Community-Based Service Coordination: Connecting Services, Emergency Response, and Aging in Place
# Community-Based Service Coordination:
Connecting Services, Emergency Response, and Aging in Place

Establishing A Firehouse Service Coordination Program

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1: Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Section 2: Aging in Place</td>
<td>8</td>
</tr>
<tr>
<td>Section 3: Background</td>
<td>16</td>
</tr>
<tr>
<td>Section 4: Sample Service Coordination Agreement</td>
<td>21</td>
</tr>
<tr>
<td>Section 5: Program Structure</td>
<td>44</td>
</tr>
<tr>
<td>Section 6: First Responder Training</td>
<td>46</td>
</tr>
<tr>
<td>Section 7: Role of the Service Coordinator</td>
<td>49</td>
</tr>
<tr>
<td>Section 8: Resident Referral and Service Coordination</td>
<td>71</td>
</tr>
<tr>
<td>Section 9: Resident Welcome Packet</td>
<td>98</td>
</tr>
<tr>
<td>Section 10: Funding and Program Support</td>
<td>110</td>
</tr>
<tr>
<td>Section 11: Aging Resources</td>
<td>112</td>
</tr>
<tr>
<td>Section 12: Program Evaluation Tools</td>
<td>117</td>
</tr>
<tr>
<td>Section 13: Forms</td>
<td>125</td>
</tr>
</tbody>
</table>
Section 1: Introduction

Replication Manual
Firehouse Service Coordination Program
Establishing A Firehouse Service Coordination Program

**Mission:** Through a service coordinator associated with the Fire Division, at-risk community residents are identified. The service coordinator assists older adults and others with disabilities to link with supportive services and service providers who can assist them to safely and successfully age in place and maintain their independence.

**Goals:**

- Help a community’s residents safely remain in their homes for as long as possible.
- Connect a community’s older and disabled citizens with available in-home services.
- Educate Fire Division personnel and City staff on the special needs of older adults and residents with disabilities.
- Save money for the City and its residents.
- Enhance and integrate existing available community and in-home services.

**Service Coordination:** The Service Coordination profession has its roots in the affordable housing network – assisting our country’s most vulnerable older adults and people with disabilities with linkages to appropriate community-based services.

Service Coordination within a Firehouse takes the concepts of affordable housing service coordination and applies them to a larger community with an aging population.

**Why Establish A Firehouse Service Coordination Program**

The health care system, social services network, and the long-term care system are often disconnected and fragmented.

A Firehouse Service Coordination Program “bridges the gap” by connecting community residents with appropriate supportive services. This allows them to “age in place” in their community more successfully through this proactive response to prevent future emergency situations.
FOR THE RESIDENT
- Quality of life – The City cares about its residents
- Safety while living in their home/community
- Timely access to appropriate support and services

FOR THE CITY/FIRE DIVISION
- Appropriate use of emergency services
- Solutions for those in need vs. repeat responses without solutions

FOR THE SOCIAL SERVICE, HEALTH CARE and LONG TERM CARE NETWORK
- Insure residents are aware of community resources – Firehouse Service Coordination coordinates referrals to community providers
- Provide cost-effective in-home services vs. more costly residential services (nursing home, assisted living, etc.)

A Glimpse At The Process

The service coordinator, representing the Fire Division, is involved during or shortly after emergency calls.

The service coordinator meets with the resident, assesses their situation, offers information about supportive services, and follows-up to insure connectivity with the services and that the resident is satisfied with their choices.

Residents tend to be receptive to the service coordinator’s involvement due to their follow-up role through the Fire Division.

Local, replicable response to a national dilemma

**CHANGING THE PARADIGM OF CARE**

Responding to individual needs by connecting health care, social services, and long-term care through first responders at the “point of entry into the system.”
This manual is provided to assist you in the establishment of a Firehouse Service Coordination Program. Its contents represent protocols used and lessons learned in the development of two innovative programs in Ohio – STAY UA (Services to Age in Your Upper Arlington), and the FAST Program (Fire and Seniors Together), Chillicothe, Ohio. Although each replicated program will differ based on location, demographics, and needs, this manual offers broad insight into program development and implementation that we hope will be helpful to your replication initiative.

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Additionally, this manual reflects recommendations from an observational study undertaken by Sarah DeAnna, MSW student at The Ohio State University, as part of the requirements for the Graduate Interdisciplinary Specialization in Aging, Summer 2011.
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For additional information . . .

If you would like to learn more about the establishment of a Firehouse Service Coordination Program, in addition to the strategies, protocols and lessons learned outlined in this manual, please feel free to contact the following individuals who were instrumental in the development of the Upper Arlington and Chillicothe, Ohio programs.

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Section 2: Aging In Place

Replication Manual
Firehouse Service Coordination Program
Aging In Place

The Center for Disease Control defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." The ability to age in place is also relevant because older adults, or any person of any age, identify themselves by where they live. This sense of identity relates to the independence and autonomy one feels in one's own home, the relationships one builds within their family, friends and social connections, their neighborhood, and their role in their home and community. Thus the community is an extension of the home, especially if this community has an “age-friendly” infrastructure supportive of the aging adult, such as a Firehouse Service Coordination Program.

Below is a collection of excerpts from a variety of resources highlighting the need to support aging in place for the older population. Although some of these were authored a few years ago, they offer foundational information that continues to be relevant as we plan for our aging population.

Excerpts on Aging in Place: “Food for Thought”

*A Quiet Crisis is Looming for America’s Seniors, Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, Final Report to Congress, June 28, 2002*

Eighteen short years from now, 53 million Americans (one in six US residents) will be aged 65 or older. Today, 12.4 percent of the US population is 65 or older; in 2020 that figure will approach 20 percent. America needs to prepare for these changing demographics; this is the “Quiet Crisis.”

Senior Americans, whether rich, poor, or somewhere in the middle, face many barriers to an old age in which very basic human desires for physical safety, appropriate health care, and maximal independence are met. For some, crucial family supports will disappear as they outlive spouses or children move to distant places. For others, limited resources will prevent them from identifying and purchasing needed services. Many will lose their homes – long a symbol of their independence – due to rising property taxes and maintenance costs. Living alone, isolated from services and perhaps coping with disabilities that prevent social interactions, a large and growing number of seniors will face triple jeopardy: inadequate income, declining health and mobility, and growing isolation.

There will be more older people than children (0-14 years) in the population for the first time in human history.

*The World Health Organization (WHO), 2007*
A system that drives seniors to needless, premature institutionalization and expensive, preventable medical interventions will burden both seniors and those who must bear the costs for their care. Seniors who are able to remain in the community should receive the services they need to be as independent as possible. Neither institutionalization nor neglect should be the only alternatives they must accept……


Aging in Place: Coordinating Housing and Health Care Provision for America’s Growing Elderly Population, Kathryn Lawler, Fellowship program for Emerging Leaders in Community and Economic Development, Joint Center for Housing Studies of Harvard University, Neighborhood Reinvestment Corporation, October 2001

The elderly population is rapidly expanding while the core tax-paying population is shrinking. The ratio of working Americans to retired Americans will drop from 5-to-1, to 2-to-1 over the next fifty years. As the elderly population grows, and subsequently the need for adequate elderly health and housing services grows, the resources to provide services will decrease. Finding a more efficient means of service delivery is of paramount importance. Today, however, the current connections between elderly health and housing are tenuous at best. As a result, the most desirable and most cost-effective method of aging – aging in place – is difficult, even under the most ideal conditions.

......Aging in place with supportive services is not only the most desirable way of aging, but can achieve the efficiencies of the customized care model. Successful aging in place strategies minimize the provision of inappropriate care, and therefore the overall costs, by offering a range of flexible services and calibrating those services to fit the needs of the individual. Rather than a rigid service-delivery system, aging in place strategies create both health care and housing options that provide support at the margin of need as defined by an individual’s personal desire and efforts to live independently. Aging in place works best as part of a comprehensive and holistic approach to the support needs of an aging individual and an aging community.

......Community-based nonprofit organizations can play a number of critical roles in the development of aging in place programs. Using the powerful assets of their community networks and revitalization programs, these organizations can serve the Naturally Occurring Retirement Communities in their neighborhoods; employ paraprofessionals needed for a range of health and housing services (e.g., handyman and personal care assistants); inject aging into the local community planning process; and recognize the benefits of keeping the economic and social contributions of seniors in their communities.

Without changes in how communities are construed and services are delivered, older adults may find it increasingly difficult to live in their communities and may have to consider institutional care, which would translate to increased costs for states.

Aging in Place: A State Survey of Livability Policies, written by the National Conference of State Legislatures and the AARP Public Policy Institute, December 2011

For the eighth consecutive year, Genworth has surveyed long-term care service providers across the country. Genworth’s survey includes 437 regions that cover all Metropolitan Statistical Areas defined for the 2010 U.S. census.

Looking back at the past six years of survey results, Genworth recognizes emerging trends across the long-term care services landscape. Overall, the cost of care among facility-based providers has steadily increased. For example, in 2005 the median annual rate for a private nursing home room was $60,225, compared with the 2011 median annual rate of $77,745.

……In contrast to facility-based care, rates charged by home care providers for “non-skilled” services have remained relatively flat over the past six years. For example, whereas the national hourly private pay median rate charged by a licensed home health agency for a home health aide was $17.50 in 2005, the 2011 hourly rate has only slowly crept up to $19.00.


[This research] synthesizes new research about the complexities associated with remaining in one's own home when he/she is over 55 and has compulsive hoarding behaviour. And it examines how a collaborative community response promotes successful aging in place for this population.

.............social and health related organizations from different sectors, that in some way supported people with hoarding behaviour in Edmonton, AB, Canada, were brought together in 2007 through the leadership of the social worker of a seniors support agency called SAGE (Seniors Association of Greater Edmonton).

.............SAGE offers support through a program referred to as This Full House. And This Full House is a direct outcome of the work of the community collaborative. The aim of This Full House for older individuals with hoarding behaviour is to prevent eviction from their home, improve their health and well-being, maintain positive social contacts, and contribute to the building of a healthy community

Members of this collaborative represented a number of expert groups: social workers, home care nurses, geriatric neuropsychologists, geriatric nurses, fire and safety investigators, public health practitioners, and environmental health and safety officers. As a result of this group working together to respond to the needs of older adults with hoarding behaviour, several themes evolved from the data demonstrating direct benefits for these individuals: being able to remain in their own homes; reducing their potential for harm, and minimizing their isolation, all which allowed them to experience a feeling of empowerment which also helped them to generate insight into issues surrounding their hoarding behaviour.

In one instance, a professional social worker described how she could now present the risks associated with hoarding behaviour more objectively to a client with greater confidence as she could make reference to and more easily call on the authoritative role of the local fire department. Because the firefighter and social worker were both members of the collaborative, a close working partnership was facilitated. This benefit was expressed in this way: “when I mention to her [the client with compulsive hoarding behavior] the possibility of having someone from [the fire department] come and just do an assessment to let her know what her risk level is [i.e., of eviction from her home], she was suddenly open to that.”

Results demonstrated that when a highly collaborative approach to planning is used, there were quite direct benefits for older adults with hoarding behavior and, at the same time, there were benefits for the members of the community collaborative. .............Viewed in this light, aging in place may not always be possible, but it must be realized that community-level social and health related supports maximize the quality of later life while aging at home.

http://www.hindawi.com/journals/jar/2012/205425/
The Aging Population

“A Picture is Worth a Thousand Words”

In 1981: 26,220,797 people in the United States were between the ages of 65 and 100+

In 2011: 41,051,865 people in the United States were between the ages of 65 and 100+
In 2041: It is projected that 80,740,660 people in the United States will be between the ages of 65 and 100+


Couple this demographic information with the following statistics from A Profile of Older Americans, 2010, Administration on Aging, Department of Health and Human Services and the Executive Summary: Genworth 2011 Cost of Care Survey:

- About 30.1% (11.4 million) of all non-institutionalized older persons in 2009 lived alone (8.3 million women, 3.0 million men).

- The proportion living alone increases with advanced age. Among women aged 75 and over, for example, half (49%) lived alone.

- A relatively small number (1.6 million) and percentage (4.1%) of the 65+ population in 2009 lived in institutional settings such as nursing homes (1.4 million). However, the percentage increases dramatically with age, ranging (in 2007) from 0.9% for persons 65-74 to 14.3% for persons 85+.

- The cost of caring for non-institutionalized older adults (1.38% yearly increase) has been stable due to competition between community providers and availability of unskilled labor, while the cost of caring for institutionalized older adults (4.35% yearly increase) has grown due to the cost of maintaining stand-alone health care facilities.

- Some type of disability (i.e., difficulty in hearing, vision, cognition, ambulation, self-care, or independent living) was reported by 37% of older persons in 2009. Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs. In 2005, almost 37% of older persons reported a severe disability and 16% reported that they needed some type of assistance as a result.
Closing Comments

We cannot ignore the aging of our society as the demographic information so poignantly illustrates. In fact, in the very near future people from all walks of life, many inexperienced and/or untrained in the field of aging, will be called upon to care for our older adults as the needs of the aging population exceed our currently available resources. The Firehouse Service Coordination Program is an innovative way to address the needs of our older population in an efficient and quality manner.
Section 3: Background
Background

In mid-2008, the City of Upper Arlington, Ohio, was considering the needs of their older adult population with regard to special accommodations for certain city services (those 60 and over represent approximately 25% of the city’s population). Conversations were undertaken with various providers, including representatives of National Church Residences/InCare (NCR), one of the nation’s largest providers of housing and services for older adults, whose national headquarters is located in Upper Arlington.

City Council members and City Administrators recognized the needs and agreed it was important to support the older adult population more fully. However, City finances and staffing were not readily available to develop and/or support new programming. A Council Sub-Committee was formed to address issues such as program goals, job description, budget, funding sources, and the overall approach to program development.

Fire Division leadership and staff were enthusiastic about what soon would become known as the STAY UA Program (Services to Age in Your Upper Arlington). They had first-hand experiences (repeated responses for non-emergency situations, complicated healthcare and family situations without solutions, referrals to other agencies without timely response or acceptance by the resident), which illustrated the many needs of the City’s older adult population. They were interested in finding appropriate solutions for residents to help them more successfully live independently and, therefore, likely avoid or lessen repeated 911 calls and hospital transports.

From these conversations and a growing recognition that many of the City’s older residents were not familiar with and/or readily able to access supportive services when needed, the STAY UA program was developed as a pilot project beginning in April 2009 to “bridge the gap” – connecting Upper Arlington residents with appropriate supportive services to allow them to “age in place” in their community. Pilot project funding was provided by the John R. Glenn Foundation (established in honor of NCR’s founder) for the first year of operations—which supported a service coordinator position three days/week, computer, and car/travel expenses.

A service coordinator (an NCR employee) was situated in the fire division offices, with dual supervision by the City’s Coordinator of EMS Services and the NCR Vice President of Supportive Services. The service coordinator became available to address family needs during emergency situations, respond to end of life situations, interact during 911 abuse calls, assist with disaster preparedness, provide aging, wellness and prevention education for Fire Division staff, and much more. The program received considerable media attention and the service coordinator served 226 people during the pilot project, with notable successes that included 211 referrals to community providers, fewer 911 calls from repeat clients served, and proactive discovery of hazardous fire situations. Not only was the program well received by the City’s residents, it received a number of awards for innovation in health care delivery and public/private partnerships.
The program implementation process was not without challenges. Extensive efforts were undertaken to communicate the program goals and protocols throughout the community, with the intent of fostering a wide network of collaborations with home health and social service providers across the community.

At the end of the pilot test period, a competitive Request For Proposals was issued and a subsequent contract was entered into for implementation of the ongoing STAY UA program.

A second pilot program was launched in Chillicothe, Ohio in December 2009, supported by the Mary Ann Hydell Trust Fund. A service coordinator was housed in the City of Chillicothe Fire Department, and the goals of the program were introduced to city personnel and community agencies. Shortly after implementation of the program, the city as a whole and the fire department faced significant financial challenges and personnel reductions, which resulted in some opposition to a new concept being introduced into a firmly established set of protocols. Despite the challenges, the F.A.S.T. (Fire and Seniors Together) Service Coordination program worked to gain validity and awareness in the city of Chillicothe, resulting in overall success of the program. During the initial one-year pilot program, the service coordinator served 193 residents and made 169 referrals to community providers resulting in many notable successes. These successes include reduction of 911 non-emergency calls, collaborating with local community resources to coordinate care for older adults resulting in fewer unnecessary trips to the Emergency Room, and providing support, education and advocacy to frail and isolated older adults who have extremely limited support networks. This second pilot program provided valuable statistical and needs/outcome information from a community with vast demographic differences.

**Advice From Lessons Learned**

- Awareness of the community’s older adult needs and support from elected leaders, Fire Division, and Administrative Staff are essential components for program implementation and sustainability.
- Recognition of the local competitive health care environment and working to communicate appropriately to all potential partners/providers is essential for program success. In Upper Arlington a World Café (community conversation) was conducted to bring all community stakeholders together, to dispel myths and share the vision for the program, and to receive feedback and ideas regarding how the program could be most successful.
- Time spent building a strong public/private partnership is time well-spent (i.e., assuming that employing a service coordinator is likely not feasible for most governmental agencies, building a trusting relationship with the private partner for a program such as STAY UA dictates the success of the program).
- Identification of on-going program funding is essential in order to avoid raising community expectations and then not following through with expected services. Grants and philanthropic opportunities should be researched and pursued.
- Building the appropriate oversight structure to include an ethics committee and/or advisory council for the program provides assurances of quality and supervision that is important to the program's image.
- Prioritizing self-determination, confidentiality and freedom of choice is essential to program success.
Conflict Of Interest

A few home health providers in the Upper Arlington area were concerned that NCR/InCare, a provider of comprehensive senior services in the area who was also operating the STAY UA pilot program, was retaining an undue number of referrals giving them a financial advantage, which represented a conflict of interest.

Following is a description of NCR/InCare’s response to community concerns as presented in a “White Paper” prepared by NCR in September 2009.

According to the Journal of Business Ethics, a conflict of interest is “... a situation in which a person has a private or personal interest sufficient to appear to influence the objective exercise of his or her official duties as, say, a public official, an employee, or a professional.” NCR maintained that the InCare association with the City is not a conflict of interest and noted that they see their relationship with the City as a hospital or doctors might see their relationships with patients. Hospitals offer many health care options to their patients and doctors recommend repeat visits to their offices for care; these situations are not considered conflicts of interest. Of course there is always the possibility of unethical practices, and NCR has safeguards against unethical practices currently in effect at InCare that include:

- Training and supervision of professional staff on ethical practices
- Strict adherence to NCR’s pillars of ethics
  1. Full disclosure
  2. Presentation of Options
  3. Never mandatory, always optional – freedom of choice
- Oversight by an outside advisory board
- Governed by a community-based volunteer board of directors as a 501C3 nonprofit organization

Additionally, NCR/InCARE emphasized that their goals were the same as the City’s goals: to learn if a service coordinator attached to a fire department could reduce the 911 calls for frail seniors by linking UA residents to appropriate services. In an effort to further address the City’s concerns, NCR reviewed with the City several other options they could take to avoid the appearance of conflict of interest in regards to the STAY UA Program. These options were:

- InCare could step out of its role in STAY UA and the program be terminated.
- The City could bid out the contract under a public Request for Proposals process, which would result in the City selecting a preferred provider.
- The City could require that STAY UA be administered only by an organization that provides no other services.
- The City and NCR/InCare could require a high standard of ethics.

The City and NCR/InCare eventually agreed to adopt a high standard of ethics, basing these on the standards already developed by the Inspector General of the U.S. Department of Health and Human Services in 1997 with respect to Medicare hospital discharge planning. At that time, concerns were expressed that hospitals that sponsored home health agencies could unduly influence referrals of patients to their own agencies. The Inspector General recommended a process of full disclosure, patient education, and freedom of choice, and these guidelines are now accepted throughout the industry. Based on these standards,
NCR/InCare recommended that the STAY UA Program provide written standards of ethics be distributed to each resident:

- Full disclosure of the relationship and possible conflict of interest
- A comprehensive offering of services available from other organizations
- A clear statement that all services recommended by the service coordinator are always voluntary, always optional and never mandatory

Finally, NCR recommended there be an ethics committee to review ethical practices, maintenance of a registry of alternative providers which would be required to be distributed to each resident, and annual public disclosure requirements. Of course, NCR also welcomed any feedback on the program regarding the appearance of a conflict of interest.

The result of the above discussions and plans between NCR/InCare and the City were to continue working together, following the ethical standards above to avoid any appearance of conflict of interest issues.

Section 4: Sample Service Coordination Agreement
SAMPLE SERVICE COORDINATION SERVICES AGREEMENT

This Service Coordination Services Agreement (this "Agreement") is made and entered into to be effective this 1st day of April 2012 (the "Effective Date"), by and among National Church Residences, an Ohio non-profit corporation, having its principal office at 2233 North Bank Drive, Columbus, Ohio 43220; (Agency), and The City of Upper Arlington (City). All provisions as set forth in the Request for Proposal dated January 25, 2012 attached as Exhibit (A) and the Proposal submitted by Agency attached as Exhibit (B) and Addendum No.1 attached Exhibit (C) and the Memorandum of Understanding submitted by Agency attached as Exhibit (D) are integrated and made part of this Agreement. If there is a conflict between this Agreement, Exhibit (A) and Exhibit (B), and Exhibit (C) and Exhibit (D) it shall be resolved in the following order: Exhibit (A) and Exhibit (C) shall prevail over any conflict with provisions including terms and conditions contained in Exhibit (B) and Exhibit (D). Exhibit (A) shall control over any terms and conditions not specifically addressed in this Agreement or Exhibit (B).

Background

Service coordinators are necessary to coordinate supportive services for the elderly, disabled, and families. Service coordinators are social service staff persons who link elderly or disabled residents to the supportive or medical services in the general community necessary for such residents to remain independent and in their own homes.

The Agency employs individuals who are qualified to perform the functions of a service coordinator. The City of Upper Arlington has chosen National Church Residences, and National Church Residences has agreed to provide one or more employees to perform the service coordinator functions for the City.

The City and the Agency desire to set forth the terms and conditions pursuant to which National Church Residences will provide the services stated in the Request for Proposals it submitted to replace the Coordination of Services provided in the STAY UA program piloted from the time frame of April 1, 2012 to March 31, 2014.

Agreement

In consideration of the following mutual promises, the parties agree as follows:

Section 1. Scope of the Agency's Services.

1.1 The Services. The Agency shall provide one employee to perform the functions of a service coordinator for the City. The functions of a service coordinator shall include without limitation those functions specified in Schedule 1 to this Agreement, as that schedule may be modified from time to time. In addition, the Agency shall provide such additional services as are specified in Schedule 2 to this Agreement, as that schedule may be modified from time to time, and such additional services as are otherwise required to fulfill the Agency's obligations under this Agreement (collectively, the performance of the service coordinator functions and the performance of the additional services shall be referred to collectively herein as the "Services").
1.2 **Relationship of Parties.** The Agency shall be an independent contractor. The Agency's employee will receive instruction on the object(s) and goal(s) for which they are responsible, but will exercise their own discretion and professional judgment to attain those goals. Each service coordinator provided by the Agency to the City to perform Services will be employees of the Agency and will at all times be subject to the direct supervision and control of the Agency, provided that the service coordinator shall observe the working rules and security regulations of the City and shall not perform his or her duties in a manner that unreasonably interferes with the City's business and operations. The Agency acknowledges and agrees that: (i) the City will have no responsibility to provide to the Agency or its assigned employees insurance, vacation, or other fringe benefits normally associated with employee status, including, but not limited to participation in any welfare benefit plan sponsored by the City for the benefit of its employees; (ii) the Agency will not hold itself or its staff out as nor claim to be an officer, partner, joint venturer, employee or agent of the City (iii) the Agency shall be responsible for reporting, withholding and payment of all income, unemployment, FICA or similar taxes for the Agency and its staff; and (iv) the Agency shall, at its own expense, comply with all applicable laws, including but not limited to the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, immigration laws, workers' compensation laws, and occupational safety and health laws and any regulations related thereto. (v) the Agency shall, at its own expense comply with the Ohio Revised Code, the Charter of the City of Upper Arlington, all City ordinances and administrative rules. (vi) the Agency shall comply with all federal laws applicable to this service including but not limited to the STARK law. The Agency shall comply with all the requirements of Municipal Income Tax as set forth in Section 4.5 of Exhibit (A). Legal actions to enforce this agreement are in accordance with Section 4.1 of Exhibit (A).

1.3 **Level of Service.** The Services will be performed by the Agency in a professional and conscientious manner by qualified employees of the Agency.

1.4 **Personnel.**

1.4.1 If requested by the City, the Agency shall designate, in addition to the service coordinator(s), a supervisor (the "Supervisor") to serve as a primary point of contact among the Agency and the City and to be responsible for the performance of the Agency's obligations under this Agreement.

1.4.2 The Agency shall have the right, at any time, to request the removal of any employee of the Agency whom the City (in either party's sole discretion) deems to be unsatisfactory. Upon such request, the Agency shall promptly replace such employee with a qualified substitute employee. It is agreed, notwithstanding the foregoing, that at all times, all employees of the Agency shall be considered, for all purposes, employees of the Agency and not of the City. The City shall not have the authority, on behalf of the Agency or otherwise, to discharge, promote, suspend or otherwise discipline any employee of the Agency assigned to perform Services under this Agreement.

1.5 **Reports.** The Agency shall prepare and submit Monthly Performance Reports as described in Exhibit D and on the schedule prescribed therein. The City Manager and Agency
shall mutually agree to the design and structure of the report noted as Exhibit D in this agreement. Exhibit (D) shall then be incorporated and made part of this Agreement.

1.6 **Books and Records.** The Agency shall keep, at its own expense, accurate, true and complete books and records with respect to the Services provided by the Agency and with respect to the costs, expenses and other charges related to the Services. Such books and records shall be kept at the Agency's principal place of business and shall be made available to the City and their representatives at all reasonable times for examination, audit, inspection, transcription and copying so as to allow the City to verify all invoices, charges, costs, expenses and fees related to the Services charged to City.

1.7 **Investigation of Service Coordinators.** The Agency agrees to conduct extensive investigations of each service coordinator. Such investigation shall include, but shall not be limited to, the following: (a) confirmation of personal data, education, and employment history; (b) checks on general reputation and character; (c) appraisal of ability to do the job based on past Performance; (d) credit references and review of civil and criminal court records; and other criminal background checks to determine prior criminal record history (e) determination of any existing or potential conflict of interest situations and (f) the submission of a request for a criminal check for all direct care givers working with the elderly as mandated under OAC 173-41-01. Investigation information shall be provided to the City of Upper Arlington.

2. National Church Residences shall designate a Manager (Enriched Housing Services Manager) to be the contact person at National Church Residences for the City of Upper Arlington/Fire Department related to daily operational issues.

National Church Residences shall designate a Director of Quality Assurance to review the written documentation and reports generated by the service coordinator on a monthly basis for completion and accuracy. The Director will do a comprehensive review of the resident files maintained by the service coordinator in AASC Online every three months. This review will include whether the service coordinator is utilizing the required forms as set forth by the American Association of Service Coordinators (Intake Form, Confidentiality Agreement, Assessment Form, Referral and Follow-up forms, Release of Information Form and Progress Notes). The review of the service coordinator's files will include an examination of whether the needs of the resident were clearly identified along with whether appropriate referrals were completed. The Director of Quality Assurance will produce a written report of findings that will be made available for review by the service coordinator, the Project Team and the City of Upper Arlington. The Director of Quality Assurance will provide on a monthly basis (or more often upon request by the City of Upper Arlington) reports utilizing the AASC Online program. The report will describe the outcomes achieved by the service coordinator related to the goals of the program.

National Church Residences shall designate a Vice President of Support Services to meet with the service coordinator for one hour every two weeks to provide clinical supervision. This hour will consist of a review of the interactions the service coordinator has had with residents over the previous two weeks. He will review with the service coordinator the number of referrals and the results of the referrals. He will consult with the service coordinator to give guidance and direction related to clients that are difficult to engage with or who are not utilizing available resources.
3. **City Manager.** The City Manager shall perform all duties as required under City ordinances and perform the obligations in this Agreement including but not limited to the enforcement of contract terms.

4. **Term and Termination.**

4.1 **Term.** This Agreement shall commence on the Effective Date and shall continue in effect for a period of two years with the City having the option for two (2) one year renewals periods, unless earlier terminated in accordance with the provisions of this Agreement. The City shall no later than thirty (30) days prior to the end of the Term provide notice of renewal to Agency. Failure to exercise this right to renewal shall result in the termination of this Agreement.

4.2 **Termination Without Cause.** Any party may terminate this Agreement with or without cause, by providing written notice to the other party of the intent to terminate this Agreement at least Ninety (90) days prior to the effective date of the termination.

4.3 **Termination With Cause.** The City may terminate this Agreement effective immediately upon providing the Agency with written notice of the termination for cause. If, through any cause, the City shall fail to fulfill in a timely manner and proper manner its obligations or if the City shall violate any of the covenants, agreements or stipulations of the contract, the Agency shall have the right to terminate the contract by giving written notice to the City of such termination and specifying the effective date of termination at least thirty (30) days prior to the effective date of the termination.

4.4 **Termination For Convenience.** This section as referenced in the RFP Exhibit (A) 4.8 is hereby deleted.

4.5 **Return of Material and Information.** Upon termination of this Agreement, or any time upon the City’s written request, the Agency shall promptly return to the City all copies of any Protected Resident Information, Protected Business Information or other data, records, information or materials provided or made available to the Agency by the City or in connection with this Agreement, as well as all data, records, information and materials prepared by the Agency or the Agency’s employees pursuant to the requirements of this Agreement.

4.5 **Survival.** All rights and obligations herein that become absolute before expiration or termination of the Term or that are of a continuing nature will survive any expiration or termination of the Term for any reason.

5. **Fees, Expenses and Payment.**

5.1 **Payment to the Agency.** In consideration of the Agency performing the Services, the City shall pay the Agency $0.00 per hour for each hour that the Service Coordinator provides Services. It is expected that the Service Coordinator(s) will provide, on average, 24 hours of Services to the City each week. The Service Coordinator shall be made available 24 hours a day for consultation purposes. The Agency acknowledges that, regardless of the amounts paid to Agency, Agency shall be solely responsible for all salary(ies) and benefits of the Service Coordinator(s), insurance and workers' compensation coverage for the Service
Coordinator(s), supervision by the Agency of the Service Coordinator(s), and the Agency's administrative expenses related to the Services.

6. **Ownership Rights.** All files containing Protected Resident information and all data, records, information and materials prepared by the Agency or the Agency's employees pursuant to the requirements of this Agreement shall be the property of the City and shall, upon the termination of this Agreement, be returned to the City in accordance with the provisions of Section 4.4 of this Agreement. In the event that the Agency needs access to any of the foregoing for review or evaluation purposes, the City shall make such items reasonably available to the Agency.

7. **Confidential Information.**

7.1 All information concerning the City's residents ("Protected Resident Information") shall be confidential. For the Term of this Agreement and thereafter, the Agency shall be responsible for assuring that only its employees and agents who have a need to know shall have access to Protected Resident Information, shall not republish or make accessible to any unauthorized person or entity any Protected Resident Information without obtaining from the Resident express written consent that complies with all applicable state and federal laws, and shall not otherwise use Protected Resident Information except as authorized by this Agreement.

7.2 All information related to City's operations that is communicated to, learned, developed or otherwise acquired by Agency (including but not limited to information regarding the City's business plans, finances, vendors, customers, research, technology, products, or developments), which is not publicly available or otherwise available to any third party, will be kept confidential. Agency will not, beginning on the date of first association or communication between the parties and continuing through the term of this Agreement and for a term of three (3) years thereafter, disclose, or permit disclosure to another, or use for the Agency's benefit or the benefit of another, any such Protected Business Information except as authorized by this Agreement. The parties expressly agree that the City will be entitled to injunctive and/or equitable relief in any court of competent jurisdiction to prevent or otherwise restrain a breach of this Agreement by Agency. This subsection will be binding on the parties and their employees, subcontractors and agents. Nothing in this section shall obligate the City to withhold information that may be deemed a public record under Ohio's Public Records laws.

7.3 Notwithstanding the foregoing, Agency will not have any obligation under this subsection with respect to Protected Business Information to the extent (i) such information is publicly available or available from a third-party not under any obligation of confidentiality or (ii) such information is independently developed by the recipient. In addition, Agency will not have any obligation under this subsection with respect to Protected Business Information or Protected Resident Information, to the extent that such information is subject to disclosure under lawful governmental subpoena or order (provided that the Agency first gives notice reasonable under the circumstances of the requirement to disclose to the City and affords them opportunity reasonable under the circumstances to resist such disclosure).

7.4 The parties acknowledge that, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), one or both of them may be required to comply with
certain confidentiality and/or security standards relating to information gathered or generated as a result of the Services provided pursuant to this Agreement. The parties agree that, should either HIPAA or any applicable regulations promulgated thereunder require the parties to adopt such additional standards relative to this Agreement the parties will in good faith negotiate any required addendum to the Agreement. The HIPAA protocol contained in Exhibit (B) shall be incorporated and controlling.

8. **Warranties.**

8.1 **Warranties of the City and National Church Residences.** The City warrants and represents that they are authorized to enter into this Agreement.

8.2 **Warranties of the Agency.** The Agency warrants and represents that: (a) the Agency has the full and unrestricted right, power and authority to enter into this Agreement and to perform the Agency's obligations in accordance with the terms of this Agreement; (b) the Agency will perform all Services exercising due care and in a professional and conscientious manner, using employees of the Agency having the proper character, experience, skills, training and professional education to render the Services which such employees of the Agency provide to the City and National Church Residences; (c) the Agency's performance of the Services does not and will not violate any (i) applicable law, rule or regulation or (ii) agreement, obligation or understanding (whether oral or written) to which the Agency is a party; (d) all Services shall be provided only by the Agency; (e) the Agency and its employees have been issued all required licenses by the appropriate local, state and federal agencies, that such licenses are current and have not been terminated, that all fees applicable to the issuance of said licenses have been paid, and that all prerequisites to the issuance of said licenses or prerequisites to the maintenance of said licenses have been complied with.

9. **Indemnification.** To the fullest extent allowed by law, the Agency shall indemnify and hold harmless the City, its employees and agents, from any liability for claims, damages, losses and expenses, including reasonable attorney fees, resulting from the negligent performance of the contract, or any negligent act or omission, by Agency, its employees, agents, subcontractors or assigns. The Agency's obligation to indemnify under this section shall not be construed to negate, abridge, or reduce other rights of indemnity or contribution to which the City, its agents or employees are legally entitled. The City does not agree to indemnify or hold harmless the Agency, its employees and agents, from any liability for claim, damages, losses and expenses, including reasonable attorney fees resulting from or arising under the contract.

10. **Miscellaneous.**

10.1 **Governing Law.** The validity, term, performance and enforcement of this Agreement shall be governed and construed by its provisions and in accordance with the laws of the State of Ohio, City of Upper Arlington including the City Charter (without regard to conflicts of laws principles) as if this Agreement were negotiated, executed, delivered and performed solely in the State of Ohio. The City hereby irrevocably and unconditionally consents to submit to the exclusive jurisdiction of the state and federal courts located in Columbus, Ohio for any action, suit or proceeding arising out of or relating to this Agreement and the transactions contemplated hereby. The provisions of this Section 9.1 shall survive any termination of this Agreement.
10.2 **Insurance.** During the term of this Agreement the Agency shall maintain the following types of insurance, in the following amounts:

- **General Liability** $1 million per occurrence
- **Automobile Liability** $1 million per occurrence
- **Worker's Compensation** Statutory coverage
- **Employer's Liability** $1 million each accident/employee/policy limit

Upon the request of the City, the Agency shall provide the City with certificates of insurance evidencing such coverage and naming the City as an additional insured thereunder. The Agency shall maintain, during the term of this Agreement, workers' compensation insurance as statutorily required and shall provide the City with a certificate of insurance evidencing such coverage. The Agency agrees to defend and hold the City harmless from and against any and all claims or liability asserted by any employee of the Agency or any individual it assigns to perform the Services. In furtherance of the foregoing, the Agency hereby expressly waives any and all statutory and/or constitutional immunity to which, but for this waiver, it might be entitled (i) as an employer in compliance with the State of Ohio's workers' compensation laws or (ii) under any other employee benefit statutes or similar laws of any jurisdiction. The City hereby incorporates the Insurance requirements as set forth in Exhibit (A) Section 4.4. Any conflict with this section on Exhibit (A), Exhibit (A) shall control.

10.3 **Waiver; Amendment.**

10.3.1 Neither the failure of any party to this Agreement to take any action or to demand compliance with its terms shall be deemed to be a waiver of any right or remedy of any party hereunder nor shall any action taken pursuant to this Agreement, including any investigation by any party hereto or any demand for partial relief or for compliance with its terms in a single instance, be deemed to constitute a waiver by the party taking such action or making such demand of any right or remedy hereunder. No waiver of any particular term hereof or in any particular instance shall in any event be deemed a waiver of any subsequent occurrence under the same or any other term contained herein. The waiver by any party of any of the conditions precedent to its obligations under this Agreement shall not preclude it from seeking a remedy for breach of this Agreement.

10.3.2 No waiver of any right or remedy hereunder and no amendment, change or modification of the term hereof or rescission or termination hereof shall be binding on any party hereto unless it is in writing and is signed by the party to be charged.

10.4 **Notices and Payments.** Any notices and any payments required or permitted to be given under this Agreement shall be properly made if in writing and hand delivered or mailed by certified or registered mail, postage prepaid with return receipt requested, to the party for whom intended at the address for such party set forth in the preamble to this Agreement, or at such other address or addresses as either party may designate from time to time by notice given in the foregoing manner. Any notice regarding this Agreement shall be to the attention of the City Manager, City of Upper Arlington, 3600 Tremont Road, Upper Arlington, Ohio, 43221.

10.5 **Remedies.** The Agency acknowledges and agrees that the City remedy at law for breach of the Agency's covenants, agreements and obligations under this Agreement will be inadequate, and that the City shall be entitled to appropriate equitable relief with respect to any such breach. The Agency further acknowledges and agrees, however, that the City shall
have the right to seek a remedy at law as well as, or in lieu of, equitable relief in the event of any such breach.

10.6 **Assignability.** This Agreement is a personal service agreement for the services of the Agency and the Agency’s interest in this Agreement, duties hereunder and or fees due hereunder may not be assigned, subcontracted or delegated to a third party without the prior written consent of the City. The benefits and duties of this Agreement are, however, assignable by the City and upon an assignment of the benefits and duties of this Agreement by the City, as applicable, shall have no further liability or obligation under this Agreement.

10.7 **Duplicate Originals.** This Agreement may be executed in one or more counterparts, each of which shall be deemed to be a duplicate original, but all of which, taken together, shall be deemed to constitute a single instrument.

10.8 **Entire Agreement.** This Agreement and the exhibits attached hereto set forth the entire understanding between the parties concerning the subject matter hereof and supersede all contemporaneous and prior negotiations, understandings, and agreements, whether oral or written, with respect to the subject matter hereof. There are no covenants, promises, agreements, conditions or understandings, whether oral or written, among the parties hereto relating to the subject matter of this Agreement other than those set forth herein. No representation or warranty has been made by or on behalf of any party to this Agreement (or any officer, director, employee or agent thereof) to induce any other party to enter into this Agreement or to abide or consummate any transactions contemplated by any term of this Agreement, except representations and warranties, if any, expressly set forth herein.

10.9 **Partial Invalidity.** If any term or provision of this Agreement or the application thereof to any person, entity or circumstance, shall be invalid or unenforceable, the remainder of this Agreement shall be unaffected thereby and each remaining term or provision of this Agreement shall be valid and be enforced to the fullest extent permitted by law.

**Section 10.10. Signing and Return of Services Agreement.** Failure by the Agency to sign and return this Services Agreement to the City before May 1, 2012, shall result in nullification of this Agreement and termination of the service-coordination relationship between the Agency and the City.

This Agreement may be executed with signatures delivered by either facsimile or scanned e-mail and copies of such signatures so delivered shall be deemed as originals.
IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the date first above written.

“Agency”

National Church Residences

________________________________________
Daniel Fagan
Vice President of Support Services

Date: __________________________

“The City”

The City of Upper Arlington

________________________________________

Date: __________________________
Schedule 1

The Service Coordinator designated by the Agency and assigned to the City will:

- Participate in National Church Residences Service Coordinator orientation program conducted by InCare.
- When possible and appropriate, participate in National Church Residences training.
- Unless prohibited by law or professional ethical standards, inform City management of any resident incident or issue which adversely impacts the City, or the safety/security of the City. (see "Confidentiality Agreement" form).
- Maintain an office in the UA Firehouse.
- Maintain specified office hours at the UA Firehouse as decided upon between Service Coordinator, EMS Captain and Service Coordinator Manager at National Church Residences. Weekly work schedule should be in writing, and changes in schedule should be discussed with EMS Captain and Service Coordinator Manager prior to implementation.
- Access and respond to National Church Residences email system at least weekly. National Church Residences will provide this email service.
- Ensure privacy and confidentiality of resident files, including the acquisition of written releases from residents with respect to the disclosure of personal information, in form that complies with all applicable state and federal requirements and that is reasonably acceptable to National Church Residences.
- Meet at least weekly with the EMS Captain and bi-weekly with Service Coordinator Manager to provide updates on planned educational sessions, agency meetings, and/or weekly schedule changes. Individual resident issues should not be discussed.
- Fill out and distribute appropriate report in a timely fashion and document appropriate information in resident files, in a form reasonably acceptable to National Church Residences Director of Quality Assurance.
- Unless prohibited by law or professional ethical standards, report any suspected cases of abuse, neglect, or exploitation of a resident to the City Manager and National Church Residences Director of Quality Assurance when possible, before notification of the appropriate public or private agency.
- Advise residents and families of service options but not force residents to accept the assistance of the Service Coordinator or the services of outside providers.
- Monitor the effectiveness of services provided to the residents and inform National Church Residences Director of Quality Assurance of any issues or concerns related to those services.
- Advise the EMS Captain of potential changes in a resident's behavior which may interfere with his or her residency in the City.
- Inform as many residents as possible of the availability and purpose of the Service Coordinator position.
- Service Coordinator will comply with STAY UA Service Coordinator Job Description

Notwithstanding the foregoing, the Service Coordinator shall not do any of the following:
- The Service Coordinator shall not act as a notary or a witness to a proxy for health care or a health care power of attorney or similar documents
• The Residence Service Coordinator shall not accept valuable gifts from residents or service providers.

**Schedule 2**

**The Agency, through its Supervisor, Will**

• Assist in the development of the service coordination program within the City.
• Provide guidance on problem-solving methods and service coordination practices.
• Recommend and monitor educational opportunities regarding service coordination.
• Provide necessary training and orientation of the Service Coordinator and the City Manager, as appropriate.
• Be available for consultation on or mediation of unresolved issues facing the Service Coordinator and the City.

**Schedule 3**

**The Vice President of Support Services will:**

• Implement this Agreement after consultation with the City Manager, the Agency, and the Service Coordinator.
• Initiate the reporting and policy procedures of the position and see to the adherence by all participants of such procedures, as National Church Residences may deem necessary or appropriate.
• Provide monitoring oversight of the Service Coordinator and other Quality Assurance functions.
• Be available for consultation on or mediation of unresolved issues facing the Service Coordinator and the City.
• Participate in setting goals and objectives for the Service Coordinator.
• Create and sustain an Ethics Committee specifically for the purposes of oversight of this program. The Ethics Committee will meet at least every two months to work through a specific agenda. The Ethics Committee will be chaired by the Vice President of Support Services. The service coordinator will attend these committee meetings upon the invitation of the committee. The City of Upper Arlington will be encouraged to designate a representative to the committee. The Upper Arlington Council on Aging will be formally offered a seat on this committee. There will be invitations extended to various senior service agencies and providers until there are at least five additional seats on the committee.

**Schedule 4**

**The City through the EMS Captain will:**

• Whenever possible, participate with the Agency in the evaluation process of the service coordination program.
• Communicate regularly and on an as-needed basis with the Service Coordinator regarding City updates.
• Advise the Service Coordinator not to perform direct planning or preparation of social or recreational activities of the over-all community. However, SC's may participate in these activities at the invitation of the City.
• Allow the Service Coordinator limited access to the EMS Captain's resident files on an as-needed basis.
• Inform the Service Coordinator of changes in residents' condition that may impact the residents' ability to continue services set up by Service Coordinator or ability to reside in their home.
• Introduce the Service Coordinator to residents, families, and known service providers.
• Use its best efforts to prevent the Service Coordinator from acting on behalf of or in place of the EMS Captain.
• Advise the Service Coordinator that he or she may not act as a Notary Public or as a witness to a Health Care Proxy or Power of Attorney.
• Advise the Service Coordinator that he or she may not accept valuable gifts from residents or service providers.
City of Upper Arlington, Ohio

Division of Purchasing
3600 Tremont Rd
Upper Arlington, Ohio 43221.1595

Request for Proposals

For

Coordination of Services for the STAY UA Program

Proposal Opening Time:

January 25, 2012
Proposals will be received by the Division of Purchasing, City of Upper Arlington, 3600 Tremont Road, Upper Arlington, Ohio 43221 until 5:00 P.M. on January 25, 2012.

Coordination of Services for the STAY UA Program

Request for Proposals may be obtained from the Purchasing Division, City of Upper Arlington, 3600 Tremont Road, Upper Arlington, OH 43221.

The City of Upper Arlington reserves the right to reject any and all proposals, to waive any and all informalities, and to disregard all non-conforming, nonresponsive, or conditional proposals.

Each Proposer must insure that all employees and applications for employment are not discriminated against because of their race, creed, color, sex, religion, national origin, age, handicap status, or veteran status.

Barbara Podnar
Purchasing Administrator

Theodore Staton
City Manager

Columbus Dispatch
1-04-12
Table of Contents

1. Legal Notice to Proposer
2. Description of STAY UA Services
3. Program Results
4. Information to Proposers
5. Proposal Submission Procedures
6. Scope of Project
2. Description of Services

The City of Upper Arlington conducted a pilot program known as STAY UA (Services to Age in Your Upper Arlington) in collaboration with InCare/National Church Residences funded by the Reverend John R. Glenn Foundation. The Pilot Program began in April 2009 and concluded in March 2010. In April 2010, through an RFP process a contract for services was awarded to InCare/NCR. The contract is due to expire in March 2012.

The goals of STAY UA:

- Assisting residents to remain safely in their homes for as long as possible
- Connect elderly and disabled residents with available in-home services.
- Educate City Staff on the special needs of elderly and disabled residents
- Enhance and integrate existing available community and in-home services
- Reduce costs for the City and its residents

The program was designed to test the viability of service coordination through first responders-Fire and EMS. A service coordinator receives referrals to the STAY UA program after emergency runs by Fire and EMS. However, referrals can be initiated by other sources including but not limited to other Upper Arlington residents, churches, the Senior Center, Police, Doctor's offices and family members. By involving a service coordinator shortly after emergency calls, the resident is most often receptive to interventions. Through this early involvement, the needs of the resident are discovered and matched with available community services. It has been stated that STAY UA is a proactive approach that bridges the gap between health care, social services and long-term care systems.

It is believed that STAY UA is one of the first formalized service coordination program associated with Fire and EMS. There has been interest in replicating the program expressed by various other fire departments in Ohio.

The City is searching for a qualified community provider or providers who will assist in the continuance of the services provided by the STAY UA program. While the City has been pleased with the results of the current STAY UA program, the City is open to considering alternative proposals that achieve the goals of the program but may differ in approach or service delivery.

3. Program Results

There have been 347 individuals referred to the STAY UA program since its inception in April 2009 through March 31, 2011. A total of 268 referrals were made by the Service Coordinator to community agencies/service providers.

Some examples of community agency/service provider groups include:
- Healthcare Services
- Mental Health Services
- Case Management
- Home Management
- Monitoring Services
- Transportation
4. Required Contract Terms

4.1 APPLICABLE LAWS: The Revised Code of the State of Ohio, the Charter of the City of Upper Arlington and all City ordinances and administrative rules insofar as they apply to the laws of competitive bidding, contracts and purchases are made a part hereof. Legal action to enforce this agreement shall only be brought in a court of competent jurisdiction in Franklin County, Ohio.

4.2 INDEMNIFICATION BY PROVIDER: To the fullest extent allowed by law, the Provider shall indemnify and hold harmless the City, its employees and agents, from any liability for claims, damages, losses and expenses, including reasonable attorney fees, resulting from the negligent performance of the contract, or any negligent act or omission, by Provider, its employees, agents, subcontractors or assigns. Provider's obligation to indemnify under this section shall not be construed to negate, abridge, or reduce other rights of indemnity or contribution to which the City, its agents or employees are legally entitled.

4.3 NO INDEMNIFICATION BY CITY: The City does not agree to indemnify or hold harmless the Provider, its employees and agents, from any liability for claims, damages, losses and expenses, including reasonable attorney fees, resulting from or arising under the contract.

4.4 INSURANCE: The Provider shall not commence work under this contract until he/she has obtained all insurance required under this paragraph and such insurance has been approved by the City nor shall the Provider allow any subcontractors to commence work on this subcontract until all similar insurance required for coverage of the subcontractor has been so obtained and approved.

4.4.1 The Provider agrees to maintain Comprehensive General Liability and Comprehensive Automobile insurance covering all operations directly or indirectly incident to the work under this contract whether such operations are by the Provider or by any subcontractor or by anyone directly or indirectly employed by either of them. Such insurance coverage shall be maintained in the types and amounts herein specified for all work sublet, either by furnishing endorsements of his/her own liability insurance coverage or by requiring the subcontractors concerned to furnish their own liability insurance of the types and in the amounts herein specified. Such Comprehensive General Liability Insurance and Comprehensive Automobile Liability Insurance shall provide coverage against claims for damages for personal injury, including accidental death, and for property damage which may arise from any operations under this contract. Without limitation on the generality of the foregoing requirements, such insurance shall include coverage for claims arising from liability assumed by the Provider under this contract including third party beneficiary liability coverage.

4.4.2 The Provider shall take out and maintain during the life of this contract, Workers' Compensation Insurance for all of his/her employees employed on the project, and, in case any work is sublet, the Provider shall require the subcontractor similarly to provide Workers' Compensation Insurance for all of the latter's employees unless such employees are covered by the protection afforded by the Provider.

4.4.3 The limits of liability of the insurance required herein shall be not less than $1,000,000 for each person; and $1,000,000 each occurrence for Bodily Injury or Accidental Death; and $500,000 each occurrence for Property Damage. To reach such limits of liability, excess liability or umbrella coverage, in at least these amounts, may be used.
4.4.4 Such insurance policies as Provider may carry to comply with these insurance requirements shall be endorsed to provide that the policies will not be changed or cancelled without twenty (20) days prior written notice to the City. Before execution of the contract the Provider shall provide an endorsement on its liability insurance policy except for workers' compensation insurance naming the City as an additional insured, along with a Certificate showing full compliance with these insurance requirements. If any part of this contract is sublet, the Provider is responsible for obtaining certificates of insurance establishing that the subcontractors have complied with the insurance requirements herein contained unless the Provider's insurance specifically covers the operations of his subcontractors. Copies of all insurance policies, endorsement thereto, and receipts for payments of premiums shall be deposited by the Provider with the Purchasing Administrator.

4.5 MUNICIPAL INCOME TAX: The Provider shall withhold all City income taxes due or payable under the provisions of the Income Tax ordinance for wages, salaries, and commissions paid to its employees pursuant to Chapter 201 of the Codified Ordinances of the City of Upper Arlington, Ohio. The Provider shall require its subcontractors to withhold any such City income taxes due for services performed under this Contract. The Provider will be required to sign a tax affidavit as required under section 5719.042 of the Ohio Revised Code.

4.6 FORCE MAJEURE: For the purpose hereof, force majeure shall be any of the following events: acts of God or the public enemy; compliance with any order, rule, regulation, decree, or request of any governmental authority or agency or person purporting to act therefore; acts of war, public disorder, rebellion, terrorism, or sabotage; floods, hurricanes, or other storms; strikes or labor disputes; or any storms; strikes or labor disputes; or any other cause, whether or not of the class or kind specifically named or referred to herein not within the reasonable control of the party affected.

A delay in or failure of performance of either party shall not constitute a default hereunder nor be the basis for, or give rise to, any claim for damages, if and to the extent such delay or failure is caused by force majeure. The party who is prevented from performing by force majeure (i) shall be obligated, within a period not to exceed fourteen (14) days after the occurrence or detection of any such event, to give notice to other party setting forth in reasonable detail the nature thereof and the anticipated extent of the delay, and (ii) shall remedy such cause as soon as reasonably possible:

4.7 TERMINATION OF CONTRACT FOR CAUSE: If, through any cause, the Provider shall fail to fulfill in a timely manner and proper manner its obligations or if the Provider shall violate any of the covenants, agreements or stipulations of the contract, the City shall thereupon have the right to terminate the contract by giving written notice to the Provider of such termination and specifying the effective date of termination. The notice may be mailed, hand-delivered, or sent electronically. In that event, and as of the time notice is given by the City, all finished or unfinished services, reports or other materials prepared by the Provider shall, at the option of the City, become its property, and the Provider shall be entitled to receive compensation for any satisfactory work completed, prepared documents or materials as furnished. Notwithstanding the above, the Provider shall not be relieved of liability to the City for damage sustained by the City by virtue of breach of the contract by the Provider and the City may withhold any payments to the Provider for the purpose of set off until such time as the exact amount of damages due the City from the Provider is determined.
4.8 TERMINATION OF CONTRACT FOR CONVENIENCE: The City may terminate the contract at any time by giving written notice to the Provider of such termination and specifying the effective date thereof, at least thirty (30) working days before the effective date of such termination. The notice may be mailed, hand-delivered, or sent electronically. In that event, all finished or unfinished services, reports, material(s) prepared or furnished by the successful Proposer under the contract shall, at the option of the City, become its property. If the contract is terminated due to the fault of the successful Proposer, termination of contract for cause relative to termination shall apply. If the contract is terminated by the City as provided herein, the successful Supplier will be paid an amount as of the time notice is given by the City which bears the same ratio to the total compensation as the services actually performed or material furnished bear to the total services/materials the successful Proposer covered by the contract, less payments of compensation previously made.

4.9 BACKGROUND CHECKS: The Provider shall furnish background checks on all employees, including the employees of subcontractors, who provide services under the contract.

5. Proposal Submission Procedures:

5.1 PROPOSAL SUBMISSION: Submission of proposals will be received at the City of Upper Arlington, 3600 Tremont Road, Upper Arlington, Ohio 43221, until 5:00 P.M. January 25, 2012. Any proposal received after the time and date specified will not be considered unless the Purchasing Administrator determines it is in the best interest of the City. The City will not be responsible for delays caused by the U.S. Postal Service or any other means of delivery employed by the Proposer. The proposals must be submitted in sealed envelopes addressed to the Purchasing Administrator of the City of Upper Arlington bearing on the outside the name and address of the Proposer.

5.1.1 Each Proposer must submit four (4) complete copies of the Proposer's entire proposal, containing original signatures, price entries and other required information and with all attachments and certificates required by the RFP documents.

5.1.2 Proposals may be modified or withdrawn by an appropriate document duly executed and delivered to the place where proposals are to be submitted at any time prior of the opening of proposals. No proposal may be modified or withdrawn for a period of ninety (90) calendar days thereafter unless the Purchasing Administrator determines it is in the best interest of the City.

5.2 QUESTIONS: Any matter concerning this RFP document that requires explanation or interpretation must be inquired upon and in writing by 5:00 P.M. January 16, 2012. All questions should be directed to Barbara Podnar, Purchasing Administrator, 3600 Tremont Rd, Upper Arlington, OH 43221, email: bpodnar@uaoh.net. Any and all questions will be responded to in the form of written addenda.

5.3 CHANGES AND ADDENDA TO RFP DOCUMENTS: Each change or addenda issued in relation to this RFP document will be on file in the Office of the Division of Purchasing no less than two (2) working days prior to the scheduled proposal opening date. In addition, to the extent possible, copies will be mailed or sent electronically to each person registered as
having received a set of the RFP documents. It is the Proposer's responsibility to check for addenda.

5.4 EXECUTION OF DOCUMENTS: Proposals by a corporation must be executed in the corporate name by the president or a vice-president (or other corporate officer accompanied by evidence of authority to sign such proposal) and attested by the secretary or assistant secretary of the corporation. The corporate address and state of incorporation must be shown below the signature. Each corporate Proposer must also submit evidence of good standing in the Proposer's state of incorporation and that the Proposer is qualified to conduct business in the State of Ohio. If the Proposer is not qualified to conduct business in the State of Ohio, the Proposer must represent and warrant to the City that such Proposer will take all necessary steps to qualify to conduct business in Ohio if the Proposer is the successful Proposer. The failure of the Proposer to submit within fourteen (14) days of Notice of Award evidence of its qualification to conduct business within the State of Ohio shall terminate the contract award unless the Purchasing Administrator determines it is in the best interest of the City.

5.4.1 Partnership documents must be executed in the partnership name and signed by partner, whose title, if any, must appear under the signature. Proper evidence of the authority of the partner who signs the proposal must accompany the proposal. The official address of the partnership must be shown below the signature.

5.5 QUALIFICATIONS: Each Proposer shall submit a Qualification Statement stating in detail the experience of the Proposer in performing work similar to the services being proposed. The Qualification Statement shall include but not be limited to the following:

1) List of management employees along with their educational and professional experiences
2) List of employees whose role would be that of service coordinator along with their educational and professional experiences
3) List of references for which Proposer has performed similar services.

The City reserves the right to request additional information with respect to the qualifications and financial condition of the Proposers, their subcontractors or personnel, which must be provided to the City in writing within five (5) days of any such request.

5.6 FINANCIAL STATEMENT: All Proposers shall supply and furnish with the proposal a financial statement, showing the net worth of the Proposer for the previous two (2) years. The City reserves the right to request additional financial information and reserves the right to reject the RFP responses based on the financial status.

5.7 CITY WILL NOT INDEMNIFY PROVIDER: The City is not legally authorized to indemnify the Provider nor hold the Provider harmless for claims, damages, losses and expenses, including reasonable attorney fees, resulting or arising from the contract. Therefore, the City Attorney will not approve to form any contract requiring the City to indemnify the Provider. Proposers should not include, and should delete from their standard terms and conditions, any language that purports to require the City to indemnify the Proposer. Failure to comply with this requirement may negatively impact consideration of the Proposer's proposal.

5.8 PROPOSAL INFORMATION IS PUBLIC: All documents submitted with any proposal may become public documents and shall be subject to Ohio Revised Code Section 149.43, which
is otherwise known as the "Ohio Public Records Law". By submitting any document to the City of Upper Arlington in connection with a proposal, the Proposer waives any claim against the City of Upper Arlington and any of its officers and employees relating to the release of any document or information submitted. Furthermore, the Proposer agrees to hold the City of Upper Arlington and its officers and employees harmless from any claims arising from the release of any document or information made available to the City of Upper Arlington arising from any proposal opportunity.

5.9 LENGTH OF CONTRACT: The City anticipates entering into an initial contract for a period of two (2) years with the City having the option for two (2) one-year renewal periods. However, the proposal should also provide the City the alternative to enter into a contract for a period of one (1) year with the City having the option for three (3) one-year renewal periods. The City anticipates service commencing April 1, 2012.

5.10 AWARD OF CONTRACT: The City intends to award a contract within a period of ninety (90) days from the submission due date. However, the City reserves the right to reject any and all proposals, to waive technicalities and to request new proposals on the required services.

5.10.1 The successful Proposer will be required to execute a written contract with the City of Upper Arlington, Ohio within ten (10) days after receiving such contract for execution.

5.10.1 The proposal should include any proposed contractual terms that the Proposer intends to request the City to include in the contract. Such terms and conditions should not conflict with the Required Contract Terms in Section 4. If the proposed contractual terms conflict with the Required Contract Terms, the City may reject the proposal. The City reserves the right, but not the obligation, to negotiate additional terms with the successful Proposer.

5.10.2 The City's notification of the award of contract does not constitute the written contract and shall not create any legal obligation on behalf of the City to enter into a contract. No binding contract shall be valid and enforceable against the City unless it has been signed by the City Manager on behalf of the City, contains the proper certificate by the Finance Director that funds are available, and contains the approval of the City Attorney as to the form and legality of the contract.

6. Scope of project:

6.1 SCOPE OF PROJECT: The City is searching for a qualified community provider for the continuance of the STAY UA program. In order for the STAY UA Program to be sustainable, the City recognizes that "Self Referrals" are necessary. The City does however express that the resident shall be given multiple choices of providers and that the resident has freedom of choice. The selected provider will need to demonstrate a willingness to work with the City by providing detailed reports evaluating effectiveness and measuring outcomes of service among other responsibilities. The proposal evaluation criteria should be viewed as standards, which measure how well a vendor's approach meets the desired requirements and needs of the City and its residents. Those criteria are set forth in this document. The City will review all proposals received and utilize its best judgment when determining whether to schedule meetings or interviews with providers, after receipt of all proposals.
Proposals should address the following requirements and include a detailed outline on how services will be provided: In addition, top candidates will be required to give an oral presentation regarding their program to a panel of interviewees. Top candidates will be contacted in early February to schedule presentations.

- History and demonstrated stability of the organization.
- The organization's experience in service coordination related to older adults and those with disabilities.
- Staffing approach, compensation, and administrative support for employing the service coordinator with availability of 24 hours a day consultation.
  - Proposals which do not require funding from the City of Upper Arlington will be considered most favorably
  - The City's involvement in the selection of the employee who will occupy the service coordinator position is desirable. However, the City's involvement shall not create an employment relationship with the City.
- Program team, their roles and their experiences.
- Plan for insuring that residents have freedom of choice in all matters related to the program.
- Protocol regarding adherence to HIPAA and all regulatory standards associated with health care and social service programs.
- Strategies for evaluating effectiveness and measuring outcomes of services.
- Plan for involving a full range of community providers in the on-going referral process.
- Statement of organization's experience in working with/reporting to an advisory board and/or working within a governmental framework.
- Provider must have sufficient local staff to provide the required services.
- Main office within 50 miles of Upper Arlington is preferred.
- If you represent a consortium of providers, include a detailed operation protocol with your proposal.
- Provide a plan of your procedure for self and across network referrals and how it will be documented and reported to the City Manager or designated representative. The City maintains the right to evaluate all Self Referrals.
- Provide a detailed plan for an Emergency Response Team when contacted at a moment’s notice.
- No proposal will be accepted that includes a fee for service coordination with resident (this includes a surcharge).
- Describe the process for conducting background checks for all employees and subcontractors.
Section 5: Program Structure
SUGGESTED PROGRAM STRUCTURE

City Manager

Fire Chief
- Provides office space and integration into City systems (e-mail, phone, fire division identity)

EMS Coordinator
- Daily supervision (shared with community provider)
- Participates in hiring, evaluation, & removal

Fire / EMS Personnel*
- Referrals & Follow-Up
- Training on aging

Firehouse Service Coordinator
- Provide service coordination for community members upon referrals and follow-up according to program protocols
- Maintain confidentiality and adhere to all HIPPA and ethics guidelines
- Build connective relationships with community providers
- Fulfill the duties of service coordination as outlined in job description

Community Provider / Agency
- (Area Agency/Council on Aging, Home health, social services, advocacy organization, health and human services, etc.)
- Employs SC & contracts with City for SC services
- Oversees supervision & QA (shared with City)

Police, Other City Staff*
- Referrals & Follow-Up
- Training on aging

*Programs decide community referral protocol, i.e., whether the service coordinator accepts referrals from the wider community vs. referrals from within the city government structure only.
Section 6: First Responder Training
Recommended First Responder Training in Aging

Most importantly, specific training regarding how and when to make referrals to the Service Coordination Program should be prioritized (with consideration for local resources, demographics, and standards) to coincide with the introduction of the program.

With the overriding goal of proactively preventing hazardous conditions and addressing safety concerns, following are some specific examples of situations that would likely prompt first responders to refer residents to the Firehouse Service Coordinator (in no particular order):

1. Resident was transported to the hospital.
2. Resident has placed multiple calls to 911.
3. Resident lives alone and/or has no immediate caregiver involved (lacks social support).
4. Resident has multiple ER visits with no admittance.
5. Resident has difficulty with medical equipment.
6. Resident has difficulty with self-care (i.e., medication use, cleanliness, mobility).
7. Home is in unsanitary or unsafe condition (i.e., lack of food in refrigerator, fall risks, lack of smoke detectors, etc.).
8. Concern for depression, dementia, or other illnesses that put resident at risk for loss of independence.
10. Signs of elder abuse or neglect.

Additionally, all emergency responders should receive periodic training in recognizing problems in older adults, which includes but is not limited to the following areas:

1. Physical
2. Functional
3. Cognitive
4. Emotional
5. Social

The following descriptions of geriatric topics are suggested educational subjects to include in aging education the service coordinator could provide and/or arrange for first responders:

- **Illnesses** such as Alzheimer’s Disease or other dementia’s, depression, osteoporosis, isolated systolic hypertension, alcoholism, drug abuse, hip and other fractures, pressure sores, strokes and TIA’s, etc.

- **Syndromes** such as falling, instability, functional impairment, deconditioning, incontinence, delirium, constipation, dehydration, sleep disorders, nutrition deprivation, elder abuse, elder neglect, family and caregiving stress, etc.

- **Characteristics** such as modified speed of recovery, altered and atypical disease presentation, modified pharmacokinetics, increased susceptibility to drug reactions, sensitivity to environmental relocation and change, etc.
• **Issues** such as institutionalization, isolation, intensity of treatment, financing health care services, risk factors for dependency, etc.

• **Skills** such as general awareness of home/living conditions for safety and health, geriatric functional assessment, objective mental status assessment, coordination of in-home services, team participation, terminal care, home visitation, etc.
Section 7: Role of the Service Coordinator
Role of the Service Coordinator

The underlying goal of service coordination is to create or maintain independence by empowering those served to pursue their own independence. To accomplish this goal, a service coordinator provides information and referrals about supportive services to frail or at risk older adults, or non-elderly residents with disabilities, which allows them to gain self-sufficiency, remain in their own homes, and prevent inappropriate or premature institutionalization.

In the Firehouse Service Coordination Program, the service coordinator functions as a member of the emergency first responder team, coordinating and responding to individual needs by connecting health care, social services, and long-term care at the point of entry into the system. In other words, the Firehouse Service Coordinator discovers the needs, matches the resident’s needs with available community services, and makes the referral. Community providers still provide their traditional services.

An initial first step in formalizing your Firehouse Service Coordination Program will be to decide and further define what role the service coordinator will play within your community. The Service Coordinator Job Description provides a list of functions and qualifications a service coordinator should fulfill as a city emergency response team member. The exact role for the service coordinator should be designed to meet the needs of the community he/she serves.

Some Tips to Consider

- The service coordination profession differs from the social work profession. A social worker is a “care” coordinator whereas a service coordinator is a “service” coordinator. Social workers may excel at counseling and one-on-one interactions with a client/resident. A service coordinator is an expert in gathering information and referring clients to community and other services. It is important for the City to envision how the Firehouse Service Coordination Program will function and match the job duties and employee appropriately.

- The service coordinator should possess a special blend of skills and talents (see Job Description for more detail):
  - Professional
  - Community network builder
  - Flexible
  - Diplomat/good communicator
  - Personable and approachable
  - Team player/member
  - Non-judgmental
  - Negotiator/collaborator
  - Aware of and able to handle “gray line” situations
  - Aware of the “big picture”

- Clearly define the relationship of the service coordinator within the Fire Division structure so all staff members understand the role of the program. It is key that Fire Division leadership supports and promotes the Firehouse Service Coordination Program to staff throughout the division.
• Locating the service coordinator in the Fire Division is critical to the success of the program. This presence fosters enhanced communication chains, trust and accountability.

• The service coordinator should do “ride alongs” when possible to gain first hand knowledge of emergency situations, older adult needs, family/caregiver needs, staff responses, etc.

• The service coordinator should wear identifying clothing that clearly communicates her/his association with the Fire Division (not an official fire uniform – likely a logo shirt).
Firehouse Service Coordination Job Description

Qualifications

- A Bachelor’s degree in social work or a related field is preferred, but not required.
- Two to three years’ experience in social service delivery with older adults and/or vulnerable or at risk populations and/or family populations.
- Demonstrated working knowledge of supportive services and other resources in the area served by the program.
- Demonstrated ability to advocate, organize, problem-solve, and provide results for the population(s) served.

Objective of the Position

The service coordinator works to empower the residents of the community to be as self-sufficient as possible through a mutually collaborative relationship with the Firehouse Supervisor, Firehouse and other emergency personnel, City, and community entities.

Functions

The Service Coordinator’s functions are as follows:

1. Provides general service management including intake, education (services available and application procedures) and referral of residents to service providers in the general community. These social services and/or referrals may include, but are not limited to:
   a. home health care (skilled nursing, therapy, personal care)
   b. preventative health screening and wellness
   c. service management services
   d. counseling
   e. physician referral services
   f. socialization options
   g. home safety equipment (smoke detectors, knox boxes, medic alert buttons)
   h. homemaking
   i. home-delivered meal service (Meals-on-Wheels)
   j. transportation
   k. financial services
   l. prescription assistance
   m. caregiver support

2. Identifies or creates and maintains an updated Community Resource Directory that includes a listing of federal, state and/or local service providers that residents can contact for assistance.
3. Participates in community educational events related to health care, agency support, life skills, referral sources, and others.

4. Monitors the ongoing provision of services from community agencies and keeps the service management plan current with the progress of the individual.

5. Serves as a liaison to community agencies, networks with community providers, and seeks out new services available to the residents.

6. Assists the residents in building informal support networks with other residents, family, and friends.

Roles

Service Coordinators fulfill the following roles:

**Service Facilitator**

Connect a community’s residents with community-based support services and other federal, state and/or local benefits by performing the following:

- Establish links to community agencies and service providers
- Develop resource directories if one is not available
- Provide basic service management and referral services
- Advocate for additional and/or more appropriate supportive services
- Teach community residents to advocate for themselves
- Monitor the ongoing provision of services from outside agencies

NOTE: It is strongly encouraged that the service coordinator restrict direct provision of services. These restrictions provide the following advantages:

- Protect service coordinators from unfair expectations of others
- Discourage a paternalistic approach toward residents
- Protect service coordinators from doing too much, focusing on too few, falling victim to their own good intentions, and even from becoming codependent
- Minimize the service coordinator’s professional liability

**Educator**

Educate residents and program staff:

- Inform residents about service availability, how to apply for services and benefits, consumer rights, and other relevant issues.
- Connect residents with educational and recreational programs through the community, senior centers, Road Scholar, or other sources.
• Distribute consumer materials (often available free) from organizations such as state and area agencies on aging, the American Association of Retired Persons, the National Council on the Aging, senior centers, legal services offices, or the services or programs themselves, such as Medicare and Medicaid.

• Educate and train Firehouse and other community emergency services staff on issues related to the special needs of aging citizens, people with disabilities, aging in place, and service coordination. This is helpful to all staff in performing their job tasks, knowing how and when to refer to the service coordinator, and promotes acceptance of the service coordinator.

**Community Relations/Community Builder**

Build a strong community presence to promote the program and educate the community on the role and services available through the Firehouse Service Coordinator. It is essential to engage in the community in the following ways:

• Actively participate in community advisory councils, task forces, or other organized community groups to network with service providers and reach potential consumers of the program.
• Perform outreach to area churches, civic organizations, and other organized groups through distribution of materials related to the program and through public speaking presentations.

**Investigator**

Conduct research on a routine basis. For example:

• Analyze the types, frequency, and other characteristics of services that residents use, need, and want
• Study available community services and the eligibility requirements of each service
• Research residents’ involvement and satisfaction with educational and social programs, residents’ interest in new programs, and barriers to greater participation
• Assess resident and community resources and capacities.
• Observe residents to identify needs.

**Additional Tasks**

Additional tasks that service coordinators perform include:

• Fulfill the educational requirement as outlined by funder of the program
• Inform residents about, and help them obtain, benefits for which they are eligible.
• Identify need and connect with appropriate providers for tasks such as:
  ◦ interpreting mail
  ◦ filling out forms
  ◦ arranging utility, phone, medical, and other payment schedules (refer them for this service because service coordinators should not do it for them)
- addressing errors or misunderstandings related to Social Security earnings, insurance billing, or death or survivors’ benefits (arrange for outside service whenever possible)
- making funeral arrangements for a loved one
- connecting with hospice and bereavement counseling or supportive services
- solving other “bureaucratic” problems

- Arrange for senior companions or volunteers or help to obtain employment
- Help residents obtain adaptive equipment and devices
- Distribute emergency forms and help residents complete the forms with vital statistics information
- Promote resident participation in local senior centers
- Get residents involved in the local, regional or area senior center computer program, SeniorNet, or other computer-oriented programs aimed at reducing isolation and increasing independence.
- Help residents work with health care providers to establish medication schedules and reminder services
- Organize other reminder systems
- Locate lower-cost providers in the community or area
- Find services that can be delivered to resident or that offer local transportation services

For more information on service coordination, go to the American Association of Service Coordinators (AASC) website at www.servicecoordinator.org.
A DAY IN THE LIFE OF A FIREHOUSE SERVICE COORDINATOR

Return calls to concerned family member

Make return visit to resident reluctant to accept services/relationship

Visit with resident in hospital

Meet with medic regarding death of resident

Attend report meeting with EMS staff

Attend ethics committee meeting

Meet with medic regarding death of resident

Conduct training session for first responders

Meet with community provider to introduce Firehouse Program

Follow-up with referral agency to see if services initiated as planned

Meet with EMS Director for updates and action plan

Follow-up on yesterday’s critical runs

Debrief with medics upon return from response

Gather information on police response to older resident

Gather information on police response to older resident

Service Coordinator

Older Resident

Firehouse & EMS

Referrals IN

Referrals OUT / Community Providers
Service Coordination Case Examples

Meet Mrs. A.
- Current situation: Older widow who lives alone in cluttered home; grandchildren providing assistance; concern about substance and alcohol abuse; smoker with cigarette burns on clothing, furniture, carpets. Three recent 911 calls.
- Emergency response: Medics called due to fall w/head injury. Adult daughter present. Mrs. A refused transport. Home safety and fire hazards noted. Smoke detectors tested and repaired. Mrs. A refuses to bathe; a strong odor of urine and feces, and soiled Depends noted in the home.
- Service Coordination Strategy: Suggested personal fall alert system; provided education about personal hygiene and home safety. Suggested all teens leave home for rest and decreased stress; referrals to two home health agencies—PT/OT, companionship, and home health aide for cooking, cleaning, transportation. Possibly move bedroom to first floor.
- Outcome: Mrs. A improving and taking control of life, grandchildren and finances. Periodic follow-up and monitoring. No further 911 calls to date.

Meet Mrs. B.
- Current Situation: 94 year old widow living alone. Has telephone check-in system and case manager. Daughter is involved caregiver.
- Emergency response: 911 call due to fall and self-described “little scrape.” 34th call to 911 in 12 months. Appears lonely and depressed; likes attention of UA Police and Fire. Some 911 calls may be due to new phones and resident’s inability to use properly to respond to check-in system.
- Service Coordination Strategy: On home visit found Mrs. B sitting in dark in oppressive heat. Resident states she “sits in the dark and thinks of her deceased husband.” Daughter concerned about ongoing depression and loneliness. Suggested personal falls alert system and made referral to community provider. Spoke with case manager about socialization and provided education to daughter about available community services and the realities of Mrs. B’s current level of function.
- Outcome: Mrs. B’s family is now considering alternative housing due to understanding of need for increased socialization and current level of care needs.

Meet Mrs. C.
- Current Situation: 77 year old widow living alone. Receives multiple services through home health, falls alert system, telephone check-in service, home-delivered meals, and homemaker assistance. 19 calls to 911 in last 14 months.
- Emergency response: Call for personal assist. Fell from walker while putting food in refrigerator. Alert and in no acute distress. No transport. 911 call later same day, transported. 911 call one month earlier for fall, transported. House clean except for bowel movement in hallway. One or more 911 calls for assistance to unlock front door to let providers into home.
- Service Coordination Strategy: Met with Mrs. C upon return from hospital, spoke with home health provider and made referral for counseling. Cleaned up feces in hallway,
warmed a meal and made phone calls for Mrs. C. Discussed possibility of moving to assisted living and accompanied her on a tour.

- **Outcome:** Mrs. C agreed to higher level of home care vs. moving to assisted living or nursing home. Situation has stabilized and will be monitored periodically. No further 911 calls to date.

## Meet Mrs. D.
- **Current situation:** 87 y.o. widow living alone. No family. Two attorneys as guardian and POA. Services from home health, church, counseling, telephone check-in service, personal falls alert system and more. Smoker, interested in remaining in her home.
- **Emergency response:** No 911 calls. Referred by attorney/guardian after Dispatch article. Service Coordinator made home visit; noticed dirty nails, hands, clothing. Smelled of urine; room was cluttered. “Lost her will to live after husband died of cancer some years ago.”
- **Service Coordination Strategy:** Followed-up week later; assessed living conditions more fully. Appeared dehydrated, liquids provided. Extensive clutter, “enjoys smoking and reading papers,” filthy kitchen and adjoining area; bugs and rotting food in refrigerator; appeared to be living on Ensure and cigarettes; strong urine/feces odor with feces on walls and soiled Depends and clothing in bath tub. Bedroom with feces and balls of human hair throughout carpet. EMS Coordinator determined fire and health hazards present and tagged residence in case of future rescue needed. Two smoke detectors placed in home.
- **Outcome:** Service Coordinator worked with resident to begin homemaking assistance in the home and to create a plan for cleaning and disinfecting the home. Spoke with the attorney regarding dehydration concerns, companionship and less than adequate living conditions, as well as payment source for supportive services.
- **Mrs. D accepted that she needs more assistance and is considering a move to a retirement community in another city.**
- **Attorney wrote letter of appreciation for STAY UA intervention.**

## Meet Mrs. E.
- **Current Situation:** 92 y.o. widow living alone. Resident’s home was unsafe and unsanitary with excessive clutter, particularly in the kitchen. Evidence of cognitive decline, lack of medical care several years back, and lack of regular food source. Declined help. Son is challenged as caregiver due to mother’s reluctance to accept help and his unfamiliarity with resources.
- **Emergency Response:** Medics responded to two 911 calls over a 3-month period. Initial and secondary referrals by EMS personnel, and later by concerned family member who stated they had previously been unaware of how to approach resident’s needs. Service Coordinator made 3 home visits before gaining some trust for resident to allow her to be helpful. Initially service coordinator counseled resident on home safety.
- **Service Coordinator Strategy:** Quarterly monitoring began after first 911 call, was maintained after initial denial of services and continued after repeated denial of help and the second 911 call due to a fall. Due to family member concern, a joint visit with the family member, resident, and service coordinator occurred 4 months after initial
contact. The resident eventually allowed community counseling service to monitor, and the resident was transferred into their care until 911 was again called 2 months later due to general failing health. This 911 call resulted in transfer to the hospital, two hospitalizations, and subsequent rehabilitation care.

- Mrs. E and her family are now communicating more effectively and working together regarding a move to assisted living.
- The son expressed appreciation and is now actively involved in his mother’s care.

Meet Mrs. F.

- Current situation: 54 year old female resident who lives alone with her service dog. Resident is legally blind and recently moved into the community and into a new apartment. Has little local support and has home health care company in place for skilled needs. Also has home health aide for assistance throughout week. Resident desires to remain living in the home but unhappy with home health care service.
- Emergency Response: One prior 911 call for lift assist. During home visit, service coordinator observed resident having difficulty navigating through the house. Resident expressed she would like grab bars in the shower area to make her feel safer. Resident stated she would like different home health company who provided better therapy. Resident had life alert button but did not wear it as she didn’t like it around her neck.
- Service Coordinator Strategy: During initial visit, the service coordinator contacted the life alert provider and requested a wristband to replace the necklace for the button. Resident not aware this was an option. The service coordinator discussed home care options and encouraged resident to speak with current home care provider regarding concerns. Explained client rights with home care companies. The service coordinator discussed services available through the Bureau of the Visually Impaired. Resident not aware of this organization and had never received services from them. Referral made to Bureau of Visually Impaired. The service coordinator contacted organizations and found two free grab bars that maintenance at apartment building will install into resident’s bathroom.
- Outcome: Follow-up appointment made one week later. Differences worked out with current home care company and services continued with resident being satisfied with service. Resident had received wrist band life alert button and wore it regularly now. Grab bars received and will be installed by maintenance at her apartment building.
- Resident appreciative of the assistance provided. No additional intervention necessary. Began quarterly monitoring with no additional concerns noted.
Service Coordination Code of Ethics

The American Association of Service Coordinators provides the “Service Coordinators Professional Code of Ethics,” a handbook that articulates a set of values and principles to guide decision making and conduct when ethical issues arise (see next page). The handbook does not provide a set of rules that dictate how service coordinators should act in all situations. This document has been created in accordance with established social work practice addressing the ethical standards that all service coordinators serving families, seniors, persons with disabilities, and/or other population groups in housing should adhere to as professional conduct. Although this document was developed in response to service coordinators working in the affordable housing environment, the professional standards are easily translatable to service coordinators working in the wider community.
# Service Coordinators Professional Code of Ethics

## Table of Contents

- Overview ...................................................... 4
- Mission and Core Values .................................. 6
- Purpose ....................................................... 7
- Ethical Standards ............................................ 8
- Residents' Rights and Needs ............................... 8
- Self Determination .......................................... 8
- Privacy / Confidentiality .................................... 9
- Informed Consent ............................................ 9
- Service Coordinator Characteristics and Attributes 9
- Competence ................................................... 9
- Respect ....................................................... 10
- Communication with Management/Owner ............. 10
- References and Resources ................................. 11
Overview

Service coordinators (SCs) are an integral part of residential communities that house families, elders and persons with disabilities. SCs link residents with supportive services allowing them to maintain self-sufficiency in their homes. Some of the typical services arranged on behalf of residents include: meals, transportation, health care and homemaking as well as other health and supportive services available through local aging and family services networks.

In service-enriched housing, the primary goal is to empower residents and promote independence. For the elderly, this may include linkages to services to increase mobility or assistance with activities of daily living so they can age in their own residences and remain independent for as long as possible. For family housing, this may include employment and education strategies (such as job counseling, training, placement, help with child care, and financial management) as well as securing provisions for food, health care, and transportation. Persons with disabilities may be interested in job training and placement, education, transportation, and referral to supportive services and arrangement of medical appointments.

It is most important that the SC understand the characteristics of the resident population and property in which they serve. Issues that may impact the differential use of services are socio-economic, age, culture, gender, race, sexual orientation, and others. Service coordination is based on the recognition that a trusting and empowering relationship between the SC and residents is essential.
to expedite the use of services and to restore or maintain the resident's independence and quality functioning to the fullest extent possible.

This handbook offers a set of values and principles to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that dictate how service coordinators should act in all situations. This document has been created in accordance with established social work practice addressing the ethical standards that all service coordinators serving families, seniors, persons with disabilities, and/or other population groups in housing should adhere to as professional conduct.

Furthermore, the handbook does not specify which values and principles are most important and outweigh others in instances when they conflict. It is up to the individual service coordinator to make informed, ethical decisions in any given situation.

The American Association of Service Coordinators (AASC) recognizes that each SC works with a variety of populations in different settings and demographic areas. This code of ethics is intended to serve as a guide to the professional conduct of the SC in the housing environment. Therefore, AASC believes that by following these values and principles, all service coordinators will uphold and advance the values, ethics, knowledge and mission of the profession. AASC hereby establishes the following code as standard protocol for the ethical behavior of all service coordinators.
Mission and Core Values

The primary mission of the service coordinator profession is to serve residents who need and desire services, while empowering them to remain self-reliant whenever possible. Particular attention is paid to the preservation of independent, affordable housing and enhancing the quality of life for the resident population at large. The mission of the service coordination profession is rooted in a set of core values. These core values are the foundation of the service coordinator’s purpose and perspective:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence
**Purpose**

This profession has an obligation to articulate its values and ethical principles. The ethical foundation of the service coordinator profession is vital to its credibility and standing as a significant and irreplaceable part of the supportive housing team and is relevant to all service coordinators, regardless of their professional functions, their work setting, or the population they serve.

This code of ethics serves the following purposes:

- Identifies the core values on which the service coordination mission is based
- Establishes a set of ethical standards that should be used to guide the practice of service coordination
- Provides ethical standards to which service coordinator professionals should be accountable
- Familiarizes new service coordinators and other professionals with the mission, values and ethical principles of service coordination
- Aids service coordinators in identifying relevant considerations when professional obligations conflict or ethical questions arise
Ethical Standards

Residents’ Rights and Needs
The service coordinator (SC) shall use his/her skills and competence to advocate on behalf of the residents, preserve their civil rights and take no actions that place the resident at risk of harm.

Self-Determination
The SC shall work in tandem with residents to empower them to utilize their own abilities and provide them with choices to make decisions regarding the services they receive. The SC shall ensure that residents are involved in the linkage and/or coordination of their services and will respect and promote their right of self-determination. SCs will assist residents in their efforts to identify and clarify their goals and shall not impose their opinions or preferences on a resident.

In issues involving a resident’s right to freedom of choice over personal safety, the resident has a right to choose to live at risk of harm or leave needs unmet, providing he/she is capable of making that choice, harms no one, and commits no crime. All residents have a right to choose their own life-style, as long as there are no lease violations and they are fulfilling their obligations of tenancy. In instances where the SC’s or resident’s safety and/or well being is threatened, the SC may need to take action to make linkages to services that may limit the resident’s right to self determination.

It must be noted that the resident has the right to refuse the services of the service coordinator or the service coordination program if they so choose.
Privacy and Confidentiality

The SC shall ensure the resident's right to privacy and ensure appropriate confidentiality when information is released to others. All information obtained by a SC about a resident is to be held in the strictest possible confidence. Additionally, the SC shall not discuss confidential matters in public or semipublic areas.

Informed Consent

Service coordinators shall assist and link residents to services only in the context of a professional relationship based, when appropriate, on valid informed consent (release of information). The SC may disclose confidential information only when legally necessary to prevent serious, foreseeable and imminent harm to themselves or someone else (this can include medical emergencies, domestic violence, mental health crisis, etc.)

Service Coordinator Professional Characteristics and Attributes

The SC shall provide assistance and linkages to services and represent themselves as competent only within the boundaries of the role of the service coordinator position.

Competence

The SC shall endeavor to be proficient in professional service coordination and in the performance of appropriate functions striving to improve in the proficiency, effectiveness, and quality of services acquired for residents. SC's shall have a knowledge base of their residents' cultures and background and be sensitive to the diversity of their residents, encouraging acceptance among different cultural groups.
Respect

The SC shall treat colleagues and residents with courtesy and respect and strive to enhance communication and cooperation among all parties. The SC shall maintain the integrity of the position by upholding and advancing the values, ethics, knowledge, and mission of the profession.

Communication with Management/Owner

The SC is obligated to communicate information to management staff regarding the following:

- the service coordinator job description/job duties;
- the service coordinator role at the property;
- SC obligations as a mandated reporter;
- requirements of the HUD service coordinator program and other important information related to the role of the SC.

The service coordinator should strive to assure lines of communication with management are timely and appropriate related to pertinent resident issues, educational programming and other service issues related to management/building policy.

The Service Coordinator should avoid any personal interest or activity that conflicts or interferes with the welfare or best interest of his/her residents/clients.
**References and Resources**

Code of Ethics, National Association of Social Worker (NASW, revised 1999 NASW Delegate Assembly)


Program Manual for Service Coordinators, American Association of Service Coordinators, March 2002

The Manager/Service Coordinator Relationship Policy Recommendations, American Association of Service Coordinators, Updated January 2006

**To join AASC, please visit our website, www.servicecoordinator.org to download an application, or contact the AASC office at (614) 848-5958**
Section 8: Resident Referral and Service Coordination
**The Referral Process**

With consideration of available resources, careful thought should be given to the appropriate referral protocol.

Referrals come from a variety of sources and need to be prioritized by the Firehouse Service Coordinator. Because the service coordinator often has multiple referrals to respond to, a formal process for determining which cases to prioritize is warranted. The prioritization of criteria is listed under Resident Interactions: Screening in this Section.

It is important to note that most communities have a variety of agencies and businesses working to address the needs of the older population. These are ready and able resources for the Firehouse Service Coordination Program referral process. The service coordinator, as outlined in the previous job description, is required to become familiar with these community-based resources.

Community-based programs, as their primary function, are equipped to address the population’s needs through their funding and manpower, and are likely to assist with thorough assessment and intervention as they are drawn into situations by the Firehouse Service Coordinator. By referring to these community resources, the service coordinator will be better able to manage the volume of referrals that is expected to come through the Firehouse Service Coordination Program.

In order to track and monitor the types of cases being referred to the service coordinator, and the types of referrals the service coordinator makes to community-based providers, a recording procedure for referrals is necessary (a suggested Referral Form is provided on the next page). The program could create categories in order to quantify types of referrals coming into the program. All of the information included in the referral form may already be in the Fire Division run report.

In an ideal world, to make the referral process easier for firefighters and thus increase the likelihood of referrals, the program should link Fire Division and service coordination technical systems so that firefighters can simply check a box in order to submit a referral to the service coordinator.
FIREHOUSE SERVICE COORDINATOR PROGRAM
REFERRAL FORM

Identifying Information

Name:________________________________________    Date:_______________________
Address: ____________________________________________________________________
Phone: _____________________________
Age: _______ Date of birth: _______________    Male: _______ Female:________
Marital Status: Married _______ Divorced _______  Widowed _______________
Living Status: Lives Alone _______ With frail spouse _________  Other _________
Condition of home: __________________________________________________________
Social Support:______________________________________________________________
Current Services:_____________________________________________________________

Presenting Problem Information

911 Call:  Yes _____   No _____
Other (describe):___________________________________________________________
Reported Problem: _________________________________________________________
____________________________________________________________________________
Was presenting problem due to fall?  Yes _____      No _____
Referred to hospital?  Yes ______  No _______
Hospital: __________________________________________________________________

Contact Information

Family Member:  Son _____ Daughter _____ Sibling _______ Other _________________
Legal Guardian: ____________________________
Power of Attorney: _________________________
Name: ________________________________    Phone No. ________________________
Contacted successfully: Yes _____     No _____

Version 1.1 01/13
Resident Interactions

Introduction

Through the Firehouse Service Coordination Program, a community’s older adults and people with disabilities have an enhanced opportunity to receive the services and coordination of care they need to continue to live independently and safely in their own homes. By documenting the services received through the Program, the service coordinator is better able to help the community’s residents meet their care and service needs.

The information below will detail how the service coordinator can apply the above directive to the Firehouse Service Coordination Program by describing each interaction a service coordinator may have with a resident and the subsequent documentation needs.

Documentation

The documentation process and service plan are essential when assisting residents to remain independent for as long as possible. Service management, which includes documentation, is defined by the Commission for Service Management Certification (http://www.ccmcertification.org/) as . . .

“. . . a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes”.

It should be noted that service coordinators do not provide direct care like a doctor, nurse, social worker, or other licensed health professional. Instead, service management for a service coordinator is described as documentation and therefore, more “limited,” “informal,” or “general” as noted by the American Association of Service Coordinators (AASC) and in HUD policies.
The following six steps are essential to coordination and documentation by service coordinators in the Firehouse Service Coordination Program:

- Screening
- Assessing
- Planning
- Implementing/Referring
- Following-Up
- Evaluating

Throughout service coordination, the service plan may need to be adjusted and/or updated to better meet the resident’s health goals.

New or continuing health issues may necessitate re-assessment.
Screening

The Firehouse Service Coordinator will likely manage multiple residents simultaneously and therefore, it is essential that newly referred residents are prioritized and screened by the service coordinator before first contact so that residents with the most critical needs are met first. While it is difficult to determine level of need without face-to-face contact with the resident, it is possible to prioritize situations with information provided by referring parties. The following are general guidelines for prioritizing cases:

**Increased Priority:**

- Was resident transported to hospital? If non-transport, increased priority.
- Does resident live alone? If yes, increased priority.
- Were they able to get immediate attention after fall or medical need? If no, increased priority.
- Did referral come directly from service provider who interacted with resident, i.e. medic or city official? If yes, increased priority.
- Multiple calls to same resident? Increased priority.
- Resident has multiple ER visits with no admittance in short period of time? Increased priority.
- Is the person having difficulties with medical equipment (i.e., Oxygen tank)? If yes, increased priority.

**Lower Priority:**

- Are services currently in place? If yes, lower priority.
- Does the resident have family or other support? If yes, lower priority.
- Did referral come from a Quality Assurance report? If yes, lower priority.

Once a resident referral is appropriately screened and triaged by the service coordinator, the assessment phase may begin upon the resident’s involvement in the Firehouse Service Coordination Program.

Assessing

Using standardized assessment tools and checklists, a face-to-face assessment may occur during or shortly after emergency 911 situations, as a result of a referral, as a general follow-up, or as a case review by the service coordinator. The service coordinator listens and observes the resident, identifying immediate needs, interests, and current situations that may indicate future service needs. At this time the service coordinator should also note any abuse or neglect of the resident and report this according to professional standards.
Key areas of observation and interviewing by the service coordinator may include:

- Demographic information
- Past and current health condition
- General observation of physical, emotional and cognitive function
- Service utilization
- Social support (family, friends, neighbors, church, other)
- Self-care knowledge and ability
- Socioeconomic and financial status
- Health insurance coverage
- Home condition and safety/risks (Home Assessment)
- Home maintenance
- Cultural beliefs, interests, wishes, needs, and values
- Religious beliefs, interests, wishes, needs, and values
- Readiness for change
Preliminary assessment is designed to help the service coordinator develop a service plan for the resident. The information gained through this assessment will help the service coordinator refer and link the resident to services or a network of services that meet the specific and immediate needs or situation of the resident.

Resident Contact Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Address 1:</td>
<td></td>
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<tr>
<td>Address 2:</td>
<td></td>
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<tr>
<td>City:</td>
<td>State:</td>
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<tr>
<td>Zipcode:</td>
<td></td>
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<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
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<tr>
<td>Other Phone:</td>
<td></td>
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<tr>
<td>E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Contact Person:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
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<tr>
<td>Other Phone:</td>
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<td>E-mail:</td>
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</table>

Caregiver Contact Information (if different from Emergency Contact):

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Other Phone:</td>
<td></td>
</tr>
<tr>
<td>E-mail:</td>
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</tbody>
</table>

Screening

Use the questions below to determine the priority level for resident assessment.

Screening Date: _________________________

**Higher Priority:**
- □ Resident was not transported to hospital.
- □ Resident lives alone
- □ Referred by service provider who interacted with resident, i.e. medic or city official
- □ Resident has made multiple 911 calls
- □ Resident has had multiple ER visits with no admittance in short period of time
- □ Resident is having difficulties with medical equipment, i.e., oxygen tank

**Lower Priority:**
- □ Resident has family or other support
- □ Resident got immediate attention for his/her medical need
- □ Referral from Quality Assurance report
- □ Services are currently in place
Resident Assessment

Assessment Date: _________________________

Gender: ____F ____M

Date of Birth: _____/_____/_____

Ethnicity:
☐ Asian ☐ Black ☐ Hispanic ☐ Non-Hispanic, White or ☐ Other _________________________

How does the resident want to be addressed?
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ First Name ☐ Nick Name ☐ Other _________________________

1. What are the resident’s current health status and/or medical conditions?

2. What are the resident’s past medical conditions?

3. Has the resident had any hospitalizations in the past 6 months? In the past year?

4. What are your observations of the resident’s . . .
   a. physical state:
   b. emotional state:
   c. cognitive function:

5. Did you observe any evidence of abuse and/or neglect? If so, please describe.
   (Report per legal requirements.)
6. What kind of social support does the resident have?

- Family
- Friends
- Neighbors
- Church
- Other

Comments:

7. Does the resident have caregiver support?

a. If a family or informal caregiver is involved, how much care is being received?

- Daily
- Weekly
- Intermittent

Comments:

b. Does this resident provide care for someone else?

- Spouse
- Child
- Other

Comments:

8. Does the resident have any of the following documentation?

- Advanced Care Directives
- Living Will
- Do Not Resuscitate Order (DNR)
- Durable Health Care Power of Attorney / Health Care Proxy
- Durable Financial Power of Attorney
- Other

Comments:

9. What services are already in place for the resident?
10. Does the resident need help with any of the following tasks?

**Katz Basic Activities of Daily Living (ADL) Scale**

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| 1. **Bathing** (sponge bath, tub, or shower)  
Receives either no assistance or assistance bathing only one part of body | | | |
| 2. **Dressing** – Gets clothes and dresses without any assistance except for trying shoes. | | | |
| 3. **Toileting** – Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night) | | | |
| 4. **Transferring** – Moves in and out of bed and chair without assistance (may use cane or walker) | | | |
| 5. **Continence** – Controls bowel and bladder completely by self (without occasional “accidents”) | | | |
| 6. **Feeding** – Feeds self without assistance (except for help with cutting meat or buttering bread) | | | |


**Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale**

<table>
<thead>
<tr>
<th>Section</th>
<th>Task</th>
<th>1. Operates Telephone on own initiative – looks up and dials numbers, etc.</th>
<th>2. Operates Telephone – dials a few well-known numbers</th>
<th>3. Operates Telephone – answers telephone but does not dial</th>
<th>4. Operates Telephone – does not use the telephone at all</th>
<th>1. Does personal laundry completely</th>
<th>2. Launders small items – rinses stockings, etc.</th>
<th>3. All laundry must be done by others</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Ability to use Telephone</strong></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
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<tr>
<td>B. <strong>Shopping</strong></td>
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<tr>
<td>1. Takes care of all shopping needs independently</td>
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<tr>
<td>2. Shops independently for small purchases</td>
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<tr>
<td>3. Needs to be accompanied on any shopping trip</td>
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<td>4. Completely unable to shop</td>
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<tr>
<td>C. <strong>Food Preparation</strong></td>
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<tr>
<td>1. Plans, prepares and serves adequate meals independently</td>
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<td>1</td>
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<tr>
<td>2. Prepares adequate meals if supplied with ingredients</td>
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<tr>
<td>3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet</td>
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<tr>
<td>4. Needs to have meals prepared and served</td>
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<tr>
<td>D. <strong>Housekeeping</strong></td>
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<tr>
<td>1. Maintains house alone or with occasional assistance (e.g. “heavy work domestic help”)</td>
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<tr>
<td>2. Performs light daily tasks such as dish washing, bed making</td>
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<td>3. Performs light daily tasks but cannot maintain acceptable level of cleanliness</td>
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<td>4. Needs help with all home maintenance tasks</td>
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<tr>
<td>5. Does not participate in any housekeeping tasks</td>
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<tr>
<td>E. <strong>Laundry</strong></td>
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<td>1</td>
<td>1</td>
<td>0</td>
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<tr>
<td>1. Does personal laundry completely</td>
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<tr>
<td>2. Launders small items – rinses stockings, etc.</td>
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<tr>
<td>3. All laundry must be done by others</td>
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<tr>
<td>F. <strong>Mode of Transportation</strong></td>
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<tr>
<td>1. Travels independently on public transportation or drives own car</td>
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<td></td>
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<tr>
<td>2. Arranges own travel via taxi, but does not otherwise use public transportation</td>
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<td>3. Travels on public transportation when accompanied by another</td>
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<td>4. Travel limited to taxi or automobile with assistance of another</td>
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<td>5. Does not travel at all</td>
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<tr>
<td>G. <strong>Responsibility for Own Medications</strong></td>
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<td>1</td>
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<tr>
<td>1. Is responsible for taking medication in correct dosages at correct time</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td>1</td>
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<tr>
<td>2. Takes responsibility if medication is prepared in advance in separate dosage</td>
<td></td>
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<td></td>
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<tr>
<td>3. Is not capable of dispensing own medication</td>
<td></td>
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<td></td>
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<td>0</td>
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<tr>
<td>H. <strong>Ability to Handle Finances</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>1</td>
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<tr>
<td>2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.</td>
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<td>1</td>
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<tr>
<td>3. Incapable of handling money</td>
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<td></td>
<td></td>
<td></td>
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<td>0</td>
</tr>
</tbody>
</table>


Version 1.1 01/13
11. According to the scoring scale provided, how did the resident perform on the Activities of Daily Living (ADL) functional assessment?

**Scoring the Katz Basic Activities of Daily Living (ADL) Scale:**

1. Residents are scored yes/no for independence in 6 functions.
   - Score of 6 “yes” answers = full function
   - Score of 4 “yes” answers = moderate impairment
   - Score of 2 or less “yes” answers = severe functional impairment
2. Independence in ADLs increases as the score approaches 6 “yes” answers.

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fully functional</td>
<td>☐ Moderately impaired</td>
</tr>
</tbody>
</table>

12. According to the scoring scales provided, how did the resident perform on the Instrumental Activities of Daily Living (IADL) functional assessment?

**Scoring the Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale:**

1. Residents are scored in 8 domains of function.
2. Points are totaled in sections A-H; the score may range from 0-8.
3. The higher the score, the greater the person’s abilities.
   - Score of 8 = high function / fully independent
   - Score of 6 = moderately high function / independent
   - Score of 4 = moderately low function / dependent
   - Score of 2 or less = very low function / fully dependent

<table>
<thead>
<tr>
<th>IADL Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fully independent / high function</td>
<td>☐ Independent / moderately high function</td>
</tr>
<tr>
<td>☐ Dependent / moderately low function</td>
<td>☐ Fully dependent / Very low function</td>
</tr>
</tbody>
</table>

13. Does the resident use adaptive equipment, i.e., cane, walker, wheelchair? If yes, describe:
14. What did you observe regarding the condition and safety of the resident’s home?

☐ Yes ☐ No Lighting adequately bright, easy-to-reach switches, night lights

☐ Yes ☐ No Flooring in good repair, carpet tacked down, surfaces not slick or slippery, no rugs or mats

☐ Yes ☐ No Hallways and exits free of clutter

☐ Yes ☐ No Stairways and steps in good repair, handrails present

☐ Yes ☐ No Drawers and cupboards closed

☐ Yes ☐ No Cords and personal items removed from floors

☐ Yes ☐ No Refrigerator clean / Food fresh

Describe areas of concern:

15. Have any other measures been taken to safeguard the home, i.e., raised toilet seats, shower grab bars, non-skid mats, etc.

16. What did you observe regarding the resident’s general home maintenance, i.e., lawn mowed, snow removed, gutters cleaned, etc.?

17. Does the resident have any of the following risk factors for falling?

☐ Yes ☐ No History of falls

☐ Yes ☐ No Uses assistive device (cane, walker)

☐ Yes ☐ No Visual or hearing deficit

☐ Yes ☐ No Needs assistance with daily activities (ADLs)

☐ Yes ☐ No Multiple medications (4 or more)

☐ Yes ☐ No Cognitive deficit (Alzheimer’s disease, vascular dementia, etc.)

☐ Yes ☐ No Home safety issues
18. Does the resident speak English? □ Yes □ No
   a. What is the resident’s native language? ____________ Country of birth? ____________
   b. Does the resident require translation services? □ Yes □ No

19. Does the resident have culturally sensitive health and/or illness beliefs and practices regarding health or social services? For example, does the resident engage in different types of healing practices, i.e., hot tea and lemon for cold, copper bracelet for arthritis, magnets, etc.?

20. How important are spirituality and religious beliefs for the resident?

   □ Do the resident’s spiritual or religious beliefs influence how he/she takes care of him/herself?

   □ How does the resident want to address his/her spiritual or religious beliefs regarding service referral?

   Describe:

21. Primary Care Doctor:

   Doctor’s Name: ____________________________
   Company: ____________________________
   Address 1: ____________________________
   Address 2: ____________________________
   City: ____________________________ State: ______ Zipcode: ______
   Phone: ____________________________ Fax: ____________________________

22. Health insurance coverage:

   □ Primary Health Coverage ____________________________
   □ Medicare ____________________________
   □ Medicaid ____________________________
   □ Other ____________________________
23. Does the resident need financial assistance to pay for health care or social services?  
☐ Yes ☐ No

24. Is the resident ready for change (choose one)?

☐ Does not want to change behavior in the foreseeable future (precontemplation)
☐ Is thinking about changing but has not made a commitment to take action yet (contemplation)
☐ Plans on taking action in the next month and/or near future (preparation)
☐ Is currently modifying his/her behavior, experiences, and/or environment to overcome problems (action)
☐ Is working to prevent relapse and maintain improved status (maintenance)

25. Current Situation / Service Plan:

a. Immediate needs:

b. Future needs:

c. Follow-Up Timeframe:

☐ Weekly: _____/_____/_____  
☐ Bi-weekly: _____/_____/_____  
☐ Monthly: _____/_____/_____  
☐ Bi-Monthly: _____/_____/_____  
☐ Quarterly: _____/_____/_____  
☐ Bi-Yearly: _____/_____/_____  
☐ Yearly: _____/_____/_____  
☐ Other: _____/_____/_____
Relationship Boundaries

Respecting and understanding boundaries between service coordinators and the residents of the community they serve is essential for optimal healthy outcomes. Service Coordinators have a professional responsibility to avoid any potential conflicts of interest between professional duty and personal interests and as such, should avoid participating in business transactions with the residents, and giving or receiving gifts or other personal services from the resident.

Furthermore, service coordinators should avoid excessive self-disclosure, although talking informally about interests to build rapport and put the resident at ease is acceptable. Excessive self-disclosure can be a boundary problem if it uses the resident to satisfy the service coordinators own needs for comfort or sympathy, and may make the service coordinator appear needy and/or vulnerable.

The service coordinator should also limit physical contact to shaking hands upon greeting the resident, which is a widely accepted practice, to avoid resident discomfort due to cultural, religious or personal preferences. The best practice is to think of the community’s residents in terms of “once a ‘client’ always a ‘client’,” which can help preserve the service coordinator’s role and foster safety, independence, privacy and autonomy on the part of the resident.


Confidentiality

Confidentiality should be addressed within the framework of professional standards and the contracts between a community partner and the City.

Confidentiality should be addressed more firmly with the service coordinator in the EMS environment due to HIPPA regulations. Training around protecting resident information is crucial to avoiding violations and to honoring resident rights. Areas of risk are apparent in inter-agency case collaboration and working with families.

Service Coordinators must be trained adequately to understand what information can be disclosed under what circumstances. The importance of confidentiality agreements and releases of information forms should be central in this discussion.

Self Determination

In a program of this kind, the service coordinator will often encounter older persons who are in a state of crisis and vulnerable. Therefore, it is very important that the service coordinator be given tools and training that will help her/him honor the right of the community resident to maintain his/her own autonomy.

Autonomy is the right of the person to self-rule or to maintain control of his or her situation if there is no risk of harm to others (Johnson, 1999). Honoring this right is often more difficult than it sounds, as the service coordinator must balance this right to self-determination against a
desire to provide beneficence to the person. Beneficence refers to the act of seeking to provide benefit to others (Johnson, 1999).

Often, even experienced social service professionals encounter ethical dilemmas relating to autonomy versus beneficence. This conflict is inherent in working with older adults who may be vulnerable and in need of help. A good example of this is the older person who refuses services although there is a great service need identified by the service coordinator. In a situation like this, one must remember that beneficence is in the eye of the beholder, and that as long as no harm comes to another, in most cases, service providers must honor a person’s right to make his or her own decisions (Johnson, 1999).

In order to confront this ethical dilemma and to honor the person’s right to self-determination, the Firehouse Service Coordination Program should institute standard policies and procedures around self-determination and autonomy of the residents of the community. Standardized ethics training upon hiring the service coordinator and throughout employment are warranted. Trainings could include such things as learning to make ethical decisions with a logic model.

**Adequate supervision** is a good way to address ethical dilemmas and the service coordinator should be encouraged to speak openly with their supervisor about potential ethical dilemmas, especially when decisions could negatively impact the resident’s ability to retain autonomy. Supervision should be given often (once per month at a minimum).

**Quality assurance** measures, such as regular file reviews, are another way to ensure that the service coordinator is honoring the consumer’s right to self-determination. The service coordinator must keep accurate case notes and file review must be done on a regular basis for this method to be effective in protecting resident’s rights.

Another way to protect a resident’s right to self-determination is to hire professionals who are licensed and held to an ethical standard that honors the right of clients to make their own decisions. Licensed professionals in some disciplines are required to complete training in this area and to continue receiving education in order to keep their licenses. Also, licensing boards have the authority to censure some professions for violating a client’s right to autonomy and self-determination.

Planning

Based on the assessment and indicated service needs, the service coordinator works in tandem with the resident to develop a service management plan that identifies, clarifies, and prioritizes goals for maintaining independence and aging in place.

The service plan may include the following:

- Resident problems, needs and desires, prioritized
- Resident long-term goals
- Resident short-term goals
- Identification of intervention(s)
  - Services
  - Community and/or healthcare providers
- Information on additional resources
- Documentation of potential barriers of meeting goals
- Projection of achievable and measurable outcomes of goals
- Time frame for reaching goals
- Approval of plan (if applicable)
- Consent of services (from client, service providers, caregivers)

The service coordinator may also gather input from other stakeholders, such as a family member, caregiver, the emergency response team, or referring party; sharing the completed service plan with each stakeholder as appropriate and permitted.

Setting Goals

The service coordinator should help the resident set moderate goals and avoid setting overly ambitious goals. The key is to set one or two moderate goals according to the prioritized list of issues, needs and desires. The service plan may also note specific steps that will be taken to accomplish the goals. Finally, it should be noted that goals can change as the health status and well-being of the resident changes.

Maintaining Realistic Expectations

Maintaining realistic expectations regarding the elderly resident’s current health issues, specifically long-term problems, can be difficult for the service coordinator and for the resident. It is important to understand that these issues may not be able to be fixed all at once, or at all. The fact of the matter is that as an older person ages he/she can expect a decline in health, usually slowly but occasionally quickly, despite the best of care. Therefore, the resident’s goals should not be an unrealistic expectation rather these goals should represent improving function, comfort, and independence if possible. This might mean focusing on objectives like better managing pain and discomfort, or maintaining mental awareness as long as possible, or getting out with family once in a while. The mantra of the service coordinator could be “here’s what we can do to make your life better right now.” Sometimes a resident or family may refuse care, and the service coordinator must learn how to let go.
Implementing / Referring

During this phase, the service coordinator begins implementation of the service plan by linking and referring the resident to appropriate community and/or healthcare providers, or other interventions identified in the resident’s service plan goals as appropriate. This may include determining the resident’s eligibility for services and assisting him/her in acquiring and/or filling out appropriate paperwork for needed services. Throughout this process, the service coordinator shares information with the resident and the resident’s support system (if applicable) about available health and social services and resources necessary to meet the resident’s needs and interests.

It is important that a current and signed HIPPA Agreement be in place to allow the EMS Captain and the service coordinator to discuss client cases while maintaining resident confidentiality.

Additionally, the service coordinator provides feedback to the first responder team as part of their team approach to care coordination and quality assurance.

Referrals to Community Providers

The Service Coordinator should follow a plan that involves a full range of community providers in the on-going referral process while insuring that residents have freedom of choice in all matters related to the program.

The Service Coordinator may develop internal systems for deciding how to best refer residents to community providers in a fair and equitable manner. One system for managing referrals is to rotate referrals from provider to provider. Many residents, due to their own unfamiliarity with resources, may rely on the service coordinator to narrow the choices of an appropriate service provider, which better allows for provider rotation. Other residents are referred based on their needs and personal choice, which may not fit into a rotation plan. Either way, meeting the resident’s choice and honoring the resident’s right to self-determination is the primary criteria for any referral to a community provider.

Further, through the RFP process, The City expresses that the resident shall be given multiple choices of providers and that the resident has freedom of choice, i.e.:

- Plan for insuring that residents have freedom of choice in all matters related to the program.
- Plan for involving a full range of community providers in the on-going referral process.

In order to represent the service coordinator’s work quantitatively, the program should categorize referrals so they can be measured. While recording referrals, the program should be careful to avoid categorizing referrals as ‘other’ and try to be as specific as possible to accurately reflect the work of the service coordinator.
The following categories are proposed (at a minimum):

- Skilled Home Care
  - nursing, therapy (physical, occupational, speech), personal care, social work, hospice
- Unskilled Home Care
  - meals, groceries, homemaking, errands, bill pay
- Transportation
- Home delivered services
- Emergency Response
- Home Safety
- Care/Service management
- Caregiver Support
- Social/Senior Center
- Financial Services
  - estate planning, insurance paperwork, tax assistance
- Public Assistance
  - housing, food, utility, etc.
- Home repair/Weatherization
- Long-term Care Planning
- Disability Services (home modification, city services)
- Medical Equipment
- Adult Protective Services
- Veteran Services

**Following-Up**

Following-up is defined as the act or instance of following up to further an end, review new developments, increase effectiveness and/or to reinforce or evaluate previous action. In following-up with a resident, the service coordinator’s purpose should be to advance the dialogue with the resident regarding the implementation of his/her service plan.

Following-up with the resident should be more aggressive for more fragile or needy elders and residents of the community with a disability. Following-up with the resident may include review, evaluation, monitoring, and reassessment of a resident’s health conditions, needs, ability for self-care, and ongoing interventions with community and/or private health providers. The service coordinator evaluates the appropriateness and effectiveness of the current service plan on the resident’s health conditions, and documents any modifications to the service plan as needed.

The completed service management plan, and any modifications, is kept in the resident’s case file, which may also contain the following documents:

**Forms:**
- Intake/Enrollment Form
- Assessment Form
- Service Management Plan
- Confidentiality Agreement
- Release of Information
• Progress Notes
• Advance Directives
• Emergency Contacts
• Disclosure Form

Interactions:
• Correspondance logs (letters, e-mails, etc.)
• Conversation notes (with residents and service providers)

Other:
• Hospitalization record
• On-Going and Unresolved Situations record
• General financial information (for income eligibility for services)
• Agency Service Provision forms
• Status of Services Information

As needed:
• Non-participation Form
• Permissions
• Informed Consent
• Other Compliance Forms

Any and all interactions with residents should have a written history of the interactions, the services provided, and the referrals made, which will help to assure that the community residents in need get timely, quality services. Current notes in a file will also help the service coordinator recall events if needed. This practice is also a way for the service coordinator to protect him/herself by:

• Meeting and following the recommended service coordinator standards of practice.
• Protecting the resident.
• Providing continuity of care.
• Having on record a history of resident behavior or changes in behavior.
• Having on file services provided to the resident.
• Having demographic and general financial information (as needed) for making community referrals on behalf of the resident.
• Following-up on services requested.
• Protecting resident confidentiality.
• Promoting resident self-determination and advocacy.
• Enhancing quality assurance.
• Protecting the resident and the organization from litigation.

It should be noted that personal judgments, opinions, hear-say and unrelated information should not be included in resident case notes.

The Program Manual provided by the American Association of Service Coordinators provides guidance regarding documentation requirements. There is also a CD available that contains sample forms. AASC members can download the Program Manual for free; non-members can purchase the manual at: www.servicecoordinator.org.
Computer-Based Documentation

As we move toward the age of a "paperless society" many local governments and social service organizations are using web-based data management systems to maintain records and information.

As one example, The American Association of Service Coordinators (AASC), in conjunction with the Pangea Foundation and with input from National Church Residences, Catholic Charities, Living Opportunities Management Companies, Volunteers of America, and Southern California Presbyterian Homes, developed a data management system for service coordination in HUD-assisted housing - AASCOnline.

AASCOnline (http://www.aasconline.com) is a web-based data management tool that can enable service coordinators to input information on industry-wide accepted forms and manage their resident data efficiently. AASC would be glad to offer a free trial of this software. You may also wish to use your agency software. Either way, all entities including the service coordinator, the firehouse supervisor, and the agency supervisor should have access to any computer-based documentation systems.
FIREHOUSE SERVICE COORDINATOR PROGRAM
PROGRESS NOTES

Date: _____________________________________________________________

Resident’s Name: _________________________________________________

REFERRAL INFORMATION:

Date of Referral: _________________________________________________

Source of Referral: _______________________________________________

Presenting problem from referral source: _____________________________

Method of contact with resident: phone ______  email ______  home visit ______

Observation during initial meeting: _________________________________

Diagnosis reported directly from the resident and/or medic report:

____________________________________________________________________

Documents reviewed and/or signed by resident, i.e., confidentiality agreement, release of information.

____________________________________________________________________

Services currently in place:

Service __________________________________________________________

Contact Information: _______________________________________________

Service __________________________________________________________

Contact Information: _______________________________________________

Resident service needs (resident expressed and/or observations made by service coordinator. Clearly state how service needs were identified.)

____________________________________________________________________

Result of contact: (i.e., referrals made, monitoring, etc.)

____________________________________________________________________

Progress Notes Page One
Future interactions planned with resident, i.e. appointments, planned timeframe to follow up.

______________________________________________________________________

Case resolution status:

______________________________________________________________________

Results of monitoring and agency follow up:

______________________________________________________________________

Meeting Notes: W/Family ______  W/Resident: ________  W/Service Provider ______

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Disposition/termination of case:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature of person taking report
Evaluating Case Status

Cases generally fall within three categories:

1. Active
2. Monitoring
3. Closed/Inactive

In order to determine whether a case should be identified as closed/inactive, the situation from the monitoring phase is analyzed to determine if the goals and objectives set forth for the resident originally are being achieved.

The evaluation process may show that original goals and objectives need to be altered or even that the entire service management plan needs to be redeveloped or has been completed. The evaluation process should take place at a set interval of time as determined by the needs of the resident to insure that goals and outcomes are being met.

It is suggested that those residents who are not actively being served are monitored on a quarterly basis and are moved to inactive status upon two satisfactory quarterly reviews with no further 911 calls. Cases may not be completely closed until the client moves from the community or passes away.
The Program should institute a standard protocol for follow-up that would both allow the service coordinator to reassess individuals’ service needs and to evaluate program efficacy. A quarterly follow-up phone call for up to a year following the initial intake is suggested. When consumers are not able to be reached on the phone, it is suggested that the service coordinator attempt to contact the consumer at the home.

Aging in Place

1. Is the resident still living in same place (i.e., house or apartment)? Yes _____ No _____

2. In general would you say that your health is:
   - □ excellent  □ very good  □ good  □ fair  □ poor

3. On a scale of 1-10, how satisfied are with your life right now?
   
   1    2    3    4    5    6    7    8    9    10

Services

4. What services are currently in place?

   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

5. On a scale of 1-10, how satisfied are you with the current services?

   1    2    3    4    5    6    7    8    9    10

6. What are your concerns about being able to stay in your home? (This can be done qualitatively or by creating categories.)

7. What additional service do you feel you need? (May want to include categories for prompting consumers.)
8. How has the Firehouse Service Coordinator Program impacted you?

9. Have you been hospitalized since the Firehouse Service Coordinator intervention? If yes, how many times?

10. How many 911 Calls since the intervention?
Section 9: Resident Welcome Packet

Replication Manual
Firehouse Service Coordination Program
INITIAL CONTACT WITH RESIDENTS:

At first meeting, the service coordinator should provide residents with information about the program, including information regarding their individual rights.

Welcome Packet Contents:

- Program Flier (individual to each program)
- Disclosure Statement
- Confidentiality Agreement
- Non-Participation Form
- Release of Information
- Contribution Pledge Form
- File of Life Program (or similar)
- Resource Directory (individual to each program)
- Brochure of Services Provided by Firehouse Service Coordinator (individual to each program)
STAY UA
Services to Age in Your Upper Arlington

From the Upper Arlington Fire Division

A primary goal of STAY UA is to reduce the stresses and costs associated with critical needs: providing our residents with links to appropriate, affordable, in-home support; reducing EMS runs that may be non-emergency in nature; and avoiding premature admission to more costly institutionalized care.

Introduction
The City of Upper Arlington’s Fire Division is excited to partner with InCare in a Service Coordinator program that facilitates keeping older adults and residents with disabilities safely in their homes.

Beginning in early April 2009, the part-time, one-year pilot program was made possible through funding from the Rev. John R. Glenn Foundation, secured by InCare’s parent organization, National Church Residences. It is believed to be the first formalized program of its kind in the country.

This program bridges the gap between services offered by the Fire Division’s emergency medical service by connecting residents with the appropriate support services that could help prevent future emergency situations.

In its first year of existence, the program helped link numerous members of our community with resources and services they did not know were available to them, resulting in immediate, cost-effective improvements to their quality of life and the ability to remain in their homes.

Effective April 2010, the program is to be established as a sustained community program supported by Upper Arlington City Council, the City of Upper Arlington, and numerous community organizations.

Upper Arlington
Emergency Information

Emergency – Police, Fire & Medical 9-1-1

Police
non-life-threatening emergencies 614-459-2800

Fire & Medical
non-life-threatening emergencies 614-451-9700

Contact the InCare Service Coordinator:
614-551-1832 | 614-583-5114 | STAYUA@UAOH.NET
About the Service Coordinator
The STAY UA Service Coordinator has the necessary skills and training to meet with, assess, counsel, and provide caring and practical support to the community’s elderly and disabled, at a time when they may be unable to seek and find the resources they want and need.

Housed in the Fire Division’s Training & EMS Office, division personnel can involve the STAY UA Service Coordinator either during or shortly after emergency calls for help. The Service Coordinator can then meet with these residents, at no cost, to discuss their situation and issues, and to provide information about the many existing supportive services that may be available to help prevent emergencies from happening in the future.

Services
The InCare Service Coordinator can help connect residents to the following services:
- Links to community services
- In-home skilled nursing
- Prescription assistance
- Access to meal programs
- Transportation assistance programs
- Counseling
- Adult day care
- Hospice
- Home safety surveys and solutions
- Financial planning assistance
- Access to social networks

Partners
The City of Upper Arlington Fire Division wishes to thank its STAY UA partners:
- National Church Residences
- InCare
- Rev. John R. Glenn Foundation

STAY UA Supporters:
- American Association of Service Coordinators
- Upper Arlington Commission on Aging
- Northwest Counseling Services
- OSU Office of Geriatrics and Gerontology
- City of Upper Arlington Senior Center
- Alzheimer’s Association
- Upper Arlington Senior Association
- Upper Arlington Area Chamber of Commerce

Upper Arlington City Council
Mayor Frank Ciocciola
Vice Mayor Mary Ann Krauss
David DeCapua, Debbie Johnson
Edward F. Seidel, Jr.
Wade Steen, Erik F. Yassenoff

City Manager
Virginia Barney

Fire Chief
Jeff Young
Goals of the Firehouse Service Coordination Program
A primary goal of the Firehouse Service Coordination Program is to reduce the stresses and costs associated with critical needs: Providing our residents with links to appropriate, affordable, in-home support; reducing EMS (Emergency Medical Services) runs that may be non-emergency in nature; and avoiding premature admission to more costly institutionalized care.

About the Firehouse Service Coordinator
The Firehouse Service Coordinator has the necessary skills and training to meet with, assess, counsel, and provide caring and practical support to our community’s elderly and disabled, at a time when they may be unable to seek and find the resources they want and need.

Fire division personnel can involve the Firehouse Service Coordinator either during or shortly after emergency calls for help. The service coordinator can then meet with these residents, at no cost, to discuss their situation and issues, and to provide information about the many existing supportive services that may be available to help prevent emergencies from happening in the future.

How can the Firehouse Service Coordinator help?
The Firehouse Service Coordinator can help connect residents to the following services:
- Links to community services
- In-home skilled nursing
- Prescription assistance
- Access to meal programs
- Transportation assistance programs
- Counseling
- Adult day care
- Hospice
- Home safety surveys and solutions
- Financial planning assistance
- Access to social networks

Where is the Firehouse Service Coordinator located?
The Firehouse Service Coordinator is housed in the ____________________ Fire Division’s station at _____________________________________ (location).

How is the Firehouse Service Coordinator funded?
*Individual Firehouse can insert their funding information here.*

Is the Firehouse Service Coordinator an employee of ________________ (city or firehouse)?  *Individual Firehouse can insert their information regarding this question.*
Am I under an obligation to use the service of, or the referrals, offered to me by the service coordinator?
Any resident referred to the Firehouse Service Coordination Program by the Fire Division is under no obligation to accept the service of the Firehouse Service Coordinator. Additionally, a resident is under no obligation to pursue or accept referrals offered by the Firehouse Service Coordinator.

What about confidentiality and anonymity?
The Firehouse Service Coordinator has an obligation to maintain each resident’s privacy. The service coordinator will maintain the confidentiality of material that has been given him/her in their professional role. Exceptions to this responsibility will occur only when there are overriding legal or professional reasons and, whenever possible, with the written informed consent of each resident (reference formal confidentiality agreement).

What if I have additional questions?
If you have additional questions, please feel free to write or call: (Firehouse name, address, and phone number listed here.)
Confidentiality is protecting another person’s right to privacy.

The information you reveal to the service coordinator will not be discussed with anyone else. This confidentiality means that your personal information is not revealed to anyone, including your family, without your written permission, unless required by law.

A Release of Information form is used to obtain this permission. As needed, the service coordinator will request that you complete and sign the Release of Information form. The properly executed form will allow the service coordinator to discuss your service needs and desires with the specified community service providers, the EMS Coordinator and Fire Division staff, family members, physicians, and/or other individuals in order to link you to programs and services that will assist you in remaining independent and self-sufficient.

Exceptions to Right of Confidentiality

Federal and/or state law may require the service coordinator to disclose the following information:

- Abuse/Neglect/Adult Protective Services: It may be necessary to report residents who are endangering themselves or others within the home to the proper authorities.
- It may be necessary to disclose information pursuant to a proper court order.
- It may be necessary to report to the proper authorities any information related to suspected fraudulent activity or other violations of the law on your part.

Confidentiality Pledge

As the service coordinator, I ________________________ (print SC’s name) agree to protect your right to privacy and confidentiality. I will not disclose any information about you without your written permission unless I am required by law or the policy above to do so.

Service Coordinator Signature ____________________________ Date ________________

I, ________________________________________________________ (print resident’s name) understand that my file may be reviewed for the purposes of assuring compliance of the Firehouse Service Coordination Program. I understand that information included in my file will continue to remain confidential.

Resident Signature _____________________________________ Date _________________

Service Coordinator: Provide the resident a copy of this signed form.
I, _________________________________, living at _______________________________,
(Name of Resident)       (Address)
understand that I am responsible for making my own decisions and choices regarding a
service(s) available to me. At this time, I am refusing to use a service(s) available as presented
by the service coordinator. The service coordinator has fully explained the:

• Rationale for accepting a service(s)
• Specifics of the service(s)
• Possible consequences of refusing to participate in the service(s)

I hold the staff of the Firehouse located in ______________________________________
(Name of Firehouse Community)
harmless in case of damage to my personal property or injury to my person caused by declining
the services presented by the service coordinator.

Conditions/Remarks:____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Resident Signature __________________________________________ Date ___________

Service Coordinator Signature ________________________________ Date ___________
Resident Name (First, Middle, Maiden, Last) ______________________________________

Date of Birth _______________________________________________________________

I presently reside at (address): _________________________________________________

I authorize the service coordinator to disclose the following information:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

To the following person or organization: __________________________________________

The purpose of this disclosure is to: _____________________________________________

Information obtained by the service coordinator will be maintained as confidential and released
only to those who have a need to know such information, as required by law, or as provided in
the Release. The service coordinator shall adhere to all applicable laws, regulations, or
professional license requirements

I understand that I may revoke this Consent to Release of Information at any time by providing
written or verbal notice of the revocation to the service coordinator. This revocation will not
apply to information that has been previously released or action that has been taken in
accordance with, and in reliance upon, this consent.

This consent (unless expressly revoked earlier) expires 180 days from the date indicated below.

Health information disclosed pursuant to this consent may be subject to re-disclosure and would
no longer be protected by 45 CFR Parts 160 and 164 unless applicable state law prohibits re-
 disclosure of the information. Federal law prohibits re-disclosure of substance abuse treatment
information to any person without the written authorization in accordance with 42 CFR Part 2.

Signature of Resident __________________________ Date __________

Signature of Guardian, if applicable __________________________ Date __________

Relationship to Resident ________________________________________________

Signature of Service Coordinator __________________________ Date __________
The Firehouse Service Coordination Program is a unique opportunity to support our community’s residents in their pursuit of independence and healthy aging. The Program operates through a public/private partnership with limited funds. If you found the experience helpful and would like to help insure that others have the same opportunity in the future, we would appreciate any contribution you might be able to make at this time. 100% of your contribution will go toward support of the Firehouse Service Coordination Program.

**Donor Information (please print or type)**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing address</td>
<td></td>
</tr>
<tr>
<td>City, State Zip Code</td>
<td></td>
</tr>
<tr>
<td>Preferred Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

*Your personal information is kept confidential.*

**Donation Information**

I (we) pledge a total of $________ to be paid: ____now ____monthly ____quarterly ____yearly.

I (we) plan to make this contribution in the form of: ____cash ____check ____credit card ____other.

<table>
<thead>
<tr>
<th>Credit card type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Credit card number</td>
<td></td>
</tr>
<tr>
<td>Expiration date</td>
<td></td>
</tr>
<tr>
<td>Authorized signature</td>
<td></td>
</tr>
</tbody>
</table>

Gift will be matched by ________________________________ (company/family/foundation).

____ form enclosed ____ form will be forwarded

**Acknowledgement Information**

Please use the following name(s) in all acknowledgements:

____ I (we) wish to have our gift remain anonymous.

<table>
<thead>
<tr>
<th>Signature(s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

Please make checks, corporate matches, or other gifts payable to:

**Organization Name**

PO Box 1234  
Some City, Texas 79999  
http://www.xyz.org
The **File of Life** program is designed to speak for you when you can't speak for yourself. The file contains important medical information that can assist emergency personnel in administering the proper medical treatment. For more information and additional forms, decals, etc., go to [http://www.folife.org](http://www.folife.org).

The File of Life is a plastic baggie that is placed on the front of your refrigerator door and should contain:

1. A completed File of Life form.  
   (Answer the questions to the best of your ability.)

2. A picture of yourself.

3. A copy of your last EKG.  
   (Your doctor should gladly provide you with a copy.)

4. Living Will or equivalent, if you have one.

5. Do Not Resuscitate (DNR) documentation, if you so choose.

6. Any other documentation or information you feel important for the emergency personnel.

An example of a File of Life form follows.
**Typical FILE or VIAL OF LIFE FORM (Sample)**

Date Completed: ________________

**EMERGENCY MEDICAL INFORMATION – FOR RESCUE SQUAD**

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>LAST NAME</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>MALE/FEMALE</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>HAIR COLOR</th>
<th>EYE COLOR</th>
<th>BLOOD TYPE</th>
<th>RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF PACEMAKER, MODEL #</th>
<th>DEFIBRILATOR, MODEL #</th>
<th>HEARING AID</th>
<th>DEAF</th>
<th>DENTURES</th>
<th>UNABLE TO SPEAK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>L R</td>
<td>L R</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VISION</th>
<th>GLASSES</th>
<th>CONTACTS</th>
<th>BLIND</th>
<th>ARTIFICIAL EYE</th>
<th>LANGUAGE SPOKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>L R</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IDENTIFYING MARKS:

CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST

- AIDS
- BLOOD PRESSURE
- EPILEPSY
- HEART CONDITION
- TUBERCULOSIS

- ANEMIA
- CANCER
- GLAUCOMA
- JAUNDICE
- OTHER:

- ARTHRITIS
- DIABETES
- HAY FEVER
- SINUS

- ASTHMA
- INSULIN Y / N
- HEPATITIS
- STROKE

CURRENTLY BEING TREATED FOR?

CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED

NAME OF DOCTOR | TELEPHONE NUMBER
----------|------------------|

NAME OF DOCTOR | TELEPHONE NUMBER
----------|------------------|

NAME OF DOCTOR | TELEPHONE NUMBER
----------|------------------|

ALLERGIES TO MEDICATIONS

HOSPITAL | LOCATION | YEAR | PATIENT #
---------|----------|------|----------|

LIVING WILL | ORGAN DONOR | REFER TO: |
----------|-------------|-----------|

MEDICAL COVERAGE

PRIMAR INSURANCE # | MEDICARE #
---------|-----------|

MEDICAID # | OTHER POLICY #
---------|-------------|

IN CASE OF EMERGENCY - NOTIFY | RELATIONSHIP
----------------|-------------|

STREET ADDRESS | APT | CITY | STATE | ZIP | PHONE
---------------|-----|------|-------|-----|------|

PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED

Version 1.1 01/13
Section 10: Funding and Program Support

Replication Manual
Firehouse Service Coordination Program
**Funding and Program Support**

Funding mechanisms for a Firehouse Service Coordination Program will likely differ to some extent in every entity replicating the program. As outlined in this replication manual, following the pilot project period which was supported by foundation funds, the Upper Arlington program was funded through a contract method which allowed the City to benefit from the expertise of a trained service coordinator who received training and oversight from her home agency. This relationship evolved for two main reasons:

- Concern regarding employment of a single employee in a work class that differed significantly from the work performed by any other city employee. There was concern that supervision and training could not be accomplished appropriately within the city structure.
- Limited finances made the affiliation through a contract/business agreement the most workable approach for the city.

As you consider replication of the Firehouse Service Coordination Program in your location, you might want to also consider other funding approaches such as:

- Area Agency on Aging or Council on Aging collaboration and possible funding through tax issues.
- Collaboration with foundations that provide funding in the areas of healthcare, aging, innovative programming, etc.
- Corporate sponsorship/donor
- Private donor (with naming rights?)
- Consortium of home health and healthcare providers entering into collaborative agreements to fund service coordinator position.

In any case, funding relationships and agreements should be fully vetted for legal ramifications, HIPPA compliance, and all other regulatory criteria relevant in your governmental structure.

**Policy Initiatives**

The American Association of Service Coordinators (AASC) is focused on advancing the interests of the service coordinator profession through advocacy, leadership, education and training. AASC works with Congress, federal and state agencies, and educates public and private agencies on the benefits and cost effectiveness of service coordination, in addition to identifying and supporting alternative funding resources and collaborative partnerships that can be duplicated.
Section 11:
Aging Resources
AGING RESOURCES

Below is a list of national organizations that provide useful resources, information, assistance and policy initiatives (and in some cases funding) on behalf of our aging population and the people who care for this population. Contact information and web site addresses are included with each.

Administration on Aging (AoA)
330 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 619-7501
Fax: (202) 260-1012
E-mail: aoainfo@aoa.gov
Website: http://www.aoa.gov/

The mission of AoA is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.

American Association of Retired Persons (AARP)
601 E Street, NW
Washington DC 20049
Tel: (888) 687-2277
E-mail: member@aarp.org
Website: http://www.aarp.org/

The AARP is “a nonprofit, nonpartisan organization that helps people 50 and over improve the quality of their lives.” Their website offers a multitude of information for older adults. The AARP Foundation also offers funding opportunities.

American Association of Service Coordinators (AASC)
P.O. Box 1178
Powell, OH 43065
Tel: (614) 848-5958
Website: http://servicecoordinator.org/

AASC is dedicated to informing, educating, and providing resources and guidance to service coordinators across the nation. They also offer an electronic documentation program for service coordinators.

Commonwealth Fund
1 East 75th Street
New York, NY 10021
Tel: (212) 606-3800
Fax: (212) 606-3500
E-mail: info@cmwf.org
Website: http://www.commonwealthfund.org/
The mission of the Commonwealth Fund is “to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.” The website has news, maps, data, information for educators, and information on funding.

Donald W. Reynolds Foundation
1701 Village Center Circle
Las Vegas, NV 89134
Tel: (702) 804-6000
Fax: (702) 804-6099
E-mail: GeneralQuestions@dwrf.org
Website: http://www.dwreynolds.org

The Reynolds Foundation is dedicated to filling unmet needs and gaining immediate transformation impact through their initiative, including improving the quality of life of America’s growing elderly population.

Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
Tel: (888) 275-4772
Website: www.hrsa.gov

This Federal agency focuses on improving the health of uninsured, isolated and medically vulnerable persons by achieving health equity through access to quality services, a skilled healthcare workforce and innovative programs.

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
Tel: (650) 854-9400
Fax: (650) 854-4800
Website: http://www.kff.org/

This Foundation produces policy analysis and research in-house, provides free-of-charge news and information, and develops and runs public health information campaigns around the globe.

International Association of Fire Chiefs (IAFC)
4025 Fair Ridge Drive, Suite 300
Fairfax, VA 22033
Tel: (703) 273-0911
Fax: (703) 273-9363
Website: http://iafc.org/
The IAFC represents the leadership of firefighters and emergency responders worldwide. They offer information, education, services and representation to current and future emergency service organizations.

**National Association of Area Agencies on Aging (NAAAA)**

927 15th Street, NW, 6th Floor  
Washington, DC 20005  
Tel: (202) 296-8130  
Fax: (202) 296-8134  
Website: [www.n4a.org](http://www.n4a.org)

The NAAAA’s primary mission is to build the capacity of its members to help older persons and persons with disabilities live with dignity and choices in their homes and communities for as long as possible.

**National Care Planning Council (NCPC)**

P.O. Box 1118  
Centerville, UT 84014  
Tel: (801) 298-8676  
Toll Free: (800) 989-8137  
Fax: (801) 295-3776  
E-mail: [info@longtermcarelink.net](mailto:info@longtermcarelink.net)  
Website: [http://www.longtermcarelink.net/eldercare/ref_state_aging_services.htm](http://www.longtermcarelink.net/eldercare/ref_state_aging_services.htm)

In addition to promoting and supporting planning for long term care, they also provide a list of State-by-State Department of Aging information and links.

**The National Council on the Aging, Inc. (NCOA)**

409 Third Street, S.W.  
Washington, DC 20024  
Tel: (202) 479-1200  
Fax: (202) 479-0735  
E-mail: [info@ncoa.org@aghe.org](mailto:info@ncoa.org@aghe.org)  
Website: [www.ncoa.org](http://www.ncoa.org)

Their mission is to improve the lives of older adults by working with nonprofit community agencies, businesses, and the government to help seniors improve their overall health and live independently in the community.

**National Institute on Aging (NIA)**

Building 31, Room 5C27  
31 Center Drive, MSC 2292  
Bethesda, MD 20892  
Tel: (301) 496-1752  
E-mail: [webmaster@nia.nih.gov](mailto:webmaster@nia.nih.gov)  
Website: [www.nia.nih.gov](http://www.nia.nih.gov)
The NIA main mission is to understand the nature of aging by supporting research in areas that address the disease, conditions, and disabilities that are often associated with older adults. Through this research, they hope to extend the health and well-being of older Americans.

**Robert Wood Johnson Foundation**
P.O. Box 2316
Route 1 and College Road East
Princeton, NJ 08543-2316
Tel: (877) 843-7953
Website: [http://www.rwjf.org](http://www.rwjf.org)

Robert Wood Johnson Foundation is one of the nation’s largest philanthropic foundations devoted to improving health policy and the public’s health. They sponsor public health programs, research, and also provide funding through grants.

**USA.gov**
Website: [http://www.usa.gov](http://www.usa.gov) or [http://www.usa.gov/Topics/Seniors.shtml](http://www.usa.gov/Topics/Seniors.shtml)

The USA.gov website is the official web portal for the U.S. Government. This is a one-stop-shop website for news, information, funding, government agency information, etc.
Section 12: PROGRAM EVALUATION TOOLS

Replication Manual
Firehouse Service Coordination Program
Evaluation is an important component of the Firehouse Service Coordination Program. This section currently contains two sample evaluations:

- **Service Coordination Program Evaluation:**
  The first evaluation is a postcard that may be mailed to residents by the Firehouse Division or other appropriate stakeholder (funding entity, the City, etc.) to assess the services provided through the Firehouse Service Coordination Program. The service coordinator should not mail this form since many of the questions pertain directly to the service coordinator’s job performance, and therefore presents a conflict of interest.

- **Replication Manual Evaluation:**
  The second evaluation form allows evaluation of the effectiveness of the *Firehouse Service Coordination Replication Manual*. Information gathered from this evaluation will be used to maintain an updated manual for future use by other Cities. This form is best completed no less than 6 months after the initiation of a Firehouse Service Coordination Program.

- **Research Outcomes (coming soon):**
  A Firehouse Service Coordination Program Evaluation will be developed in conjunction with a research study currently underway that is examining the effects of a Firehouse Service Coordination Program on community-based services, utilization of healthcare, and long term care. An evaluation will be developed on the outcomes of this study and at that time, published in professional journals and this replication manual.

With data and information gathered through evaluation, stakeholders are better able to improve the overall program and develop strategies for sustaining an efficient and effective Firehouse Service Coordination Program.
Service Coordination Program Evaluation

This postcard template may be edited to best reflect your program, and then mailed to the residents served by your Firehouse Service Coordinator Program. Upon return, responses may be analyzed to help you understand the effectiveness of the services provided through your Firehouse Service Coordination Program.
**The Firehouse Service Coordination Program**

Please tell us your opinion of the services you received from the Firehouse Service Coordination Program recently by filling out the information below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable (N/A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I got advice or help when needed</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>I was able to easily contact you</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>The Service Coordinator (SC) was courteous &amp; helpful</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>The SC listened to me &amp; answered my questions</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>The SC encouraged me to make my own decisions</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>The SC explained things in a way I could understand and kept me informed</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
</tr>
</tbody>
</table>

My overall satisfaction with the Firehouse Service Coordination Program is:

- Excellent
- Very Good
- Good
- Neutral
- Fair
- Poor

Are you male or female? Male Female

What is your age? 55 55-64 65-74 75-84 85+

What is your marital status?
- Married
- Widowed
- Separated
- Never married
- Divorced

How long have you lived in your current residence? ________________

Would you recommend the Firehouse Service Coordination Program to others? YES NO

How can we improve our services to you?
Replication Manual Evaluation

This evaluation will allow the authors of the Replication Manual to maintain a high quality and up-to-date manual for future use by other Cities. It is best filled out at least 6 months after the initiation of a Firehouse Service Coordination Program. Staff from the Office of Geriatrics and Gerontology will also contact you about this evaluation.
This survey is intended to evaluate the effectiveness of the “Firehouse Service Coordination Replication Manual” in providing guidance and resources to cities, communities or other entities implementing a Firehouse Service Coordination Program. Please complete this survey no less than 6 months after implementing a Firehouse Service Coordination Program in your community; program staff will also call to check in on your progress. Return completed survey to the address listed at the end of this document.

**PART 1:** Choose one (1) answer below that reflects your level of satisfaction with the replication manual.

1. **Was the manual useful in helping you implement a Firehouse Service Coordination Program in your community?**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The manual contained relevant information for program implementation.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The manual was comprehensive in its coverage of the topic.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**Comments:**

2. **Was the manual efficiently organized?**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content was well organized and structured in a logical manner.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The manual was easy to use.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**Comments:**
**PART 2:** Choose one (1) answer that best reflects your opinion about the quality of the replication manual sections.

<table>
<thead>
<tr>
<th>Section Name</th>
<th>Extremely Poor</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Aging in Place</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Background</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Sample Agreement</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Program Structure</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>First Responder Training</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>The Service Coordinator</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>The Resident</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Resident Welcome Packet</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Funding &amp; Program Support</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Aging Resources</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Forms</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Program Evaluation</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

Comments:

**PART 3:** Let us know how your community utilized the *Firehouse Service Coordination Program Replication Manual* to meet your overall needs.

1. What elements of the replication manual met your needs and/or worked well for your Firehouse Program implementation?

2. What elements of the replication manual did not meet your needs and/or work well for your Firehouse Program implementation?

3. Please let us know how we can improve the replication manual.
4. Would you recommend this replication manual to other cities, communities or entities?
   O Yes, O No

5. Any other comments?

Send completed evaluation to:

Linda Mauger
Office of Geriatrics and Gerontology
The Ohio State University Wexner Medical Center
1581 Dodd Drive
McCampbell Hall, 5th Floor
Columbus, OH 43210

Thank you!
Section 13: Forms
All the forms included in this section have been previously shown in their respective sections of the manual. We offer them here as a matter of convenience.

- Confidentiality Agreement
- Contribution Pledge Form
- Disclosure Statement
- File of Life
- Non-Participation Form
- Progress Notes
- Quarterly Follow-Up Report
- Release of Information
- Referral Form
- Screening and Assessment Form
Confidentiality is protecting another person's right to privacy.

The information you reveal to the service coordinator will not be discussed with anyone else. This confidentiality means that your personal information is not revealed to anyone, including your family, without your written permission, unless required by law.

A Release of Information form is used to obtain this permission. As needed, the service coordinator will request that you complete and sign the Release of Information form. The properly executed form will allow the service coordinator to discuss your service needs and desires with the specified community service providers, the EMS Coordinator and Fire Division staff, family members, physicians, and/or other individuals in order to link you to programs and services that will assist you in remaining independent and self-sufficient.

Exceptions to Right of Confidentiality

Federal and/or state law may require the service coordinator to disclose the following information:

- Abuse/Neglect/Adult Protective Services: It may be necessary to report residents who are endangering themselves or others within the home to the proper authorities.
- It may be necessary to disclose information pursuant to a proper court order.
- It may be necessary to report to the proper authorities any information related to suspected fraudulent activity or other violations of the law on your part.

Confidentiality Pledge

As the service coordinator, I ______________________ (print SC’s name) agree to protect your right to privacy and confidentiality. I will not disclose any information about you without your written permission unless I am required by law or the policy above to do so.

Service Coordinator Signature ____________________________ Date ________________

I, ________________________________________________ (print resident’s name) understand that my file may be reviewed for the purposes of assuring compliance of the Firehouse Service Coordination Program. I understand that information included in my file will continue to remain confidential.

Resident Signature _________________________________ Date ________________

Service Coordinator: Provide the resident a copy of this signed form.
**FIREHOUSE SERVICE COORDINATION PROGRAM**
**CONTRIBUTION PLEDGE FORM**

The Firehouse Service Coordination Program is a unique opportunity to support our community’s residents in their pursuit of independence and healthy aging. The Program operates through a public/private partnership with limited funds. If you found the experience helpful and would like to help insure that others have the same opportunity in the future, we would appreciate any contribution you might be able to make at this time. 100% of your contribution will go toward support of the Firehouse Service Coordination Program.

**Donor Information (please print or type)**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing address</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Preferred Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

*Your personal information is kept confidential.*

**Donation Information**

I (we) pledge a total of $__________ to be paid: ____now ____monthly ____quarterly ____yearly.

I (we) plan to make this contribution in the form of: ____cash ____check ____credit card ____other.

| Credit card type |  |
| Credit card number |  |
| Expiration date |  |
| Authorized signature |  |

Gift will be matched by ________________________________ (company/family/foundation).

_____ form enclosed _____ form will be forwarded

**Acknowledgement Information**

Please use the following name(s) in all acknowledgements:

_____ I (we) wish to have our gift remain anonymous.

| Signature(s) |  |
| Date |  |

Please make checks, corporate matches, or other gifts payable to:

**Organization Name**

PO Box 1234  
Some City, Texas 79999  
http://www.xyz.org
Goals of the Firehouse Service Coordination Program
A primary goal of the Firehouse Service Coordination Program is to reduce the stresses and costs associated with critical needs: Providing our residents with links to appropriate, affordable, in-home support; reducing EMS (Emergency Medical Services) runs that may be non-emergency in nature; and avoiding premature admission to more costly institutionalized care.

About the Firehouse Service Coordinator
The Firehouse Service Coordinator has the necessary skills and training to meet with, assess, counsel, and provide caring and practical support to our community’s elderly and disabled, at a time when they may be unable to seek and find the resources they want and need.

Fire division personnel can involve the Firehouse Service Coordinator either during or shortly after emergency calls for help. The service coordinator can then meet with these residents, at no cost, to discuss their situation and issues, and to provide information about the many existing supportive services that may be available to help prevent emergencies from happening in the future.

How can the Firehouse Service Coordinator help?
The Firehouse Service Coordinator can help connect residents to the following services:

- Links to community services
- In-home skilled nursing
- Prescription assistance
- Access to meal programs
- Transportation assistance programs
- Counseling
- Adult day care
- Hospice
- Home safety surveys and solutions
- Financial planning assistance
- Access to social networks

Where is the Firehouse Service Coordinator located?
The Firehouse Service Coordinator is housed in the Fire Division’s station at (location).

How is the Firehouse Service Coordinator funded?
*Individual Firehouse can insert their funding information here.*

Is the Firehouse Service Coordinator an employee of (city or firehouse)? *Individual Firehouse can insert their information regarding this question.*
Am I under an obligation to use the service of, or the referrals, offered to me by the service coordinator?
Any resident referred to the Firehouse Service Coordination Program by the Fire Division is under no obligation to accept the service of the Firehouse Service Coordinator. Additionally, a resident is under no obligation to pursue or accept referrals offered by the Firehouse Service Coordinator.

What about confidentiality and anonymity?
The Firehouse Service Coordinator has an obligation to maintain each resident’s privacy. The service coordinator will maintain the confidentiality of material that has been given him/her in their professional role. Exceptions to this responsibility will occur only when there are overriding legal or professional reasons and, whenever possible, with the written informed consent of each resident (reference formal confidentiality agreement).

What if I have additional questions?
If you have additional questions, please feel free to write or call:
(Firehouse name, address, and phone number listed here.)
The File of Life program is designed to speak for you when you can't speak for yourself. The file contains important medical information that can assist emergency personnel in administering the proper medical treatment. For more information and additional forms, decals, etc., go to http://www.folife.org.

The File of Life is a plastic baggie that is placed on the front of your refrigerator door and should contain:

1. A completed File of Life form.  
   (Answer the questions to the best of your ability.)

2. A picture of yourself.

3. A copy of your last EKG.  
   (Your doctor should gladly provide you with a copy.)

4. Living Will or equivalent, if you have one.

5. Do Not Resuscitate (DNR) documentation, if you so choose.

6. Any other documentation or information you feel important for the emergency personnel.

An example of a File of Life form follows.
## Typical FILE or VIAL OF LIFE FORM (Sample)

**Date Completed:** ______________________

### EMERGENCY MEDICAL INFORMATION – FOR RESCUE SQUAD

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>INITIAL</th>
<th>LAST NAME</th>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>MALE/FEMALE</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>HAIR COLOR</th>
<th>EYE COLOR</th>
<th>BLOOD TYPE</th>
<th>RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IF PACEMAKER, MODEL #</th>
<th>DEFIBRILATOR, MODEL #</th>
<th>HEARING AID</th>
<th>DEAF</th>
<th>DENTURES</th>
<th>UNABLE TO SPEAK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VISION</th>
<th>GLASSES</th>
<th>CONTACTS</th>
<th>BLIND</th>
<th>ARTIFICIAL EYE</th>
<th>LANGUAGE SPOKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IDENTIFYING MARKS:**

**CIRCLE CONDITIONS YOU HAVE BEEN TREATED FOR IN THE PAST**

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Conditions</th>
<th>Conditions</th>
<th>Conditions</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>BLOOD PRESSURE</td>
<td>EPILEPSY</td>
<td>HEART CONDITION</td>
<td>TUBERCULOSIS</td>
</tr>
<tr>
<td>ANEMIA</td>
<td>CANCER</td>
<td>GLAUCOMA</td>
<td>JAUNDICE</td>
<td>OTHER:</td>
</tr>
<tr>
<td>ARTHRITIS</td>
<td>DIABETES</td>
<td>HAY FEVER</td>
<td>SINUS</td>
<td></td>
</tr>
<tr>
<td>ASTHMA</td>
<td>INSULIN Y / N</td>
<td>HEPATITIS</td>
<td>StROKE</td>
<td></td>
</tr>
</tbody>
</table>

**CURRENTLY BEING TREATED FOR?**

**CURRENT MEDICATIONS/DOSAGE/FREQUENCY/LOCATED**

**NAME OF DOCTOR**

**TELEPHONE NUMBER**

**NAME OF DOCTOR**

**TELEPHONE NUMBER**

**ALLERGIES TO MEDICATIONS**

**LAST HOSPITALIZATION**

**HOSPITAL**

**LOCATION**

**YEAR**

**PATIENT #**

**LIVING WILL**

**REFER TO:** ORGAN DONor

**REFER TO:**

**MEDICAL COVERAGE**

**INSURANCE #**

**MEDICARE #**

**MEDICAID #**

**OTHER POLICY #**

**IN CASE OF EMERGENCY - NOTIFY**

**RELATIONSHIP**

**STREET ADDRESS**

**APT**

**CITY**

**STATE**

**ZIP**

**PHONE**

**PLACE ON FRONT OF REFRIGERATOR AND UPDATE AS NEEDED**
I, _________________________________, living at _______________________________,
(Name of Resident)       (Address)
understand that I am responsible for making my own decisions and choices regarding a
service(s) available to me. At this time, I am refusing to use a service(s) available as presented
by the service coordinator. The service coordinator has fully explained the:

• Rationale for accepting a service(s)
• Specifics of the service(s)
• Possible consequences of refusing to participate in the service(s)

I hold the staff of the Firehouse located in ________________________________________
(Name of Firehouse Community)
harmless in case of damage to my personal property or injury to my person caused by declining
the services presented by the service coordinator.

Conditions/Remarks:____________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Resident Signature __________________________________________ Date ___________

Service Coordinator Signature _________________________________ Date ___________
Date: ________________________________________________________________

Resident’s Name: ____________________________________________________

**REFERRAL INFORMATION:**

Date of Referral: ______________________________________________________

Source of Referral: __________________________________________________

Presenting problem from referral source: ________________________________

Method of contact with resident: phone _____  email _____  home visit _____

Observation during initial meeting: ______________________________________

Diagnosis reported directly from the resident and/or medic report:

_____________________________________________________________________

Documents reviewed and/or signed by resident, i.e., confidentiality agreement, release of information.

_____________________________________________________________________

Services currently in place:

Service: ____________________________________________________________

Contact Information: _________________________________________________

Service: ____________________________________________________________

Contact Information: _________________________________________________

**Resident service needs** (resident expressed and/or observations made by service coordinator. Clearly state how service needs were identified.)

_____________________________________________________________________

Result of contact: (i.e., referrals made, monitoring, etc.)

_____________________________________________________________________

Progress Notes Page One
Future interactions planned with resident, i.e. appointments, planned timeframe to follow up.)

Case resolution status:

Results of monitoring and agency follow up:

Meeting Notes: W/Family _____  W/Resident: _______  W/Service Provider ______

Disposition/termination of case:

Signature of person taking report
The Program should institute a standard protocol for follow-up that would both allow the service coordinator to reassess individuals’ service needs and to evaluate program efficacy. A quarterly follow-up phone call for up to a year following the initial intake is suggested. When consumers are not able to be reached on the phone, it is suggested that the service coordinator attempt to contact the consumer at the home.

**Aging in Place**

11. Is the resident still living in same place (i.e., house or apartment)?  Yes _____  No _____

12. In general would you say that your health is:

   - [ ] excellent
   - [ ] very good
   - [ ] good
   - [ ] fair
   - [ ] poor

13. On a scale of 1-10, how satisfied are with your life right now?

   1 2 3 4 5 6 7 8 9 10

**Services**

14. What services are currently in place?

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

15. On a scale of 1-10, how satisfied are you with the current services?

   1 2 3 4 5 6 7 8 9 10

16. What are your concerns about being able to stay in your home? (This can be done qualitatively or by creating categories.)

17. What additional service do you feel you need? (May want to include categories for prompting consumers.)
18. How has the Firehouse Service Coordination Program impacted you?

19. Have you been hospitalized since the Firehouse Service Coordinator intervention? If yes, how many times?

20. How many 911 Calls since the intervention?
Resident Name (First, Middle, Maiden, Last) ______________________________________

Date of Birth _______________________________________________________________

I presently reside at (address): _________________________________________________

I authorize the service coordinator to disclose the following information:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

To the following person or organization: __________________________________________

The purpose of this disclosure is to:  _____________________________________________

Information obtained by the service coordinator will be maintained as confidential and released only to those who have a need to know such information, as required by law, or as provided in the Release. The service coordinator shall adhere to all applicable laws, regulations, or professional license requirements.

I understand that I may revoke this Consent to Release of Information at any time by providing written or verbal notice of the revocation to the service coordinator. This revocation will not apply to information that has been previously released or action that has been taken in accordance with, and in reliance upon, this consent.

This consent (unless expressly revoked earlier) expires 180 days from the date indicated below.

Health information disclosed pursuant to this consent may be subject to re-disclosure and would no longer be protected by 45 CFR Parts 160 and 164 unless applicable state law prohibits re-disclosure of the information. Federal law prohibits re-disclosure of substance abuse treatment information to any person without the written authorization in accordance with 42 CFR Part 2.

Signature of Resident ___________________________ Date ______________

Signature of Guardian, if applicable ___________________________ Date ______________

Relationship to Resident ________________________________________________

Signature of Service Coordinator ___________________________ Date ______________
## FIREHOUSE SERVICE COORDINATION PROGRAM
### REFERRAL FORM

### Identifying Information

<table>
<thead>
<tr>
<th>Name: ________________________________</th>
<th>Date: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ____________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Phone: _____________________________</td>
<td></td>
</tr>
<tr>
<td>Age: ______ Date of birth: __________</td>
<td>Male: ______ Female:__________</td>
</tr>
<tr>
<td>Marital Status: Married __________ Divorced __________ Widowed ______________</td>
<td></td>
</tr>
<tr>
<td>Living Status: Lives Alone ______ With frail spouse ________ Other ____________</td>
<td></td>
</tr>
<tr>
<td>Condition of home: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Social Support: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Current Services: ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

### Presenting Problem Information

<table>
<thead>
<tr>
<th>911 Call: Yes _____ No _____</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (describe):____________</td>
<td></td>
</tr>
<tr>
<td>Reported Problem: ______________</td>
<td></td>
</tr>
<tr>
<td>____________________________________________</td>
<td></td>
</tr>
<tr>
<td>Was presenting problem due to fall? Yes _____ No _____</td>
<td></td>
</tr>
<tr>
<td>Referred to hospital? Yes _____ No _____</td>
<td></td>
</tr>
<tr>
<td>Hospital: ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

### Contact Information

| Family Member: Son _____ Daughter _____ Sibling _______ Other ________________ | |
| Legal Guardian: ____________________________ | |
| Power of Attorney: ____________________________ | |
| Name: ____________________________ Phone No. ____________________________ | |
| Contacted successfully: Yes _____ No _____ | |
Preliminary assessment is designed to help the service coordinator develop a service plan for the resident. The information gained through this assessment will help the service coordinator refer and link the resident to services or a network of services that meet the specific and immediate needs or situation of the resident.

**Resident Contact Information**

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address 1:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address 2:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zipcode:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Cell Phone:</th>
<th>Other Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E-mail:</th>
</tr>
</thead>
</table>

**Emergency Contact Person:**

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Cell Phone:</th>
<th>Other Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E-mail:</th>
</tr>
</thead>
</table>

**Caregiver Contact Information (if different from Emergency Contact):**

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Cell Phone:</th>
<th>Other Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E-mail:</th>
</tr>
</thead>
</table>

**Screening**

Use the questions below to determine the priority level for resident assessment.

Screening Date: _____________________________

**Higher Priority:**
- Resident was not transported to hospital.
- Resident lives alone
- Referred by service provider who interacted with resident, i.e. medic or city official
- Resident has made multiple 911 calls
- Resident has had multiple ER visits with no admittance in short period of time
- Resident is having difficulties with medical equipment, i.e., oxygen tank

**Lower Priority:**
- Resident has family or other support
- Resident got immediate attention for his/her medical need
- Referral from Quality Assurance report
- Services are currently in place
Resident Assessment

Assessment Date: _________________________

Gender: ____ F ____ M

Date of Birth: _____/_____/_____

Ethnicity:
☐ Asian ☐ Black ☐ Hispanic ☐ Non-Hispanic, White or ☐ Other ________________

How does the resident want to be addressed?
☐ Mr.  ☐ Mrs.  ☐ Ms.  ☐ Dr.  ☐ First Name ☐ Nick Name ☐ Other ________________

1. What are the resident’s current health status and/or medical conditions?

2. What are the resident’s past medical conditions?

3. Has the resident had any hospitalizations in the past 6 months? In the past year?

4. What are your observations of the resident’s . . .
   a. physical state:
   b. emotional state:
   c. cognitive function:

5. Did you observe any evidence of abuse and/or neglect? If so, please describe.
   (Report per legal requirements.)
6. What kind of social support does the resident have?

- Family
- Friends
- Neighbors
- Church
- Other

Comments:

7. Does the resident have caregiver support?

a. If a family or informal caregiver is involved, how much care is being received?
   - Daily
   - Weekly
   - Intermittent

Comments:

b. Does this resident provide care for someone else?
   - Spouse
   - Child
   - Other

Comments:

8. Does the resident have any of the following documentation?

- Advanced Care Directives
  - Living Will
  - Do Not Resuscitate Order (DNR)
  - Durable Health Care Power of Attorney / Health Care Proxy
- Durable Financial Power of Attorney
- Other

Comments:

9. What services are already in place for the resident?

Comments:
10. Does the resident need help with any of the following tasks?

### Katz Basic Activities of Daily Living (ADL) Scale

<table>
<thead>
<tr>
<th>Task</th>
<th>Independent</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Bathing</strong> (sponge bath, tub, or shower)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receives either no assistance or assistance bathing only one part of body</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Dressing</strong> – Gets clothes and dresses without any assistance except for trying shoes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Toileting</strong> – Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Transferring</strong> – Moves in and out of bed and chair without assistance (may use cane or walker)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Continence</strong> – Controls bowel and bladder completely by self (without occasional “accidents”)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. Feeding</strong> – Feeds self without assistance (except for help with cutting meat or buttering bread)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>


### Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale

#### A. Ability to use Telephone

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Operates Telephone on own initiative – looks up and dials numbers, etc.</td>
<td>1</td>
</tr>
<tr>
<td>2. Dials a few well-known numbers</td>
<td>1</td>
</tr>
<tr>
<td>3. Answers telephone but does not dial</td>
<td>1</td>
</tr>
<tr>
<td>4. Does not use the telephone at all</td>
<td>0</td>
</tr>
</tbody>
</table>

#### E. Laundry

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does personal laundry completely</td>
<td>1</td>
</tr>
<tr>
<td>2. Launders small items – rinses stockings, etc.</td>
<td>1</td>
</tr>
<tr>
<td>3. All laundry must be done by others</td>
<td>0</td>
</tr>
</tbody>
</table>

#### B. Shopping

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Takes care of all shopping needs independently</td>
<td>1</td>
</tr>
<tr>
<td>2. Shops independently for small purchases</td>
<td>0</td>
</tr>
<tr>
<td>3. Needs to be accompanied on any shopping trip</td>
<td>0</td>
</tr>
<tr>
<td>4. Completely unable to shop</td>
<td>0</td>
</tr>
</tbody>
</table>

#### F. Mode of Transportation

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Travels independently on public transportation or drives own car</td>
<td>1</td>
</tr>
<tr>
<td>2. Arranges own travel via taxi, but does not otherwise use public transportation</td>
<td>1</td>
</tr>
<tr>
<td>3. Travels on public transportation when accompanied by another</td>
<td>1</td>
</tr>
<tr>
<td>4. Travel limited to taxi or automobile with assistance of another</td>
<td>0</td>
</tr>
<tr>
<td>5. Does not travel at all</td>
<td>0</td>
</tr>
</tbody>
</table>

#### C. Food Preparation

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plans, prepares and serves adequate meals independently</td>
<td>1</td>
</tr>
<tr>
<td>2. Prepares adequate meals if supplied with ingredients</td>
<td>0</td>
</tr>
<tr>
<td>3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet</td>
<td>0</td>
</tr>
<tr>
<td>4. Needs to have meals prepared and served</td>
<td>0</td>
</tr>
</tbody>
</table>

#### G. Responsibility for Own Medications

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is responsible for taking medication in correct dosages at correct time</td>
<td>1</td>
</tr>
<tr>
<td>2. Takes responsibility if medication is prepared in advance in separate dosage</td>
<td>0</td>
</tr>
<tr>
<td>3. Is not capable of dispensing own medication</td>
<td>0</td>
</tr>
</tbody>
</table>

#### D. Housekeeping

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintains house alone or with occasional assistance (e.g. “heavy work domestic help”)</td>
<td>1</td>
</tr>
<tr>
<td>2. Performs light daily tasks such as dish washing, bed making</td>
<td>1</td>
</tr>
<tr>
<td>3. Performs light daily tasks but cannot maintain acceptable level of cleanliness</td>
<td>1</td>
</tr>
<tr>
<td>4. Needs help with all home maintenance tasks</td>
<td>1</td>
</tr>
<tr>
<td>5. Does not participate in any housekeeping tasks</td>
<td>0</td>
</tr>
</tbody>
</table>

#### H. Ability to Handle Finances

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank)</td>
<td>1</td>
</tr>
<tr>
<td>2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.</td>
<td>1</td>
</tr>
<tr>
<td>3. Incapable of handling money</td>
<td>0</td>
</tr>
</tbody>
</table>

11. According to the scoring scale provided, how did the resident perform on the Activities of Daily Living (ADL) functional assessment?

**Scoring the Katz Basic Activities of Daily Living (ADL) Scale:**

1. Residents are scored yes/no for independence in 6 functions.
   - Score of 6 “yes” answers = full function
   - Score of 4 “yes” answers = moderate impairment
   - Score of 2 or less “yes” answers = severe functional impairment
2. Independence in ADLs increases as the score approaches 6 “yes” answers.

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fully functional</td>
<td></td>
</tr>
<tr>
<td>☐ Moderately impaired</td>
<td></td>
</tr>
<tr>
<td>☐ Severely impaired</td>
<td></td>
</tr>
</tbody>
</table>

12. According to the scoring scales provided, how did the resident perform on the Instrumental Activities of Daily Living (IADL) functional assessment?

**Scoring the Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale:**

1. Residents are scored in 8 domains of function.
2. Points are totaled in sections A-H; the score may range from 0-8.
3. The higher the score, the greater the person’s abilities.
   - Score of 8 = high function / fully independent
   - Score of 6 = moderately high function / independent
   - Score of 4 = moderately low function / dependent
   - Score of 2 or less = very low function / fully dependent

<table>
<thead>
<tr>
<th>IADL Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fully independent / high function</td>
<td></td>
</tr>
<tr>
<td>☐ Independent / moderately high function</td>
<td></td>
</tr>
<tr>
<td>☐ Dependent / moderately low function</td>
<td></td>
</tr>
<tr>
<td>☐ Fully dependent / Very low function</td>
<td></td>
</tr>
</tbody>
</table>

13. Does the resident use adaptive equipment, i.e., cane, walker, wheelchair? If yes, describe:
14. What did you observe regarding the condition and safety of the resident's home?

- Yes  No  Lighting adequately bright, easy-to-reach switches, night lights
- Yes  No  Flooring in good repair, carpet tacked down, surfaces not slick or slippery, no rugs or mats
- Yes  No  Hallways and exits free of clutter
- Yes  No  Stairways and steps in good repair, handrails present
- Yes  No  Drawers and cupboards closed
- Yes  No  Cords and personal items removed from floors
- Yes  No  Refrigerator clean / Food fresh

Describe areas of concern:

15. Have any other measures been taken to safeguard the home, i.e., raised toilet seats, shower grab bars, non-skid mats, etc.

16. What did you observe regarding the resident’s general home maintenance, i.e., lawn mowed, snow removed, gutters cleaned, etc.?

17. Does the resident have any of the following risk factors for falling?

- Yes  No  History of falls
- Yes  No  Uses assistive device (cane, walker)
- Yes  No  Visual or hearing deficit
- Yes  No  Needs assistance with daily activities (ADLs)
- Yes  No  Multiple medications (4 or more)
- Yes  No  Cognitive deficit (Alzheimer’s disease, vascular dementia, etc.)
- Yes  No  Home safety issues
18. Does the resident speak English? □ Yes □ No
   
   a. What is the resident’s native language? ____________ Country of birth? ____________

   b. Does the resident require translation services? □ Yes □ No

19. Does the resident have culturally sensitive health and/or illness beliefs and practices regarding health or social services? For example, does the resident engage in different types of healing practices, i.e., hot tea and lemon for cold, copper bracelet for arthritis, magnets, etc.?

20. How important are spirituality and religious beliefs for the resident?

   □ Do the resident’s spiritual or religious beliefs influence how he/she takes care of him/herself?

   □ How does the resident want to address his/her spiritual or religious beliefs regarding service referral?

   Describe:

21. Primary Care Doctor:

<table>
<thead>
<tr>
<th>Doctor’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company:</td>
</tr>
<tr>
<td>Address 1:</td>
</tr>
<tr>
<td>Address 2:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

22. Health insurance coverage:

   □ Primary Health Coverage _________________________________
   □ Medicare _________________________________
   □ Medicaid _________________________________
   □ Other _________________________________
23. Does the resident need financial assistance to pay for health care or social services?
   □ Yes □ No

24. Is the resident ready for change (choose one)?
   □ Does not want to change behavior in the foreseeable future (precontemplation)
   □ Is thinking about changing but has not made a commitment to take action yet (contemplation)
   □ Plans on taking action in the next month and/or near future (preparation)
   □ Is currently modifying his/her behavior, experiences, and/or environment to overcome problems (action)
   □ Is working to prevent relapse and maintain improved status (maintenance)

25. Current Situation / Service Plan:
   a. Immediate needs:
   
   b. Future needs:
   
   c. Follow-Up Timeframe:
      □ Weekly: _____/_____/_____
      □ Bi-weekly: _____/_____/_____
      □ Monthly: _____/_____/_____
      □ Bi-Monthly: _____/_____/_____
      □ Quarterly: _____/_____/_____
      □ Bi-Yearly: _____/_____/_____
      □ Yearly: _____/_____/_____
      □ Other: _____/_____/_____