5 4 3 2 1

with care-giving concerns.

7. If you had a need in the future, would you use

 the I & A service again? Yes No

8. Would you recommend the I & A service to others? Yes No

Please add any further comments:

Appendix 6

**TOOL FOR SOLICITING VOLUNTARY CONTRIBUTIONS**

(Agency Letterhead)

Dear (caller):

Thank you for calling our *Information and Options Counseling Program*. We hope you will find the information in this envelope useful. If you have any questions, or if we can further serve you, please call the phone number below.

Our program advises senior citizens and those who care for them about the services and opportunities available to them. The service is partially funded through the North Carolina Home and Community Block Grant. Contributions from the public help us to extend our services to more people. We encourage you to contribute what you can.

Sincerely,

Information and Options Counseling Specialist

Phone Number

Appendix 7

**Action Plan**

Name Contact

 Phone or Email

|  |
| --- |
| **Identified Need:** |
| Action Steps | Responsible Party | Target Date |
|  |  |  |
|  |  |  |
|  |  |  |
| **Potential Resources:** |

|  |
| --- |
| **Identified Need:** |
| Action Steps | Responsible Party | Target Date |
|  |  |  |
|  |  |  |
|  |  |  |
| **Potential Resources:** |

|  |
| --- |
| **Identified Need:** |
| Action Steps | Responsible Party | Target Date |
|  |  |  |
|  |  |  |
|  |  |  |
| **Potential Resources:** |

|  |
| --- |
| **Identified Need:** |
| Action Steps | Responsible Party | Target Date |
|  |  |  |
|  |  |  |
|  |  |  |
| **Potential Resources:** |

Unresolved concerns:

Agreed upon follow up date

Options Counselor Name Phone

Date plan created

[ ]  Copy of Action Plan given to the individual.

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 Appendix 8

Initial Application for Options Counseling Certification

**Please read this page prior to completing the application**

**Eligibility criteria**

1) Your agency/organization must be affiliated with a CRC, or Area Agency on Aging, or other agency as designated by the Division of Aging and Adult Services.

2) Per Information and Options Counseling Standard XII - Staff Competence and

 Supervision:

Options Counselors shall have:

* a BSW with 2 years work-related experience or
* a MSW with 1 year work-related experience or
* a bachelor’s degree in a relevant Human Services field with 3 years’ experience in providing support to individuals needing Long Term Services and Supports or
* a master’s degree in a relevant Human Services field with 2 years’ experience in providing support to individuals needing LTSS or
* a bachelor’s or master’s degree in a non-Human Services field with

 4 years’ experience in providing support to individuals needing LTSS

* An approved waiver request

**Instructions for Application Completion and Submission**

**A.**

1. Prior to application submission, the applicant and supervisor must read

 the Information and Options Counseling Standards.

1. Complete application form including appropriate signatures

3) Submit application form, resume, and validation of any co-requisite training

 previously completed.

**B.** An individual who does not meet the above education and work experience criteria can request a waiver. Waivers shall be considered on a case-by-case basis. The process for making the request is as follows:

Submit to the Area Agency on Aging (AAA):

1. a letter from the applicant requesting a waiver to the above education and experience requirements that offers rationale and justification for the request. Supporting documentation may be attached to the letter.
2. a letter of recommendation from the applicant’s supervisor that addresses the individual’s suitability as an applicant for Options Counseling certification.
3. a completed Options Counseling Initial Application for Certification and resume.

The AAA reviews waiver documentation; informs individual of the decision. If waiver is denied, the decision is final. If waiver is approved, the AAA sends all the documentation to the Division of Aging and Adult Services for final review, approval or denial of initial application. If the waiver request is for a staff member of the AAA, then the request shall be sent directly to DAAS.

**Options Counseling Initial Application**

**Type of Print Clearly**

Applicant Name:

Job Title:

CRC/AAA/Other DAAS Designated Affiliation:

 CRC/AAA/Other DAAS Designated Agency Name

Agency/Organization Name:

Agency/Organization Mailing Address:

 PO Box or Street

 City State Zip Code

Work Phone:

Email:

Supervisor’s Name:

Work Phone:

Email:

**Applicant’s Educational Information**

1) Check the highest level that applies:

 [ ]  BSW [ ]  MSW [ ]  Bachelor’s degree – Specify field of study:

 [ ]  Master’s degree – Specify field of study: [ ]  Other – Specify:

**Applicant’s Work Experience**

Please attach a resume to this application.

**Required** **Options Counseling Initial Certification Training**

Please check all trainings that you have completed and attach validation (i.e. copy of certificate of completion for corresponding training, verification letter from instructor)

[ ]  Options Counseling Concepts and Standards training (On-line)

[ ]  Person-centered Thinking training

[ ]  SHIIP Counseling training

[ ]  Options Counseling On-line training

[ ]  Disability Rights NC Systems Advocacy training

[ ]  Medicaid Training: Medicaid Foundations & Medicaid for LTSS (Webinars)

[ ]  I have read the Information and Options Counseling Standards and understand the requirements of this service.

X

 Applicant signature Date

**For completion by Supervisor:**

[ ]  I have read the Information and Options Counseling Standards and understand the requirements of this service. This agency is committed to providing Options Counseling per the Information and Options Counseling Standards. I recommend this applicant for Options Counseling Certification training.

**Please check one of the following:**

[ ]  I agree to complete the Options Counseling Concepts and Standards training and perform Options Counseling supervisor responsibilities as outline in Standard XII.C.2.c.

[ ]  I previously completed the Options Counseling Concepts and Standards training and agree to perform Options Counseling supervisor responsibilities as outlined in Standard XII.C.2.c.

X

 Supervisor Signature Date

**Submit:**

* + 1. Initial Application
		2. Resume
		3. Validation of any required Options Counseling Initial Certification training previously completed

Email to: Jan.Moxley@dhhs.nc.gov, or Fax: 919-715-8399

Revised 2/22

 Appendix 9

Options Counseling Recertification Form

**Type or Print Clearly**

[ ]  Check here if your contact information has changed [ ]  Check here if your supervisor’s contact information has changed

Counselor Name:

Job Title:

CRC/AAA/Other DAAS Designated Affiliation:

 CRC/AAA/Other DAAS Designated Agency Name

Agency/Organization Name:

Agency/Organization Mailing Address:

 PO Box or Street

 City State Zip Code

Work Phone:

Email:

Expiration date of current certification:

**Complete ONLY if there has been a change to any of the supervisor information.**

Supervisor’s Name:

Work Phone:

Email:

**Training**

List 20 hours of continuing education completed during your current certification period. Attach validation (i.e. copy of training certificate, verification from instructor)

|  |  |  |
| --- | --- | --- |
| **Name of Training** | **Date of Training** | **Hours Awarded** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

X

 Counselor Signature Date

**For completion by Supervisor:**

I confirm that has conducted

 Name of Options Counselor

Options Counseling within the two-year certification period.

**Copies of completed annual Documentation Checklist (one for each year of the two-year certification period) are included with this recertification application.**

Check one:

[ ]  I recommend recertification

[ ]  I do not recommend recertification

X

 Supervisor Signature Date

**Submit:**

1.Recertification form

2. Continuing Education training validation

3. **Completed Documentation Checklists** (Appendix 13)

Email to: Jan.Moxley@dhhs.nc.gov, orFax:919-715-8399

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Appendix 10

Initiating the OC Process

Adopted from Virginia ADRC

Do you understand the information I have given you?

Staff member provides initial information in response to request or in discussion with person/supporter

One of the following situational elements is found to exist with the individual:

* A life altering personal event or situation;
* A significant change in the individual’s circumstances;
* Concerns expressed by the individual or the individual’s family member or surrogate decision-maker;
* A life transition;
* A referral or self-referral to Options Counseling; and/or
* Availability of new benefits and supports.

Staff member continues to listen, gather information, provide information, and asks the following questions to seek further clarity on the need for OC

Individual (person on behalf of individual) contacts or is known to service agency

Yes

No

Do you need additional information?

No

Yes

Do you know what your

next steps are?

No

Yes

Ensure that other issues are addressed and other needed service/supports are coordinated

**OFFER TO REFER TO OPTIONS COUNSELING**

Appendix 11

**Options Counseling Certification Reapplication**

**for certification that has lapsed beyond a year**

**Type of Print Clearly**

Applicant Name:

Job Title:

CRC/AAA/Other DAAS Designated Affiliation:

 CRC/AAA/Other DAAS Designated Agency Name

Agency/Organization Name:

Agency/Organization Mailing Address:

 PO Box or Street

 City State Zip Code

Work Phone:

Email:

Supervisor’s Name:

Work Phone:

Email:

X

 Applicant signature Date

**For completion by Supervisor:**

[ ]  I have read the Standards and understand the requirements of this service. This agency is committed to providing Options Counseling per the Information and Options Counseling Standards. I recommend this applicant for reapplication of Options Counseling Certification.

**Please check one of the following:**

[ ]  I agree to complete the Options Counseling Concepts and Standards training and perform Options Counseling supervisor responsibilities as outline in the Standards.

[ ]  I previously completed the Options Counseling Concepts and Standards training and agree to perform Options Counseling supervisor responsibilities as outlined in the Standards.

X

 Supervisor Signature Date

Rev. 2/22

 Options Counseling Performance Validation Checklist **(Optional)** Appendix 12

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Quality** ***The individual brings the content, the listener brings the guidance*** | **Needs Improvement** | **Satisfactory** | **Excellent** | **N/A** |
| ***Effective Communication with Individual-Building Rapport*** |  |  |  |  |
| * Professional greeting: warm tone of voice, kind, courteous,

 appropriate language |  |  |  |  |
| * Builds rapport, unhurried attitude, remains calm
 |  |  |  |  |
| * Guides instead of leads or offering advice or judgment
 |  |  |  |  |
| * Allows individual to communicate in his/her own style
 |  |  |  |  |
| * Maintains confidentiality
 |  |  |  |  |
| * Uses OARS Effectively: Open-ended questions, affirmations,

 reflections, summary |  |  |  |  |
| ***Accurate Assessment of the Individual’s Problems or Concerns*** |  |  |  |  |
| * Identifies and clarifies individual’s needs-Reflective statements
 |  |  |  |  |
| * Explores needs beyond presenting problem
 |  |  |  |  |
| * Highlights strengths instead of all weaknesses
 |  |  |  |  |
| * Looks at short and long term solutions
 |  |  |  |  |
| * Facilitates individual’s readiness for change if needed
 |  |  |  |  |
| * Helps individual look at the problem from many perspectives
 |  |  |  |  |
| Summarizes what the individual presents as the issues and how they want to proceed. |  |  |  |  |
| ***Utilizes Available Resources*** |  |  |  |  |
| * Searches resource database for accurate information
 |  |  |  |  |
| * Is creative in assisting the individual to find options of interest to

him/her. |  |  |  |  |
| * Asks permission before proceeding with an action plan or

 offering decision support |  |  |  |  |
| * Gives specifics on eligibility and process to apply for other

 resources |  |  |  |  |
| * Does not use only one resource in each category but is objective
 |  |  |  |  |
| * Assists individual in getting connected with resources if they are

unable-or develops informal supports to assist individual |  |  |  |  |
| * If resistant to options-rolls with it
 |  |  |  |  |
| * Supports self-efficacy of individual-encourages individual to do for him/herself if able
 |  |  |  |  |

Overall Comments:

Strengths/Weakness:

Areas to develop:

Name of Options Counselor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:

Name of Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Documentation Checklist (**Annual Completion by Supervisor Required**) Appendix 13

 **Mark each item with an “S” for “Satisfactory” or “NI” for “Needs Improvement” or “N/A” for Not Applicable**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Certification Year Reviewed** (select one): [ ]  **Year 1** [ ]  **Year 2** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|  **Insert Client Initials for each file reviewed**  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Documentation of contacts** |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Name of individual receiving Options Counseling is present.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Setting (i.e. office, home) and/or method (i.e. phone, email) of contact(s) is noted.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Each contact is dated, and amount of time spent is recorded.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Summary of each contact provides a clear picture of the individual’s situation, what was discussed, and what was decided.

At some point within the entire body of documented contacts the following are addressed: |  |  |  |  |  |  |  |  |  |  |  |  |
| D-1. Preferences and needs.*Preferences and needs are identified and there is ongoing notation on how they are addressed*. |  |  |  |  |  |  |  |  |  |  |  |  |
| D-2. Options/information discussed *Options presented and discussed are clearly outlined*  |  |  |  |  |  |  |  |  |  |  |  |  |
| D.3. Options selected. |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Counselor’s initials or signature and date are present for each contact.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. A summary, electronic attachment, or written copy of Action Plan. Notes indicate if development of an Action Plan. Is declined.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Follow-up outlines the individual’s: current situation; outcomes since last contact; whether steps in Action Plan occurred, if not, why; and any next steps needed. It is noted if follow-up is declined.

*If follow-up has not occurred at the time of the review because the follow-up date listed on the Action Plan is after the review date, note this in comments section.* |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Notation and date when Options Counseling ends is present
 |  |  |  |  |  |  |  |  |  |  |  |  |
|   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| **Insert Client Initials for each Action Plan reviewed**  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Action Plan** |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Needs are specifically identified.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Action steps are clearly outlined.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Responsible party designated for each action step and target date set.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Potential resources identified and listed.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Any unresolved concerns are noted.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Follow-up date established, unless declined and noted.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Counselor contact information is listed.
 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Date of plan is present.
 |  |  |  |  |  |  |  |  |  |  |  |  |

S Supervisor’s comments:

A Areas to improve:

 Options Counselor’s comments:

O On this date, a review and discussion of my documentation performance was conducted by my supervisor. All questions, comments, and a any areas needing improvement were addressed.

O Options Counselor Name: Signature/Date:

 Supervisor Name: Signature/Date:

Revised 2/2020