FY 2016 Title III Service Reporting Updates

Area Agency on Aging, Region 8

Inter Tribal Council of Arizona, Inc.

Tuesday, October 6, 2015

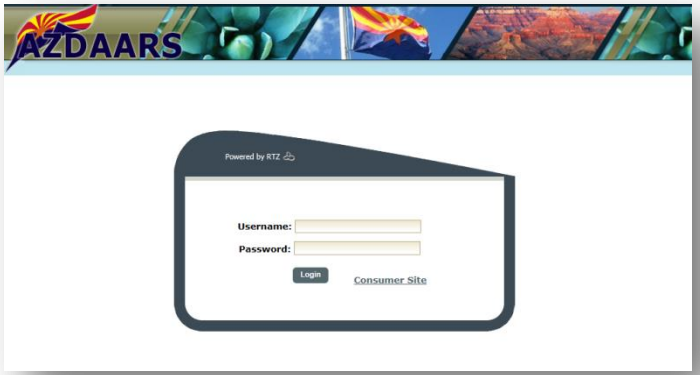
Program Manager's Meeting - AICOA Quarterly

FY 2016 Important Updates

- Title III Fiscal Year 2016
  - **July 1, 2015 – June 30, 2016**
- DAARS will be used for Title III Reports
  - Reports beginning July 1, 2015 – June 30, 2016
- Congregate Meals Nutritional Assessment
  - Completion Date: Mid-October 2015
- RFA 2016-2020
  - Reviewing applications at the moment
  - Once completed will issue Notifications of Grant Awards (NOGAs)
  - Once NOGA received, tribe can begin submitting Title III FY2016 Monthly Reports

DAARS Updates

- DAARS
  - New Database that is administered by AZ DES Department of Aging & Adult Services (DAAS)
  - Each Tribe has a designated DAARS data entry person
    - If you don't, then please contact me ASAP to start the enrollment process
    - DAARS users must complete a mandatory online security training
      - Requires a passing score
      - Submit Certificate of completion to Cynthia Freeman, AAA Program Coordinator
  - Website: azdaars.getcare.com
    - Only designated DAARS have access
      - Passwords are not be shared
    - Contact AZ DES with any log-in issues



FY 2016 Reporting Forms

	FY 2016 Title III Services	FY 2016 Required Reporting Forms
1	**Congregate Meals**	DAARS Nutritional Assessment
2	**Home Delivered Meals**	DAARS Short Form Intake Document (SFID)
3	**Personal Care**	
4	**Respite**	
5	**House Keeping**	
6	**Caregiver Outreach**	Non-Registered Services Monthly Report
7	**Caregiver Information & Referral**	
8	**Caregiver Training**	Registered Services Monthly Report
9	**Transportation**	Social Services Report (SSR) Form
10	**Socialization & Recreation**	
11	**Enhance Fitness**	
12	**State Health Insurance Assistance Program (SHIP)/ Senior Medicare Patrol (SMP)**	Client Contact Form (SHIPTalk) SHIP/SMP PAM Form
13	**Long Term Care Ombudsman Program**	Monthly Ombudsman Data Collection Form Time Sheet for Staff and Volunteers

Congregate Meals (DAARS)

- DAARS – Nutritional Assessment
  - Must be completed for each client receiving Congregate Meals
  - Nutritional Assessment Application available ITCA-AAA website: http://itcaonline.com/?p=16038
- DAARS Data Entry
  - DAARS user should add client's information to DAARS
  - Under "Assessments," select "Add New Assessment"
  - Begin entering the client's demographic information into DAARS
- Please upload all CNG clients into DAARs by mid-October
  - If additional time, please provide status updates to Cynthia Freeman, AAA Program Coordinator

Congregate Meals (DAARS)

Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8

Title III Congregate Meals - Nutritional Assessment

☐ New ☐ Reassessment ☐ Change ☐ Review ☐ Close	Assessment Date:	DAARS ID:

PART I: INTAKE INFORMATION

A. Client Profile & Referral Information

First Name:	Last Name:	M.I.
SSN (*optional*):	Date of Birth:	Phone No.
Mailing Address:		
City:	State:	Zip code:

Information for interview was obtained from:

☐ Self-report ☐ Medical records ☐ Other (specify):

Name of referral source:	*Phone #:*	*Referral Date:*

Eligibility Category:
- ☐60 and over
- ☐Spouse of client age 60 and over
- ☐Under 60 with a disability
- ☐Caregiver of eligible client

Eligible Client (associated with Spouse/Caregiver):

Name: _____

SSN: _____

B. DEMOGRAPHICS

Type of Disability:
- ☐ Physical
- ☐ Intellectual disability/ Developmental disability (ID/DD)
- ☐ Mental Illness
- ☐ Traumatic Brain injury
- ☐ Dementia
- ☐ Other (*specify*): _____
- ☐ None:

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to state

Race:
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Declined to state
- ☐ Other (*Specify*):

Relationship Status:
- ☐ Divorced
- ☐ Domestic partner
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Declined to state

Language:
- ☐ English
- ☐ American Indian (w/Eng)
- ☐ American Indian (w/o Eng)
- ☐ Spanish (w/Eng)
- ☐ Spanish (w/o Eng)
- ☐ Other (*Specify*): _____
- ☐ Declined to state

English Fluency:
- ☐ Fluent
- ☐ Limited
- ☐ Needs translation
- ☐ Declined to state

Education:
- ☐ Grade school or less
- ☐ Some high school
- ☐ High school graduate
- ☐ Post high school
- ☐ College degree
- ☐ Declined to state

ITCA Area Agency on Aging, Region 8
2214 N. Central Ave., Phoenix, AZ 85004
Ph. (602) 258-4822/Fax. (602) 258-482

9/1/2015

Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8

Title III Congregate Meals - Nutritional Assessment

Client's Name: | **DAARS ID:**

Residence Type:
- ☐ Apartment
- ☐ Assisted Living facility
- ☐ Board and care
- ☐ DD group home
- ☐ Foster care
- ☐ House
- ☐ Mobile
- ☐ Nursing home
- ☐ Declined to state
- ☐ Other (specify): _____

Living Arrangement:
- ☐ No pay
- ☐ Owns
- ☐ Rents
- ☐ Subsidized
- ☐ N/A
- ☐ Declined to state

Number in Household:

Household Composition:
- ☐Institutionalized
- ☐Lives alone
- ☐With domestic partner
- ☐With non-relative(s)
- ☐ With other relative(s)
- ☐ With parent(s)
- ☐ With spouse
- ☐ Declined to state
- ☐ Other (*specify):*

Urban/Rural:
- ☐Rural
- ☐Urban
- ☐Declined to state

At or Below 100% FPL:
- ☐Yes
- ☐No
- ☐Declined to state

Gender:
- ☐Female
- ☐Male
- ☐Unknown

Veteran:
- ☐No
- ☐Child
- ☐Spouse
- ☐Veteran (*Veteran #):*
- ☐Declined to state

Legal Status:
- ☐Independent
- ☐ Guardian
- ☐ Child
- ☐ LTC Payee
- ☐Conservator
- ☐DP7 Payee
- ☐Declined to State
- ☐Other (Specify):

Emergency Contact *(First, Last Name):* _____

Relationship: _____ **Phone #:** _____

PART II: NUTRITIONAL STATUS

Does the client have a special diet?	☐ Yes	☐ No	If yes, specify:
Does the client have a food allergy?	☐ Yes	☐ No	If yes, specify:

Nutritional Screening (*Check all that apply and total the score shown for each selected responses*):

☐ I have an illness or condition that changed the kind and/or amount of food I eat. (2)	☐ I don't always have enough money to buy the food I need. (4)
☐ I eat fewer than 2 meals per day. (3)	☐ I eat alone most of the time. (1)
☐ I eat few fruits or vegetables or milk products. (2)	☐ I take 3 or more different prescribed or over-the-counter drugs a day. (1)
☐ I have 3 or more drinks of beer, liquor or wine almost every day. (2)	☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
☐ I have tooth or mouth problems that make it hard for me to eat. (2)	☐ I am not always physically able to shop, cook and/or feed myself. (2)

Total Score(*0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk*)**:**	**Height** (*optional):*	**Weight** (*optional):*

Comments:

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9/1/2015

Congregate Meals (DAARS)

Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8

Title III Congregate Meals - Nutritional Assessment

Client's Name:	**DAARS ID:**
PART III: SERVICE ENROLLMENTS	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	
☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor:
Scope of Work:	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units:	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other:
Comments:	

PART IV: AUTHORIZATION

_______ I have received a copy of the Clients Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

_______ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

_______ I was provided the opportunity to contribute voluntarily to the cost of services.

Client's Signature or Mark ______________ Date ______

Responsible Party's Signature ______________ Relationship ______________ Date ______

Worker's Name ______________ Worker's Signature ______________ Date ______

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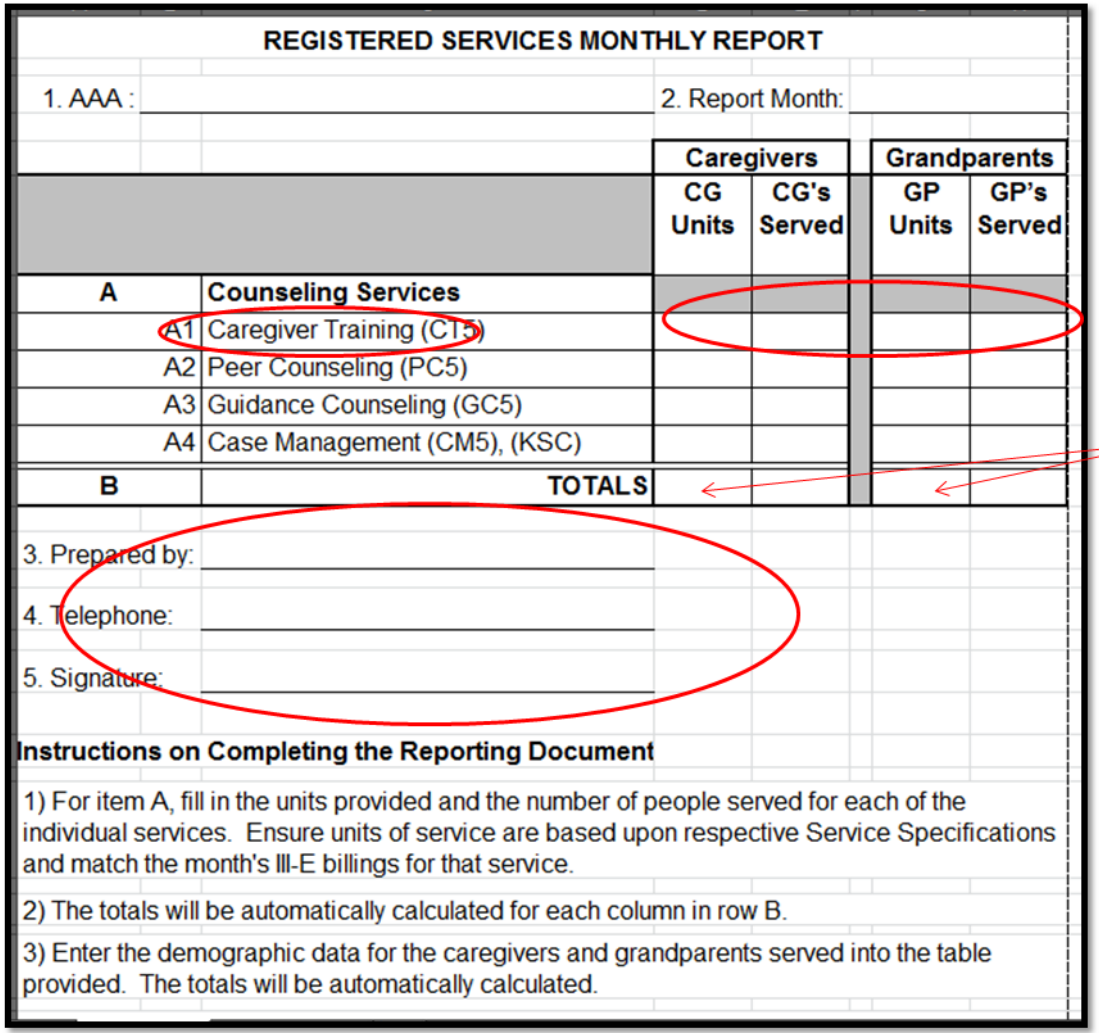
9/1/2015

- **Title III CNG Nutritional Assessment**
  - 3 page document
  - Must be completed for each CNG client
    - Client must initial and sign page 3
    - Update assessment as needed
    - Maintain records under lock & key
  - Annual reauthorization required
    - Example: Client A is assessed on 10/5/15. Client A will need to be Reassessed before 10/5/2016.
    - Please be sure to maintain updates
    - Steps on how to access listing of Reassessments will be posted to the ITCA-AAA website

Other Services (DAARS)

- DAARS SFID Required:
  - Home Delivered Meals (HDM)
  - Personal Care
  - Respite
  - House Keeping
- Tribes with these Home & Community Based Services (HCBS) have already completed the SFID for FY 2015
- Reminder: SFIDs need to be updated annually
  - Example – If client P is entered on 8/12/15, then P's SFID will have to be updated and assessed before 8/12/16
- Additional information on completing SFID can be provided upon request

Caregiver Training (Registered Services Monthly Report)



REGISTERED SERVICES MONTHLY REPORT

1. AAA : _____ 2. Report Month: _____

		Caregivers		Grandparents	
		CG Units	CG's Served	GP Units	GP's Served
A	**Counseling Services**				
A1	Caregiver Training (CT5)				
A2	Peer Counseling (PC5)				
A3	Guidance Counseling (GC5)				
A4	Case Management (CM5), (KSC)				
B	**TOTALS**				

3. Prepared by: _____

4. Telephone: _____

5. Signature: _____

Instructions on Completing the Reporting Document

1) For item A, fill in the units provided and the number of people served for each of the individual services. Ensure units of service are based upon respective Service Specifications and match the month's III-E billings for that service.

2) The totals will be automatically calculated for each column in row B.

3) Enter the demographic data for the caregivers and grandparents served into the table provided. The totals will be automatically calculated.

Total = CG Units and GP Units

- Submit Reports by the **3rd of Every Month** to Mary Weston, FCSP Specialist

Caregiver Outreach
Caregiver Information & Referral

- Non-Registered Services Monthly Report

NON-REGISTERED SERVICES MONTHLY REPORT

1. AAA : _____ 2. Report Month: _____

		Caregivers		Grandparents	
		CG Units	CG's Served	GP Units	GP's Served
A	**Information**				
A1	Outreach (IR5)				
A2	Community Education and Info (EI5)				
	Sub-totals				
B	**Access Assistance**				
B1	Information and Referral (IN5)				
B2	Intake (INT)				
	Sub-totals				
C	**TOTALS**				

3. Prepared by: _____

4. Telephone: _____

5. Signature: _____

Instructions for Completing the Non-Registered Services Monthly Report

1) For item A, fill in the units provided and the total estimated audience size for the events and activities of the month. Ensure units of service are based upon the service specifications for each service and match that month's

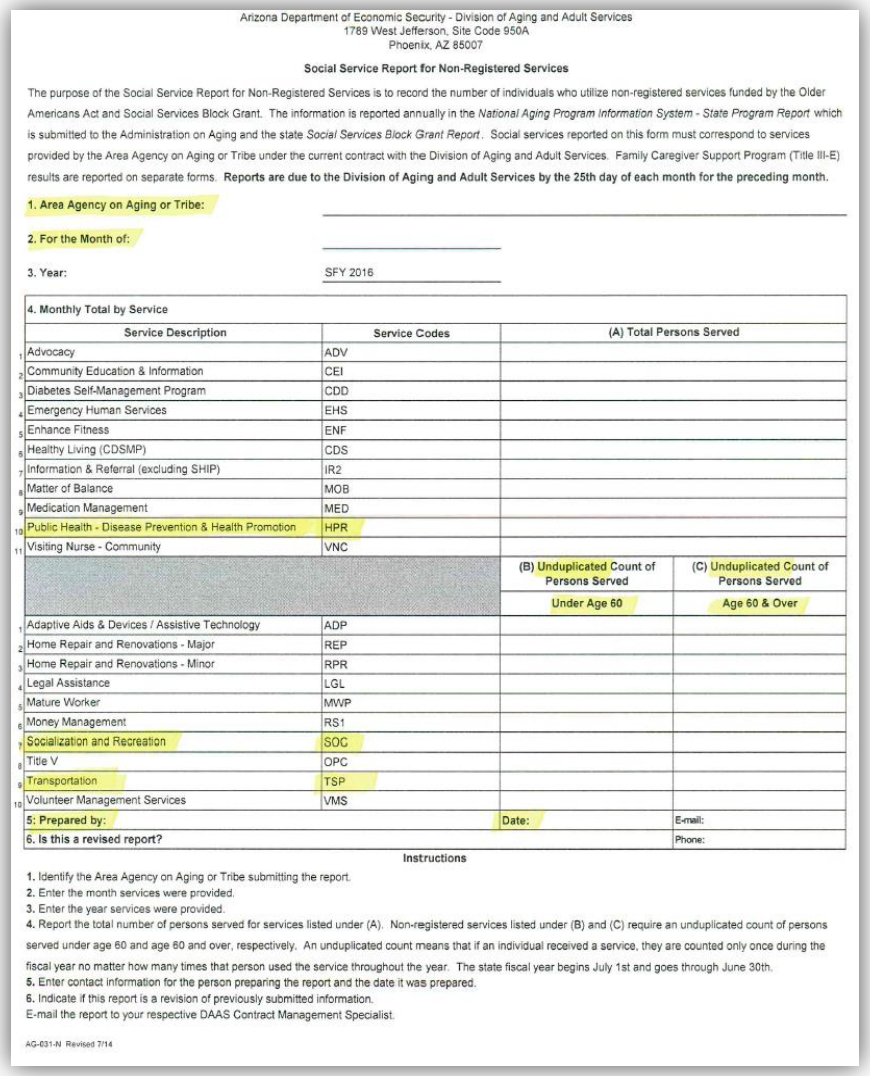
2) For item B, fill in the units provided and the total number of people served by each of the individual services. Ensure units of service are based upon the service specifications for each service and match that month's billings.

Note: Total CG Units & GP Units is amount used for reporting purposed by the finance department

Social Services Report (SSR)

- SSR Form to be used for:
  - Transportation
  - Socialization & Recreation
  - Enhance Fitness
- "Unduplicated Count"
  - Count client once even if the client participates in service

    several times a year
- Under Age 60/Over Age 60
  - Tracking by DOB
  - Enter client into DAARS



Arizona Department of Economic Security - Division of Aging and Adult Services
1789 West Jefferson, Site Code 950A
Phoenix, AZ 85007

Social Service Report for Non-Registered Services

The purpose of the Social Service Report for Non-Registered Services is to record the number of individuals who utilize non-registered services funded by the Older Americans Act and Social Services Block Grant. The information is reported annually in the *National Aging Program Information System - State Program Report* which is submitted to the Administration on Aging and the state *Social Services Block Grant Report*. Social services reported on this form must correspond to services provided by the Area Agency on Aging or Tribe under the current contract with the Division of Aging and Adult Services. Family Caregiver Support Program (Title III-E) results are reported on separate forms. **Reports are due to the Division of Aging and Adult Services by the 25th day of each month for the preceding month.**

1. Area Agency on Aging or Tribe: _____

2. For the Month of: _____

3. Year: SFY 2016

4. Monthly Total by Service

	Service Description	Service Codes	(A) Total Persons Served	
1	Advocacy	ADV		
2	Community Education & Information	CEI		
3	Diabetes Self-Management Program	CDD		
4	Emergency Human Services	EHS		
5	Enhance Fitness	ENF		
6	Healthy Living (CDSMP)	CDS		
7	Information & Referral (excluding SHIP)	IR2		
8	Matter of Balance	MOB		
9	Medication Management	MED		
10	Public Health - Disease Prevention & Health Promotion	HPR		
11	Visiting Nurse - Community	VNC		
			(B) Unduplicated Count of Persons Served Under Age 60	(C) Unduplicated Count of Persons Served Age 60 & Over
1	Adaptive Aids & Devices / Assistive Technology	ADP		
2	Home Repair and Renovations - Major	REP		
3	Home Repair and Renovations - Minor	RPR		
4	Legal Assistance	LGL		
5	Mature Worker	MWP		
6	Money Management	RS1		
7	Socialization and Recreation	SOC		
8	Title V	OPC		
9	Transportation	TSP		
10	Volunteer Management Services	VMS		
	5. Prepared by:		Date:	E-mail:
	6. Is this a revised report?			Phone:

Instructions

1. Identify the Area Agency on Aging or Tribe submitting the report.
2. Enter the month services were provided.
3. Enter the year services were provided.
4. Report the total number of persons served for services listed under (A). Non-registered services listed under (B) and (C) require an unduplicated count of persons served under age 60 and age 60 and over, respectively. An unduplicated count means that if an individual received a service, they are counted only once during the fiscal year no matter how many times that person used the service throughout the year. The state fiscal year begins July 1st and goes through June 30th.
5. Enter contact information for the person preparing the report and the date it was prepared.
6. Indicate if this report is a revision of previously submitted information.

E-mail the report to your respective DAAS Contract Management Specialist.

AG-631-N Revised 7/14

Socialization & Recreation

FY 2016 Title III
Monthly Reporting Form – SOCIALIZATION & RECREATION
Tribe's Name: _____

Staff's Name:		Month:		Year:	

Date	Event Description	Location of Event	Total Staff Hours
1 UNIT = 60 Minutes of Staff Time		Monthly Total (Staff Hours):	

Staff's Signature:		Date Signed:	
Supervisor's Signature:		Date Signed:	

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Transportation

Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8
FY 2016 Title III
Transportation Services - Monthly Report Form

Tribe's Name: _____

DRIVER'S NAME: _____ MONTH: _____ YEAR: _____

Date	Time of Departure	Starting Location	Ending Location	Beginning Odometer Reading	Ending Odometer Reading	Total Mileage	Name of Participant (Print)	Initial	Number of Units
1 UNIT = ONE TRIP PER PERSON ONE WAY							TOTAL UNITS		

DRIVER'S SIGNATURE:		**DATE SIGNED:**	
SUPERVISOR'S SIGNATURE:		**DATE SIGNED:**	

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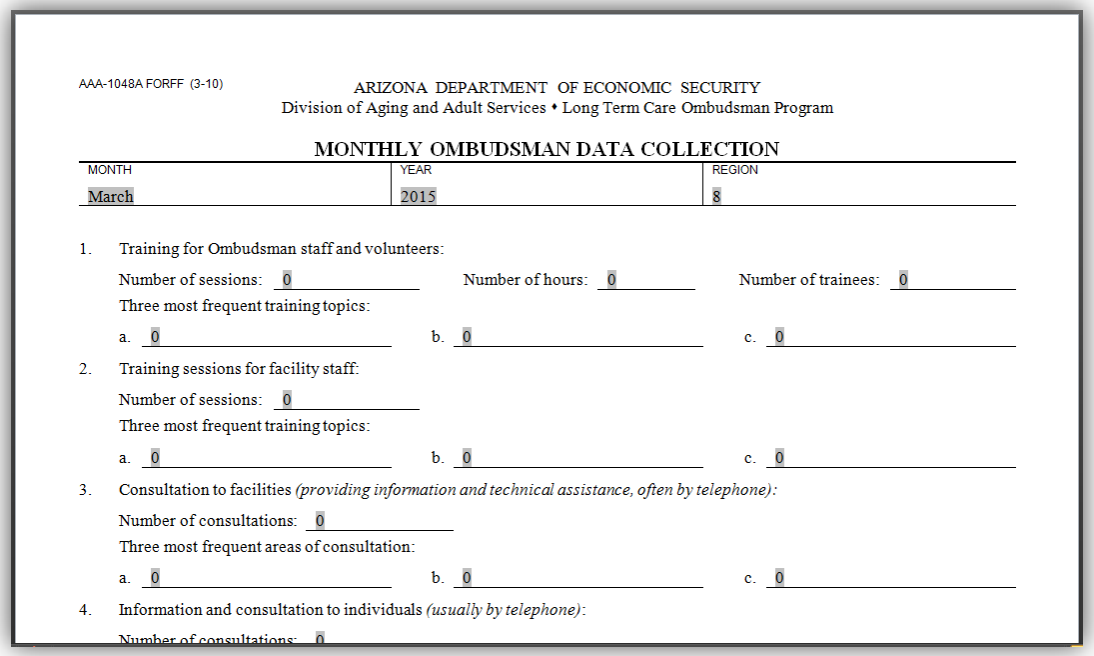
Long Term Care Ombudsman

- Monthly Ombudsman Data Collection Form
  - #1 = zeros (always) should be used because that is for Edith Thomas, Independent Living Support Specialist
  - #2-18 = Tribal Ombudsman completes these sections
  - #5-6 = Unduplicated numbers for facilities visited



AAA-1048A FORFF (3-10)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services • Long Term Care Ombudsman Program

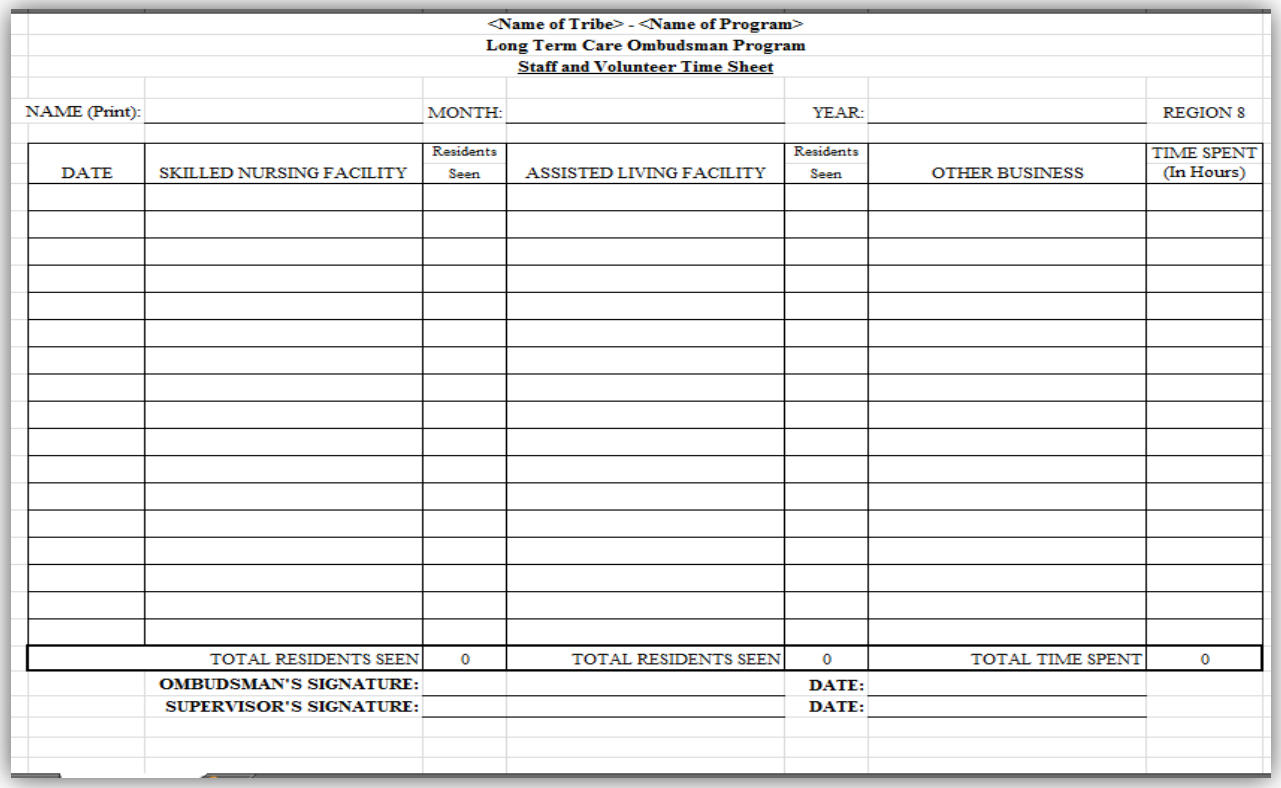
MONTHLY OMBUDSMAN DATA COLLECTION

MONTH	YEAR	REGION
March	2015	8

1. Training for Ombudsman staff and volunteers:
   Number of sessions: 0 Number of hours: 0 Number of trainees: 0
   Three most frequent training topics:
   a. 0 b. 0 c. 0
2. Training sessions for facility staff:
   Number of sessions: 0
   Three most frequent training topics:
   a. 0 b. 0 c. 0
3. Consultation to facilities *(providing information and technical assistance, often by telephone)*:
   Number of consultations: 0
   Three most frequent areas of consultation:
   a. 0 b. 0 c. 0
4. Information and consultation to individuals *(usually by telephone)*:
   Number of consultations: 0

Long Term Care Ombudsman

- LTC Staff Hours Form (Timesheet)
  - Total Time Spent
  - Report monthly units – **Due the 5th of every month**
    - One unit equals one hour of staff time



<Name of Tribe> - <Name of Program>
Long Term Care Ombudsman Program
Staff and Volunteer Time Sheet

NAME (Print): _____ MONTH: _____ YEAR: _____ REGION 8

DATE	SKILLED NURSING FACILITY	Residents Seen	ASSISTED LIVING FACILITY	Residents Seen	OTHER BUSINESS	TIME SPENT (In Hours)
	TOTAL RESIDENTS SEEN	0	TOTAL RESIDENTS SEEN	0	TOTAL TIME SPENT	0

OMBUDSMAN'S SIGNATURE: _____ DATE: _____
SUPERVISOR'S SIGNATURE: _____ DATE: _____

FY 2016 Financial Reporting Update

FY 2015 TITLE III GRANT			
	Total Budget	ITCA	Tribes
Total Budget Awarded:	1,623,833	558,869	1,064,964
Total Reported Expenses:	1,430,434	554,426	876,008
Remaining Budget - 12%:	193,399	4,443	188,956

Assisted Living Grant	(50,000)	
These were funds that the State pulled back from the Regions.		
Returned funds from tribes	(19,696)	
Reason for funds being returned:		
1. Service couldn't be used		
2. Carryover/Amendment wasn't accepted		
If this is a scenerio that may occur, please let us know in a timely		
manner so we can allocate these funds to other tribes		

FY2016 Financial Reporting Update

Services with unspent balances:	**Unspent %**
SHIP	7%
Personal Care	10%
Housekeeping	69%
Transportation	18%
LTC Ombudsman	33%
Congregate and Home Del. Meals	5%
Socialization & Recreation	45%
HPR Enhanced Fitness	39%
Respite	29%
IIIE Caregiver Training	41%
IIIE Info & Referral	30%

Questions?

- **Contact Information**

  ITCA-AAA, Region 8

  Phone: (602) 258-4822/Fax: (602) 258-4825

  Email Contacts:

  - Laurai.Atcitty@itcaonline.com
  - Karen.Primmer@itcaonline.com
  - Cynthia.Freeman@itcaonline.com

Thank you for your Attention