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	1. File Number: APD # 18-01-05	**2. Disposition:** Note well and file for reference
	3. Issuance Date: May 2, 2017	**4. Effective Date:** May 2, 2018
	5. Program Area: AAA Administration	
6. Origin: Aging and Disability Resources Office	**7. Contact:** Aging and Disability Resources Office 717-783-4502	

AGING PROGRAM DIRECTIVE

SUBJECT: **Pennsylvania Link to Aging and Disability Resources**

TO: AREA AGENCIES ON AGING
EXECUTIVE STAFF
PENNSYLVANIA COUNCIL ON AGING
ADMINISTRATION ON AGING
COMPTROLLER
PENNSYLVANIA ASSOCIATION OF AREA AGENCIES ON AGING

FROM: 
Teresa Osborne
Secretary
Pennsylvania Department of Aging

PURPOSE:
The purpose of this document is to outline the process and guidance for the Pennsylvania Link to Aging and Disability Resources Program, known as PA Link.

BACKGROUND:
During fiscal year 2014-2015 the PA Link reorganized the local program structure from 52 Links to 15 Service Areas. This local regionalization process helped to reduce fragmentation and increase programmatic consistency across the Commonwealth.

GENERAL REQUIREMENTS:

The 15 regionalized PA Link Service Areas are structured as follows:

Service Area 1: Erie, *Crawford, Forest/Warren, Clarion, Venango
Service Area 2: Lawrence, Mercer, *Butler
Service Area 3: Allegheny, Beaver, *Fayette/Greene/Washington
Service Area 4: Cameron/Elk/McKean, *Clearfield, Jefferson, Potter
Service Area 5: Armstrong, Indiana, *Westmoreland
Service Area 6: Blair, Cambria, *Somerset, Huntington/Bedford/Fulton
Service Area 7: *Bradford, Sullivan, Susquehanna, and Tioga
Service Area 8: Centre, Clinton/Lycoming, Columbia/Montour, Northumberland, *Union/Snyder, Schuylkill
Service Area 9: Mifflin/Juniata, Franklin, Adams, *Cumberland, Perry, Dauphin, York
Service Area 10: Pike, Monroe, *Wayne
Service Area 11: Luzerne/Wyoming, Lackawanna, *Carbon
Service Area 12: *Lehigh, Northampton
Service Area 13: Berks, *Lancaster, Lebanon
Service Area 14: Bucks, Chester, *Montgomery and Delaware
Service Area 15: *Philadelphia
**AAA Recipient of PA Link funding for Service Area*

Specific Program Recommendations

1. **Each Service Area may designate a Lead Coordinator to work within the job description to meet program requirements.** See Program Guidelines for Coordinator Job Description and Program Requirements.
2. **Each Service Area may form an Oversight Committee to oversee and manage the program budget and program requirements. It is recommended the composition of the Oversight Committee include representation from:**
    a. All Area Agencies on Aging in Service Area
    b. At least one Under 60 Disability Services Provider Agency such as a Center for Independent Living, United Cerebral Palsy organization, etc.
    c. At least one administrative entity for each of the following - Intellectual Disabilities/Developmental Disabilities, Behavioral Health, and Substance Use
    d. Veteran services representation
    e. Consumer representation
    f. Any other agencies committed to full participation whom the Managing Partner Agencies agree upon.
        i. Examples of appropriate agencies would include: County Assistance Office, Community Action Agency, United Way/211, Housing Agency, Transportation Agency
3. **It is suggested the Oversight Committee adopt written guidelines and sign the Acknowledgement of Managing Partner Agency Guidelines for managing the Service Area.** Reference Program Guidelines document for template.
4. **Oversight Committee should meet quarterly, at a minimum, with meetings held in an accessible location with teleconference or videoconferencing capability.**
5. **Quarterly meeting agenda should include at a minimum:**

a. Review of previous quarter spending and program activities;
b. Discussion of current and upcoming program activities and anticipated spending;
c. Review and discussion of surveys/evaluations and other quality control items

6. **Oversight Committee should serve as, or designate, a Quality Control/Review Board.**
7. **Each service area, through its managing partner agencies and overall partner network should work together to accomplish a core set of activities, goals and objectives that collectively meet program compliance for a fully functioning Aging and Disability Resource Center (ADRC) program within a No Wrong Door Structure. The following serve as that core set of activities:**
   a. **Person-Centered Counseling**
      i. Reference Person-Centered Counseling APD
   b. **Person-Centered Transition Support**

      Person-Centered Transition Support activities address issues often experienced by individuals moving between life stages or settings.
      i. Each service area, during the first half of the fiscal year, will assess and report on any current efforts regarding the following types of transitions:
         - Care Transitions
         - Nursing Home Transitions
         - Transition-Age Youth Transitions
         - Veterans Transitions
         - Justice System involved Transitions

      ii. Reference Program Guidelines for report templates, descriptions of transition categories, and ideas on how they can be addressed/supported.
   c. **Partnership Development**

      Maintaining and strengthening relationships with and between current partners, building relationships with organizations where major transitions occur across settings and life stages, and fostering partnerships with key referral sources and other stakeholders to broaden the type, and increase the number, of organizations actively engaged in the PA Link network.
      i. Plan and implement activities that address partnership development. Reference Program Guidelines for ideas and best practices.
      ii. Maintain an up-to-date list of partners participating in their service area and supply to Regional Coordinator on a quarterly basis.
   d. **Training**

      Education provided to professionals and agency staff that promotes resource and knowledge development, enhances skill sets, and increases the ability of professionals to provide individuals, families and caregivers with the information and services they seek through a quality service experience.
      iii. The goal is to facilitate a minimum of **six (6)** separate training topics per program year. Reference Program Guide for a list of training topics.
      iv. Training locations should be accessible.
      v. Each training will use the standardized sign-in sheet and training evaluation.
   e. **Community Outreach and Education**

      Information and education provided to the general public, including consumers, family members and caregivers that informs them of available resources, how to access those resources, and how to connect to long term services and supports. These efforts also address topics important to individuals, families and caregivers. Community outreach and education activities are meant to be mobile (*meet people where they are at*) and should include a focus on "hard-to-reach' or underserved populations.
      i. The goal is to facilitate at least **one (1)** effort in each county of the service area.

Budget Guidance

Allocations cover Coordinator expenses and expenses related to fulfilling program goals and objectives.

In addition to covering the program requirements specified above, program funds may also be used to identify and/or support efforts that address community needs and/or gaps in service (formerly the Special Projects category). Efforts must be approved by the Regional Coordinator prior to implementation. Additional funds may be requested, but are not guaranteed, for these efforts.

Up to 10% of actual expended budget may be used to cover administrative costs. Fiscal Management is a subset of administrative costs.

pennsylvania
DEPARTMENT OF AGING

PENNSYLVANIA
Link™
TO AGING AND DISABILITY RESOURCES

PROGRAM GUIDELINES

May 2, 2018

The information within this document is intended for the purpose of providing guidelines. These guidelines are not to be used to take the place of or contradict any applicable state or Federal laws or statutes. An Oversight Committee may implement alternative measures consistent with the Older Americans Act for the purpose of managing their Service Area's PA Link to an Aging and Disabilities Resources Center.

Overview of the PA Link to Aging and Disability Resources

A. ADRC Initiative

"The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the U.S. Administration on Community Living (including AoA as of April 2012) and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points of entry into the long term supports and services system for older adults and people with disabilities. In a networked or virtual system such as the Pennsylvania Link, any Partner Agency can serve as that single point of entry thus creating a No Wrong Door System as defined by ACL.

"The goal is to have Aging and Disability Resource Centers in every community, serving as highly visible and trusted places where people of all incomes and ages can turn for information on the full range of long term support options and a single point of entry for access to public long term support programs and benefits."
Source: Federal ADRC website (http://www.adrc-tae.acl.gov).

The core components and criteria of a fully functional ADRC include:

- Information, Referral and Awareness
- Person Centered Counseling, formerly known as Options Counseling
- Streamlined Eligibility Determination for Public Programs
- Person Centered Transition Support
- Consumer Populations, Partnerships, and Stakeholder Involvement
- Quality Assurance and Continuous Improvement.

The ADRC Fully Functional Criteria can be found in Appendix 1. A copy of the federal No Wrong Door schematic can be found in Appendix 2. A copy of the No Wrong Door National Key Elements can be obtained from the Regional Coordinator.

B. PA Link to Aging and Disability Resources

In Pennsylvania, ADRC is known as the Pennsylvania Link to Aging and Disability Resources, commonly referred to as the PA Link. It is designed to be a cross-age, cross-system network of partner agencies that collaborate to serve individuals who need long term services and supports. The coordinated network of partners allows an individual to initiate contact with any PA Link partner and access needed information, assistance, resources, or next step in the process. The No Wrong Door approach attempts to minimize duplication of efforts by both individuals and providers, thereby streamlining access, reducing confusion, preserving resources, and creating a safety net for the most vulnerable. PA Link partners assist the following populations, regardless of income: adults age 60+, individuals of any age living with any type of disability, Veterans, persons living with behavioral health or substance use disorder issues, and the caregivers and family members of these populations.

C. PA Link Mission Statement:

The mission of the PA Link to Aging and Disability Resources is to improve access to long term services and supports for individuals, their loved ones and caregivers, regardless of age, income, or ability, through an integrated network of partner agencies committed to expanding the use of

community based solutions, promoting person centered decision making, and enhancing the quality of services.

Program Structure

The PA Link to Aging and Disability Resources is a statewide program consisting of fifteen Service Area s that collectively encompass all sixty-seven counties in PA. Those fifteen Service Area s are divided into four regions. Maps of the regions and Service Area s can be found in Appendix 3. Each PA Link Service Area should convene an Oversight Committee, designate a Lead Coordinator, and establish, maintain and grow the partner network.

A. Program Office

- The function of the Program Office is to develop and implement policies, procedures, standards, and guidelines to ensure effective operation of state and federal compliance of the ADRC Program (PA Link).
- The Program Office consists of a State Program Director, a State Program Manager, a Project Manager, and four Regional Coordinators. See Appendix 4 for a listing of State Program Office staff and contact information.

B. Oversight Committee

- The purpose of the Oversight Committee is to plan, implement, review, and improve upon activities and functions of the PA Link to Aging and Disability Resources within their corresponding Service Area. The Oversight Committee should continually strive to attain fully-functioning status as an ADRC. It should provide guidance on how to enhance the provision of long term services and supports.
- The Oversight Committee(s) should complete written guidelines for local service operation(s), sign the Acknowledgement of Managing Partner Guidelines, and submit to the Program Office. See Appendix 10 for guidance on written guidelines, and the Acknowledgement of Managing Partner Guidelines.
- The Oversight Committee shall reflect composition required by the current Aging Program Directive (see list below). Each agency represented on the Oversight Committee should be called a Managing Partner. Each Managing Partner should designate a primary representative. This primary representative should participate in required meetings. If this primary representative changes, the Managing Partner should inform the Oversight Committee and Lead Coordinator of the change.
- The Oversight Committee shall include representation from:
    - Area Agency on Aging
    - Center for Independent Living or other disability provider
    - Intellectual/Developmental Disability (I/DD) agency
    - Behavioral Health (BH) agency
    - Substance Use Disorder (SA) agency
    - Veterans Services representative or a Veteran who can represent Veterans' interests
    - Person who is 60+ years of age and/or a person under 60 living with a disability
    - Agencies committed to full participation approved by the Oversight Committee members. Examples of appropriate agencies might include, but are not limited

to: APPRISE, County Assistance Office (CAO), Community Action Agency, United Way/211 Agency, Housing Agency, and Transportation Agency.

- Oversight Committee should meet not less than quarterly, for a minimum of (4) four meetings per fiscal year (FY).
- Oversight Committee meetings should be held in an accessible location that has telephone conference and/or video conferencing capability.
- Oversight Committee meetings should be scheduled in advance for the program year by the Lead Coordinator with the involvement of the Regional Coordinator. Lead Coordinator should be present during Oversight Committee meetings. Meeting dates should be communicated to the Program Office with the budget proposal each fiscal year.
- Budget Proposal must be submitted to the Program Office by the end of the current fiscal year for the upcoming fiscal year.
- Oversight Committee should serve as, or designate, a Quality Control/Review Board. (See section on Quality Assurance and Continuous Improvement).
- Oversight Committee should authorize approval of all PA Link activities and expenditures according to the guidelines it develops and in conjunction with all federal and state guidelines.
- Oversight Committee meeting agenda should include at a minimum:
  - Review of previous quarter activities and expenditures
  - Overview of current and upcoming activities and anticipated spending
  - Review of training evaluations and/or Person Centered Counseling participant surveys from previous quarter
- Lead Coordinator should provide a summary of the meeting and distribute to the Oversight Committee, the Regional Coordinator, and maintain in a file.
- Oversight Committee may choose to form subcommittees to track and report on the various aspects of PA Link. Subcommittees could be comprised of various Managing Partners, other PA Link partner representatives, individuals who receive services, caregivers and/or other stakeholders.

C. Lead Coordinator

- One Lead Coordinator shall be designated per Service Area. A current list of Lead Coordinators and their contact information can be obtained from the Regional Coordinator.
- Lead Coordinator should work within their position duties to ensure the success of the PA Link within the respective Service Area. See Appendix 5 for Lead Coordinator Duties.
- Lead Coordinator duties may be revised to meet the specific needs of the Service Area, as approved by the Oversight Committee.
- The Oversight Committee should determine whether additional coordinator assistance is needed to ensure the success of PA Link throughout the entire Service Area. If additional coordinator assistance is required, the names, agencies, and contact information for any additional coordinators should be submitted to the Regional Coordinator.
- Coordinator hours may be reimbursed out of PA Link funds based on guidelines agreed upon by the Oversight Committee.
- Reporting Timeframes are available in Appendix 11.

D. Partner Network

- The Partner Network consists of Managing Partners, and all other entities, whether public or private, who have a vested interest in the welfare, independence and personal choice of the target populations.
- Partners may represent traditional human service and healthcare entities, as well as nontraditional groups, such as faith-based, non-profit and civic groups. Examples of potential partners can be found in Appendix 6.
- The Partner Network collaborates to fulfill the mission of the PA Link to Aging and Disability Resources and fulfill the requirements of a fully functional ADRC.
- Partner Agencies:
    - Serve as a No Wrong Door agency to ensure that individuals, families and caregivers receive a consistent consumer experience through a person centered approach to get what they need, or at least the next step in planning.
    - Participate and assist in trainings and outreach activities in an effort to inform and educate the public about the PA Link network.
    - Maintain the confidentiality of sensitive consumer information, agree that such information should not be disclosed without proper authorization, and abide by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) regarding protected health information.

E. Allocation

- Each PA Link Service Area will receive an allocation outlined by the state level fiscal department.
- An Area Agency on Aging within each Service Area receives the ADRC funds. The Oversight Committee can determine if the AAA acts as Fiscal Manager or sends the funds to another agency to serve as Fiscal Manager.
- PA Link funds must be used in accordance with program guidelines.
- The Fiscal Manager provides reporting to the Oversight Committee and Program Office of how program dollars are spent at each Oversight Committee meeting and upon request.
- The fiscal management agency can be paid for their services. The ADRC APD sets guidelines for fiscal management fees.
- The Regional Coordinator may coordinate requests to change the Fiscal Manager.

Program Requirements

A. Information, Referral and Assistance (I+R/A)

The I+R/A function provides a point of contact to initiate inquiries about long term living supports and services. Depending on the specific requests and needs of each individual, this phase of service may involve only a brief contact for the provision of information and materials, or this phase may identify the need for more extensive assistance to the participant, such as Person Centered Counseling. The purpose of I+R/A is to provide No Wrong Door access, ensuring that linkages to appropriate community services and programs are provided with minimal confusion.

- Agencies should follow their own internal policies and procedures regarding I+R/A.
- Agencies should provide I+R/A without bias to any program, service or agency.

- I+R/A services should be provided to anyone regardless of age, income or ability.
- Agencies that utilize SAMS for tracking I+R/A should ensure accurate/timely entry of information.

B. Person Centered Counseling (PCC)

The Pennsylvania Link to Aging and Disability Resources Office designed the Person Centered Counseling program in order to better guide Pennsylvanians on the wide range of public and private resources available to them. The goals of the program include: reducing gaps in service, empowering individuals to take action regarding their long term care, and streamlining eligibility. It was introduced in the state in 2011. Since then, hundreds of individuals across the state have been trained in Person Centered Counseling, and have been able to assist the public in accessing long term services and supports (LTSS).

Who can perform Person Centered Counseling (PCC)?

Organizationally

All Managing Partners are approved to be reimbursed for PCC. Organizations outside of the Oversight Committee may be reimbursed for PCC as long as the local Oversight Committee has approved the organization. Oversight Committees are responsible for developing a uniform approval process for organizations that request approval within their Service Area. Organizations will be required to receive approval from each of the Oversight Committees in each of the Service Areas that they request reimbursement.

Organizations performing PCC should be required to be Medical Assistance Providers.

Individually

Individuals must be employed within an organization that has been approved to provide Person Centered Counseling by that Service Area's Oversight Committee.

Training Program to provide PCC

- PCC classroom training is required in order for a staff member to perform PCC.
- Certification in order to perform the service of PCC is in the process of being developed and will be communicated via an appendix upon finalization of criteria.
- As federal guidelines for PCC evolve, PA Link may need to revise program requirements for PCC.
- There are also online modules available on the Long Term Living Training Institute (LTLTI) website (http://www.ltltrainingpa.org/). Those modules currently include:
    - Telephone Communication Essentials
    - Accessing Financial Support
    - Help with Housing Costs
    - Help with Medical Costs
    - Help with Food Costs
    - Communication Essentials
    - Paying for Long Term Care
    - Legal and consumer Safety Issues
    - Health and Wellness Program
    - Employment, Volunteer and Recreation Opportunities
    - Home and Community Based Services Options
    - Options in Care and Residence

- Intellectual Disabilities/Developmental Disabilities
- Person Centered Counseling Documentation
- Veteran's Services

Oversight Committee's responsibility to ensure PCC coverage

The PA Link to Aging and Disability Resources Office is committed to total, statewide coverage of PCC. An Oversight Committee is responsible for ensuring that the Service Area has the ability to accommodate PCC requests, regardless of age or ability level, within their counties. If Managing Partners do not have the capacity to meet the PCC needs in their Service Area they must enlist an organization(s) who has the capacity to carry out the work. Oversight Committees are also responsible for ensuring that PCC funds are budgeted appropriately to accommodate the need within their Service Area.

The agencies performing PCC will notify Lead Link Coordinator of changes to their PCC staff.

Eligibility requirements to receive PCC are as follows:

The individual must be either a person with a disability and/or an older adult.

PCC focuses on improving the quality of service delivery and access to public and private resources for people with disabilities and older adults. A disability is self-identified by the person in need. Disability can encompass several diverse categories, such as: physical, mental, behavioral, intellectual and/or developmental disability. An older adult is defined as an individual who is 60 years old, or older.

- The individual must be a person with two or more unique LTSS Needs
- The Administration for Community Living, the federal body that oversees ADRC, the Administration on Aging, and the Administration on Disabilities, defines LTSS as: ***Long Term Services and Supports (LTSS)*** *–Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. These are sometimes referred to as Long Term Resources or simply Long Term Supports.*
- Some of the categories that define potential LTSS needs are as follows:
  - Abuse/Neglect
  - Advocacy
  - Assistance Coordinating Care
  - Assistive Technology
  - Bill Pay/ Financial Assistance
  - Communication Needs
  - Community Integration
  - Domestic Violence
  - Food
  - Healthcare
  - Health Literacy
  - Home Repairs
  - Housing
  - Housing Modifications

- Immigration Services
- Language Assistance
- Legal Assistance
- LGBT Services (lesbian, gay, bisexual, transgender)
- Mental Health/ Behavioral Health
- Peer Support
- Personal Care Help
- Relationship Building
- Social Recreation
- Social Security
- Substance Use Disorder Support
- Transitioning from a Hospital
- Transitioning from a Nursing Home
- Transitioning from Secondary Education
- Transitioning, Other
- Transportation
- Veterans' Services
- Vocational Services

Individuals with a Care Manager of Supports Coordinator can still be eligible for PCC. However, there are a few stipulations:

- The individuals should be referred back to their Care Manager or Supports Coordinator (CM/SC) for LTSS assistance.
- The CM/SC cannot be employed with the same organization, or subcontracted with the same organization as the PCCer. The one exception to this stipulation is if the individual is transitioning from OPTIONS or ACT 150 into a waiver. If this is the case, PCC can be performed by someone who is not the CM/SC at the same organization.
- The individual could be referred to the OLTL Participant Helpline at 1-800-757-5042.

Five Core Competencies

Every PCC unit will involve the completion of each of the five Core Competencies. These are defined as follows:

1) *Personal interview*- time spent talking with a person about their specific goals, preferences, and strengths. The individual in need may identify other support persons to be involved in the process, and will dictate the depth of involvement of the persons that they have identified.
2) *Comprehensive overview of resources*- The Person Centered Counselor (PCCer) will review all known public and private resources with the individual in need. Organizations and individuals will develop and maintain mechanisms to ensure that they have knowledge of currently available and appropriate resources that may serve persons in need. PCCers will help individuals build on existing strengths (such as informal supports), refer to private resources and assist individuals with applying for public resources.

3) *Decision support*- PCCers will help individuals develop priorities based on their identified strengths and preferences. During this phase, PCCers will assist the individual in need to determine their short-term and long-term priorities.
4) *Develop action plan*- PCCers will develop an action plan with the individual in need. The action plan will identify what resources will be pursued and what needs they will address. The action plan must be made available to the individual if requested. Most individuals will benefit from receiving an action plan that outlines the contact information for the resource they request. It is important to note that each individual will require a personalized action plan. Some individuals will need more assistance in accessing resources than others. Listening to the individual's strengths, preferences, and values will highlight the most effective method of connecting that person to resources.
5) *Follow-up*- Follow-up will occur based on timelines agreed upon by the individual and the anticipated length of time to address the needs. PCCers will follow up with the individual in need to ensure that:
    - The resources pursued were appropriate.
    - The person's needs were addressed.
    - Both parties (PCCer and individual in need) were able to complete action items.
    - PCCers will attempt to contact the individual at least three times, and document outcome.
    - If the individual's situation has evolved and they are still in need of assistance, PCCers will discuss additional resources.

One unit of PCC will involve all of the steps above at a minimum. Individuals may need more than one follow-up to ensure that they were connected to resources that meet their specific needs. If an individual is pursuing waiver enrollment, they are assumed to have two LTSS and would be eligible for PCC. If one of the areas a PCCer is working with an individual around is waiver enrollment, they should keep the session of PCC open until the person is connected to their LTSS. Person Centered Counseling can be conducted in person, but may be performed via phone, and is dependent upon the preference of the individual.
If the individual undergoes a life-changing event, such as the death of a spouse, or a major hospitalization, another unit of PCC can be performed with the individual based on their new needs.

Involvement of the person
In PCC, it is essential that the individual in need is as involved as possible from the earliest point possible. PCC is carried out in a way where the individual in need is the central character throughout the entire process. While they may identify support persons, PCC cannot be conducted without consent of the individual in need to work with those persons, and in the capacity identified by the person in need. PCC can be conducted for a caregiver who is also an older adult, or a person with a disability. These individuals often have their own LTSS needs related to the demands of caregiving.

The documentation process
PCC units will be captured via the Person Centered Counseling Assessment in SAMS and Mobile Assessments within the Harmony/Mediware database. Gaining access to Harmony/Mediware and Mobile Assessments is achieved through the completion of forms and

tutorials. The Regional Coordinator will provide instructions on the process of gaining access. Should someone no longer need access to Harmony/Mediware, they should email their Regional Coordinator so that their license can be utilized by someone else.
Documentation instructions will be available via recorded webinars on the LTLTI online learning management system. The documentation should be entered during the PCC process, and no later than the end of the month following the date that the unit was completed. The data entered will be used in order to approve units, perform quality assurance, process reimbursement, and measure the effectiveness of the work.
Service Deliveries will also need to be submitted within the same timeframe; the end of the month following the completion date. For example, if a session was completed on July 20th, the Assessment and Service Delivery will be due no later than the last Friday of August. There is a recorded webinar on LTLTI's website that reviews the process of entering Service Deliveries. There is an attached Tips for Documenting that can be used for guidance in filling out the Person-Centered Counseling Assessment and FAQs for Service Deliveries attached. There is also a recorded webinar on LTLTI's website that reviews the process for entering in the PCC Assessment.

The approval process
Quality assurance reports are generated monthly. The reports are reviewed by the ADRO staff in order to determine whether or not the work sufficiently qualified as PCC. Some of the measures that will be assessed are:

- Was the PCCer approved for PCC?
- Was the individual in need the central figure throughout the entire process?
- Was the individual a person with a disability or an older adult?
- Were there at least two unique LTSS needs?
- Were the Core Competencies carried out in a way that incorporated the individual's strengths, preferences, and values?
- Was follow-up completed as outlined?

The reimbursement process
Refer to current APD for guidelines in Person Centered Counseling documentation and reimbursement. Currently, units of PCC are vetted through the ADRO office through the criteria listed above. Approval is given directly to the organizations doing the work and the Fiscal Manager of the Service Area . This is done on a monthly basis, and the funds are given to the Fiscal Manager annually. Oversight Committees are responsible for ensuring that they have enough funds budgeted annually to accommodate the PCC in their Service Area . It is recommended that this is reviewed quarterly. If there is more work being done than what was allocated within the budget, it is important to communicate this with the Program Office the first quarter that an annual overage is expected. Mileage related to Person Centered Counseling is reimbursable through program funding. Reimbursement rates are decided by the PA Link Service Area, not to exceed the current federal reimbursement rate.

C. Benefits Counseling
Benefits counseling is an important way for the public to gain awareness and understanding of what benefits are available to them. It may help individuals obtain the services and supports to remain as independent as possible in the setting of their choice. Benefits counseling is a key

component to streamlining access to public programs and helping people understand private pay options. Benefits Counseling may be part of a PCC session.

Benefits include, but are not limited to:

- Private pay
- Medicaid (MA)
- Older Americans Act- AAA, Senior Center
- Medicare
- Low Income Subsidy (LIS) and Medicare Savings Program (MSP)
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary cash assistance for needy families (TANF)
- Social Security Income (SSI)
- Social Security Disability Income (SSDI)
- Low income home energy assistance program (LIHEAP)
- Veterans Benefits
- Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE / PACENET)

D. Application Assistance

Application Assistance is important in helping individual's access public programs and private pay resources as effectively as possible. Applications can be overwhelming, and organizing the vast array of paperwork and documents required when submitting an application can be daunting. Application Assistance may be part of a PCC session.

- The various steps involved in Application Assistance may include:
    - Understanding the various sections of the application
    - Completing/preparing the application in full
    - Organizing documents required for submission with the application
    - Successfully submitting the application
    - Following-up on the status of the application's approval
- When appropriate, PCC may be utilized for identifying supports/services while awaiting an application's approval or when an application is denied.
- Applications may include but are not limited to: MA, SSI, SSDI, SNAP, LIHEAP, MSP, LIS, Housing and Transportation.
- Partners may be asked to provide information regarding Application Assistance being performed in their agency.

E. Person Centered Transition Support

Person Centered Transition Support activities address issues often experienced by individuals moving between life stages or settings. The goal is for persons to move between settings or systems as successfully as possible and in accordance with their preferences, needs and values. Individuals in any type of transition are more likely to need support, direction, or Person Centered Counseling to minimize confusion and frustration.

Person Centered Transition Support activities within the PA Link can augment and complement an existing program, or create and foster a new transition program altogether. Examples include:

- Transition age youth with disabilities- school to work/college transition/independent living
- Veterans Reintegration - military service to civilian life transition
- Transitions between systems/settings related to aging, disabilities, substance use disorder or behavioral health
- Housing transitions
- Care Transitions
- Nursing Home Transitions (NHT)
- Employment transitions
- Reentry-individuals moving between the justice system and community

- Service Area s should have an understanding of the various efforts already happening in their respective counties that address the types of transitions noted above.
- Ideas for Person Centered Transition Support may include:
  - Creating a conference
  - Hosting focus groups
  - Supporting outreach activities
  - Creating a resource guide
  - Focusing on assistance with application completion

F. Partner Development

Partner Development involves maintaining and strengthening relationships with and between current partners, and fostering new partnerships with key referral sources and other stakeholders. These activities broaden the type and increase the number of partners actively engaged in the partner network.

The goals of partner development include:

- Growing the partner network
- Educating partners
- Keeping partners engaged
- Supporting county Aging/ID Teams
- Supporting Community Resource Teams
- Identifying gaps in services – special project initiatives

1. Growing the Partner Network
   - This involves outreach to stakeholder groups, as well as organizations where major transitions occur across settings life stages and systems.
   - Atypical agencies, professionals or groups may also be invited to join the partner network. Examples include:
     - Faith based organizations
     - Civic Groups such as Lions, Chambers of Commerce, Rotary, etc.
     - Local Charitable Foundations
     - Banks, Financial Planners, Legal agencies
     - Legislators or key community figures such as Commissioners/Mayors

- First Responder Groups/Organizations
- Other area businesses that serve the target populations

- Partner growth is a function of the entire partner network, not just the responsibility of the Lead Coordinator.
- Partner resource management is of key importance. A list of partners and other resources in the area should be maintained by the Lead Link Coordinator, and routinely shared with the Regional Coordinator, Oversight Committee, and partner network, especially Person Centered Counselors.

2. Educating Partners
   Please reference the section on "Training".

3. Keeping Partners Engaged
   Best Practices include:
   - Offer opportunities for networking or collaborate with other pre-existing networking groups.
   - Keep partner network informed of Oversight Committee decisions and areas of focus.
   - Provide opportunities for partners to give input on planning and implementation of PA Link activities, perhaps as members of subcommittees.
   - Keep partners informed of Special Project status and how they can be involved.
   - Send out emails containing information that may interest partners such as newsletters, press releases, training opportunities, etc.
   - Hold local partner meetings as applicable. Best practices for these meetings include:
     - Combine with meetings already being held by other collaborative groups such as Inter-Agency Councils or Human Service Councils
     - Hold meetings in conjunction with required Trainings
     - Use a sign-in sheet to track attendance
     - Create and disseminate a summary of the meeting

4. Supporting Aging/Intellectual Disability (ID) County Team(s):
   Aging/ID County Teams are comprised of representatives from the Area Agencies on Aging, the administrative entities for ID, and other community partners. The teams strive to effectively utilize the resources available to both systems, develop effective intervention strategies for older adults with ID, and encourage the development of integrated community services.

   Best practices for collaborating with an existing County Team:
   - Co-host a training on ID/Aging.
   - Look for opportunities to educate providers and/or the public on issues related to aging with ID or issues facing aging family members who care for a loved one living with ID.
   - Create a seamless referral process for clients identified during the County Team case review process who might benefit from Person Centered Counseling.
   - Incorporate the members of the County Team into the PA Link Partner Network if not already involved

G. Training

Education provided to professionals and agency staff that: promotes resource and knowledge development; enhances skill sets; and increases the ability of professionals to provide individuals, families and caregivers with information and services through a quality service experience.

- Training Requirements:
  - Complete the minimum number of trainings as referenced in current APD.
  - Any mandatory training topics will be noted in the current APD.
  - The current APD will reference the number of trainings that must be selected from the list of topics provided below.
  - Hold trainings in a physically accessible location.
  - Use the designated sign in sheet at each training. A sample can be found in Appendix 7 and the most current version should be obtained from the Regional Coordinator.
  - Use the Training Evaluation at each training. A sample can be found in Appendix 8 and the most current version should be obtained from the Regional Coordinator.

- Training Best Practices:
  - Invite agencies that are not yet PA Link partners as a way to recruit them.
  - Open trainings up to the public or specific groups when appropriate.
  - Offer trainings in an area where all partners have the opportunity to attend. This may require replicating training throughout the Service Area .
  - Consider trainings that should address components of various PA State Plans. Examples include: PA State Plan on Aging, PA State Plan for Alzheimer's Disease and Related Disorders, PA State Plan for Independent Living.
  - Consider offering a Certificate of Attendance or Continuing Education Credits (CEU) when able to do so.

- For a comprehensive list of training ideas see Appendix 13.

H. Community Outreach and Education

Community Outreach and Education is defined as information and education provided to the general public. This includes individuals, family members and caregivers informing them of available resources, how to access those resources, and how to connect to long term services and supports. Community outreach and education activities are meant to be mobile (meet people where they are) and should include a focus on hard to reach populations. Examples of hard to reach populations include- minorities, persons living in rural areas, LGBT, persons with visual and hearing impairments, and persons with limited English speaking proficiency.

Community Outreach and Education activities include, but are not limited to:

- Partner newsletters
- Attendance at health fairs or expos
- Programming at senior centers or drop-in centers

- Advertising via various media outlets
- Public education sessions on topics important to individuals or caregivers Examples include, but are not limited to:
  - Caregiver stress and caregiver support
  - How to access services
  - Living wills, trusts, Power of Attorney, etc.

- Advertising must be approved by the Regional Coordinator prior to publication/airing and must include approved logo(s) provided by Regional Coordinator.
- Required Community Outreach and Education elements should be identified in the current APD.

I. Special Projects

Special Projects address a community-based need, and involve collaboration between multiple partners. The goal of a special project is to increase access to home and community based services. Projects are measureable and sustainable. Ensure that all parties involved have a clear understanding of what measures should be tracked and reported, and agree on a method for collecting and reporting those measures prior to the start of the special project. The special project does not have to impact/benefit/involve all counties within the Service Area. See Appendix 9 for Special Project Proposal.

- Oversight Committee should review and approve concept of special projects.
- Lead Link Coordinator should submit special project on proposal form to Regional Coordinator for approval to implement. Regional Coordinator should approve before implementation or commitments are made.
- Special projects are an allowable ADRC expense, even if not required by APD.
- Best Practices:
  - Partner and pool resources with other programs such as Healthy Steps, Chronic Disease Self-Management, Care Transitions.
  - Consider a special project that focuses on other PA Link program requirements such as Person Centered Transition Support or Benefits Counseling/Application Assistance.
  - Provide seed funding for programs/activities/initiatives.
  - Welcome input from the partner network as to what projects may be most beneficial.
  - Keep the partner network informed of project status and outcomes as well as ways that they and their participants/individuals /patients can be involved.

J. Quality Assurance and Continuous Improvement

Quality Assurance and Continuous Improvement are essential to program development and success. At a local level, the Oversight Committee should serve as or designate a Quality Control/Review Board that should monitor:

- Training outcomes as evidenced by training evaluations. Compile and present results to Oversight Committee and Regional Coordinator.
- Oversight Committee makes quality assurance changes as needed.
- Quarterly Reports on provided form submitted to Regional Coordinator, and Oversight Committee.
- Person Centered Counseling satisfaction results.

At the state level, ADRO will monitor quality assurance utilizing various methods including but not limited to:

- Person Centered Counseling
- PA Link to Community Care website

Appendix 1: ADRC Fully Functional Criteria

Aging & Disability ResourceCenter
An initiative of the U.S. Department of Health and Human Services
TECHNICAL ASSISTANCE EXCHANGE

Core Components and Criteria of a Fully Functional Aging and Disability Resource Center (ADRC) At-A-Glance
Updated March 2012

Information, Referral and Awareness (I&R/A)

- Formal Marketing Plan for All Ages, Income Levels, Disability Types
- Marketing to and Serving Private Paying Populations
- Systematic I&R Processes Provided Across all Operating Organizations
- Follow-Up on I&R Services
- Online Comprehensive Resource Database, Public and Searchable

Options Counseling and Assistance

- Formal Standards and Protocols Guiding Delivery to All Income Levels and Disabilities
- Short-term Support in Crisis/Urgent Situations (Preventing Institutionalization)
- Follow-Up on Options Counseling Services
- Futures Planning for Long Term Service and Support (LTSS) Needs

Streamlined Eligibility Determination for Public Programs

- Coordinated/Integrated Process for Financial and Functional Eligibility
- Standardized Intake and Screening Across all Operating Organizations
- Uniform Criteria to Assess Risk of Institutionalization
- Functional Eligibility Determined On-Site or Through Seamless Referral Process
- Personalized Assistance in Financial Application Completion
- Financial Eligibility Determined On-Site or Through Electronic Exchange
- Applicants Tracked through Determination Process; Follow-up with Ineligible Individuals

Person-Centered Transition Support

- Formal Agreements with Critical Pathway Providers and Protocols for Providing Transitions Support, Referral Processes, and Staff Training
- Local Contact Agency Designation (MDS 3.0 Section Q)

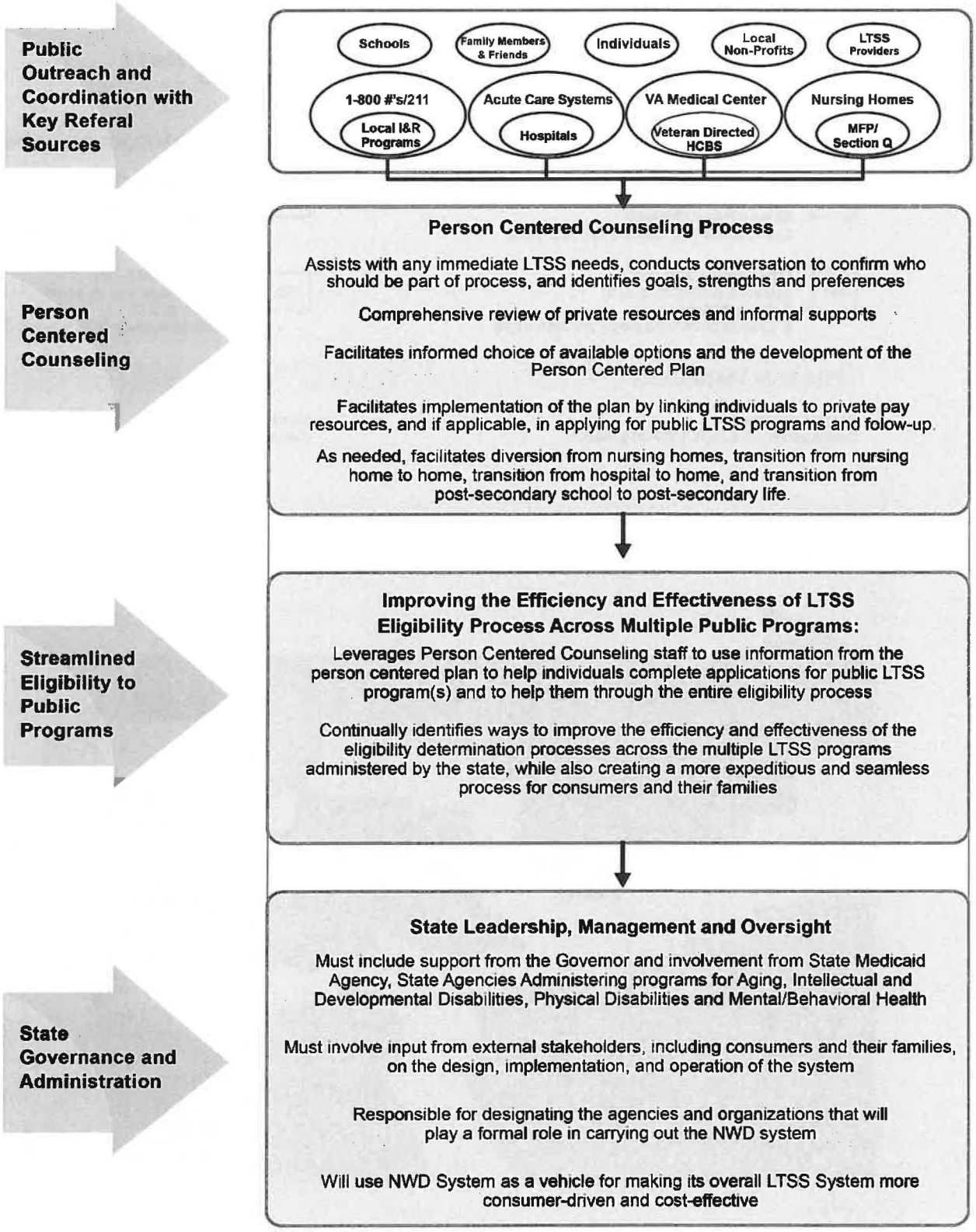
Consumer Populations, Partnerships and Stakeholder Involvement

- Staff with Capacity and Training to Serve All Ages and Disability Types
- Consumer Involvement in Program Design, Operation, and Quality Improvement
- Formal Partnership Agreements, Protocols, or Contracts with:
  - Critical Aging and Disability Organizations
  - Medicaid
  - State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), and 2-1-1
  - Veteran's Administration (VA) Medical Center(s)

Quality Assurance and Continuous Improvement

- Formal Sustainability Plan with Diverse Funding Sources
- Adequate Staffing and Management
- Continuous Quality Improvement Plan and Procedures in Effect
- IT/MIS Supports All Program Functions
- Routine State Level Performance Tracking
- Routine Local Level Performance Tracking

Appendix 2: No Wrong Door Schematic (Source: ACL)



Appendix 3: Map of PA Link Service Area s and Regions

PENNSYLVANIA LINK TO AGING & DISABILITY RESOURCES
SERVICE AREAS AND REGIONAL CONTACTS

PENNSYLVANIA LINK TO AGING & DISABILITY RESOURCES REGIONAL COORDINATORS

NW — NORTHWEST REGION
SERVICE AREAS 1, 4, 7
SAMANTHA COSSMAN
C-SCOSSMAN@PA.GOV | 717-743-4745

NE — NORTHEAST REGION
SERVICE AREAS 8, 10, 11, 12
VALORIE HINKLE
C-VHINKLE@PA.GOV | 717-614-0043

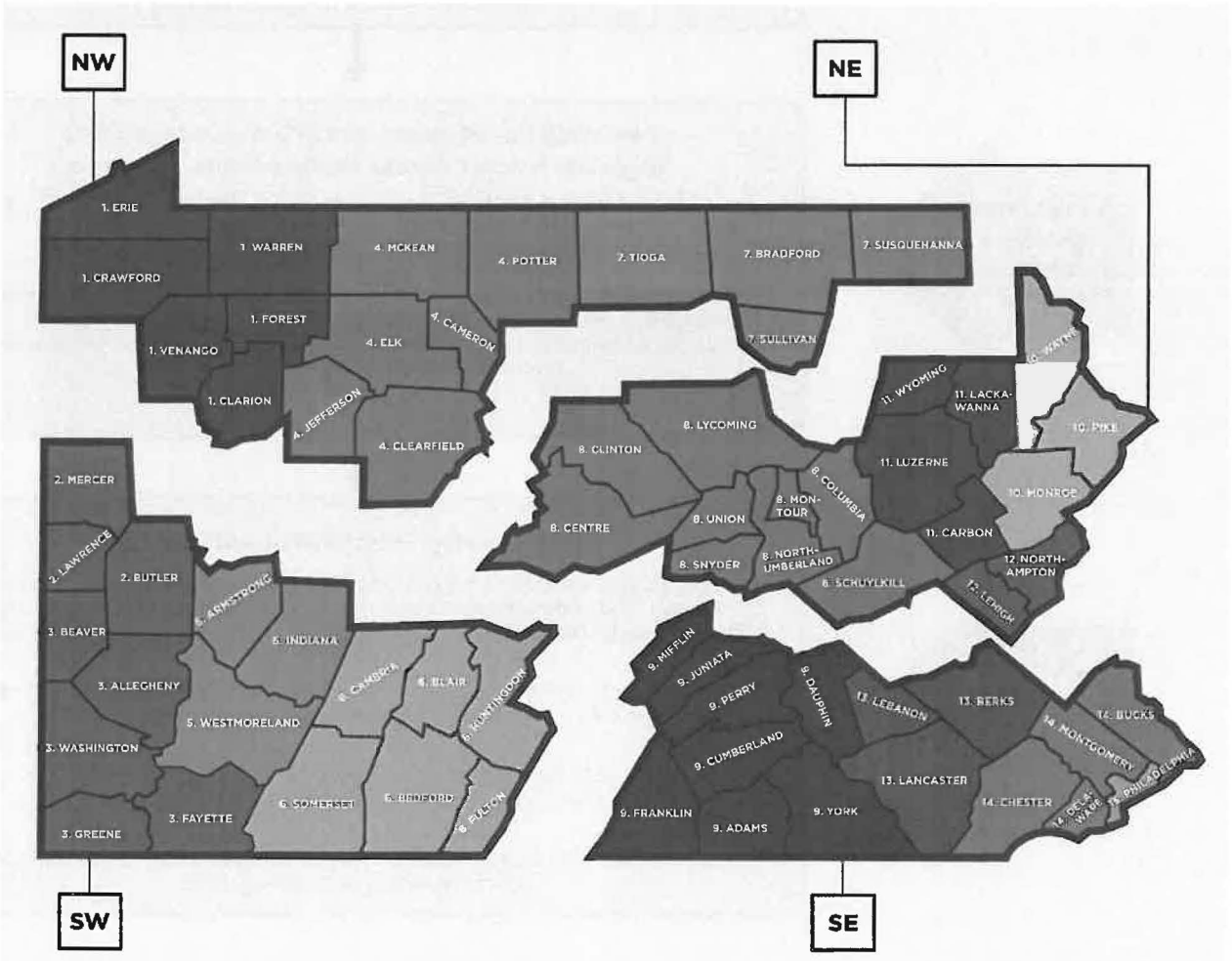
SW — SOUTHWEST REGION
SERVICE AREAS 2, 3, 5, 6
DAWN BROWN
C-DAWBROWN@PA.GOV | 717-480-8055

SE — SOUTHEAST REGION
SERVICE AREAS 9, 13, 14, 15
AMANDA BLACK
C-AMBLACK@PA.GOV | 717-756-0376

PROJECT MANAGERS

FAITH HAEUSSLER
C-FHAEUSSL@PA.GOV | 717-736-9402

PATRICK LALLY
C-PLALLY@PA.GOV | 717-783-4502



Appendix 4:
Program Office Staff Names and Contact Information

State Program Director
Vacant

State Program Manager
Patrick Lally
c-plally@pa.gov
(717) 783-4502

Project Manager
Faith Haeussler
c-fhaeussl@pa.gov
(717) 736-9402

Four Regional Coordinators

Northern Regional Coordinator
Samantha Cossman
c-scossman@pa.gov
(717) 743-4745

Northeast Regional Coordinator
Valorie Hinkle
c-vhinkle@pa.gov
(717) 614-0043

Southeast Regional Coordinator
Amanda Black
c-amblack@pa.gov
(717) 756-0376

Southwest Regional Coordinator
Dawn Brown
c-dawbrown@pa.gov
(717) 480-8055

Appendix 5: Lead Link Coordinator Duties

Service Area : _____
Lead Coordinator Name: _____

The Lead Link Coordinator is to continually work to achieve the mission, goals and objectives of the Pennsylvania Link to Aging and Disability Resources, and has responsibilities to both the Aging and Disabilities Resource Office (ADRO) and the Oversight Committee.

A. Responsibilities to the ADRO: *(Specific duties and general assignments)*

1. Communication:
    a. Maintain open communication and participate in routine follow up with the ADRO. Examples include conference calls, webinars, trainings, meetings with Regional Coordinator.
    b. Submit events to Regional Coordinator for inclusion in PDA Friday Wrap-Up in the approved format and specified time frame
    c. Seek procurement of appropriate approvals from Regional Coordinator in regards to program requirements, included but not limited to: advertising and marketing materials; special projects; budget proposals.

2. Submit reports in approved format according to required time frames:
    a. Quarterly Reports to the Regional Coordinator Due on the 3rd Friday of month after reporting period. (Oct., Jan., April, July)
    b. Updating the Person Centered Counselors list for Service Area.
    c. Updated Partner List for the Service Area with the Quarterly Report
    d. Budget Proposal annually.
    e. Federal reporting as requested.
    f. Other reports as assigned.

B. Responsibilities to the Service Area :

1. Oversight Committee:
    a. Schedule the minimum number of Oversight Committee meetings as set forth by current APD, in collaboration with the Regional Coordinator.
        - All meetings should be held in a location that is physically accessible and has teleconference or videoconference capability.
        - Meeting minutes/summary should be recorded and provided to Oversight Committee members and Regional Coordinator, and maintained in a file for review upon request.
    b. Ensure that there is representation on the Oversight Committee as set forth by current APD.
    c. Submit timesheet or explanation of hours worked, and expenses as applicable.

d. Seek approval for program expenses according to Oversight Committee procedures.

2. Partner Network:

    a. Schedule local partner meetings as applicable.
    b. Continuously work to increase the number of agencies committed to PA Link partnership.
    c. Maintain a partner list in the provided form, which includes a main contact person and their contact information.

3. Fulfill program requirements of current APD using Program Guide as reference:
    a. Trainings
        - Schedule the minimum number of trainings as set forth by current APD.
        - Utilize ADRO approved sign in sheet.
        - Utilize ADRO approved training evaluation.
        - Present summary of training evaluations to Oversight Committee for quality assurance and continuous improvement.
        - Reference Program Guide section on training for other requirements associated with trainings
    b. Community Education and Outreach
        - Implement minimum number of community education and outreach as set forth by current APD.
        - Refer to Program Guide for further detail on Community Education and Outreach.
    c. Lead Link Coordinator should work with supplemental coordinators to fulfill requirements of the APD and Program Guide.

C. Individual Assignments:

Actively educate self on needs of the population served by the PA Link program and / or Service Area.

D. Minimum Education, Training and Experience:

1. Bachelors or Associates degree preferred (Combination of knowledge and experience can be considered in place of degree)
2. 5+ years of experience within Aging, Disability or human service related field.
3. Knowledge of services available in specified Service Area preferred.

Qualifications also include proven written communication experience, word processing and other computer skills, excellence in interpersonal relations, self-starter, confidence in public speaking and proven initiative/creativity along with flexible personality and problem-solving skills.

E. Additional position requirements:

1. Travel required
2. Office and computer equipment skills.
3. Effectively communicate orally and in writing.

4. Ability to organize groups and conduct presentations.
5. Represent the agency in a professional manner.

I understand and accept the duties of the Lead Link Coordinator position

_____ _____

Lead Coordinator's Signature *Date*

_____ _____

Supervisor's Signature (if applicable) *Date*

_____ _____

Regional Coordinator *Date*

OR

Signatures/Dates of Oversight Committee Members:

Appendix 6: Potential PA Link Partner Network

Please use this list for ideas of various agencies, organizations, and groups that could become PA Link Partners. All may not apply in your area.

Aging Services	Senior Housing / Accessible Housing Complexes
Area Agency on Aging	other housing providers
Senior Centers (if not managed under the AAA)	Utility Providers
Meals on Wheels (if not housed within AAA)	**Food and Clothing Related**
APPRISE program (if not housed within AAA)	Soup Kitchens
LIFE program	Food Pantries
other aging service providers	Clothing Closets
Disability Services	other community programs addressing these needs
Center for Independent Living	**Benefits Related**
Disability Service Providers (non-county based)	County Assistance Office (CAO)
Disability Advocacy groups	Social Security Administration
Drop-In Centers	**Information and Referral**
Independent Enrollment Broker	I+R Providers
Service Coordination agencies	PA 2-1-1
ARC	Info Links or Helplines
County-affiliated Human Service Offices	**Veterans Services/Providers**
Substance Use Disorder	County VA Rep/Director
Mental/Behavioral Health	American Legion
Intellectual/Developmental Disability	VFW
Other Human Service Providers (non-county based)	VA Healthcare Facilities
Community Action	Veteran-specific housing programs
United Way	Veteran-specific transportation (i.e. DAV)
Substance Use Disorder providers (non-county based)	other Veterans organization/services
Mental/Behavioral Health (non-county based)	**Health Care Providers**
Domestic Violence services	Hospitals
Transportation Related	Geriatric Psych Units
Transit Authority	Specialists Offices
Medical Assistance Transportation Program provider	Home Health Providers
other transportation providers	In-Home Care providers
Housing and Utility Related	Visiting Nurse Association (VNA)
Housing Authority	Hospices
Regional Housing Coordinator	Personal Care Homes
Landlord Associations	Assisted Living Facilities
Homelessness programs	Nursing Homes/Skilled Rehab Centers
Emergency Shelter / Transitional Housing	Acute Rehabilitation Centers
Housing related to substance use disorder / mental health	PT / OT / ST Providers
Developers trying to create accessible housing	Accountable Care Organizations

- Rural Health Clinics
- Physician's Groups/offices
- Psychiatrists
- Dentists
- Audiologists
- Eye Doctors / Vision Providers
- Pharmacies
- Department of Health office
- Wellness Centers / Gyms / Silver Sneaker programs

Assistive Technology/Home Modification

- Assistive Tech Providers
- Home Modification Providers
- Durable Medical Equipment Providers
- Vehicle Modification Providers
- Funding Programs for AT/Home Mods
- Construction Companies

Civic Groups/Community Groups

- Salvation Army
- YMCA / YWCA
- Chamber of Commerce
- Lions / Rotary / Kiwanis / Elks / Mason / Moose / Eagles
- Community Centers
- other civic group/community organization

Community Leaders/Government

- Commissioners
- Mayor
- State Representative offices
- Congressman offices

Educational

- Community Education Council
- Penn State Cooperative Extension Office
- Libraries
- Intermediate Units
- School Districts
- Colleges/Universities

Employment / Vocational / Volunteer Services

- Office of Vocational Rehabilitation
- Bureau of Visual and Blindness Services
- Office of Deaf and Hard of Hearing
- Career Link
- Experience Works
- SCSEP - Senior Community Service Employment Program
- Goodwill Industries
- Sheltered Workshops
- Vocational / Tech Training Centers
- Retired Senior Volunteer Program (RSVP)

Faith-Based Groups

- Ministeriums / Churches
- Faith-based food pantries and soup kitchens
- Faith-based clothing closets
- Faith-based community service programs
- Organizations like Knights of Columbus, etc.

Age, Disease or Disability-Specific Organizations

- Alzheimer's Association
- American Cancer Society
- American Heart Association
- MS Society
- Parkinson's Foundation
- Autism Programs/Organizations
- AARP
- Disability Advocacy groups
- other specific organizations or groups

Community Businesses that offer special services to help

- Banks
- Elder Law Attorneys, other lawyers or legal services
- Grocers
- Funeral Homes
- Insurance Agencies
- Cleaning / De- Cluttering / Organization Companies
- Security Companies

Emergency Services

- American Red Cross
- Ambulance / EMS Companies
- Fire Companies
- Police / Law Enforcement
- Disaster / Emergency Preparedness Agency

Other Collaborative Groups such as …

- Local Housing Options Teams (LHOTs) / Housing Collab.
- Community Collab. or Human Service Councils
- Children and Youth Councils / Family Service Councils
- Independent Council on Aging
- Wellness Councils / Community Health Consortiums
- Emergency Preparedness Group / Team

Appendix 7: Sign-In Sheet

PA Link Sign-In Sheet

Date: Location: Training Topic:

Name	Agency	Email Address	Phone #	Can we add you to our email list?

Appendix 8: Training Evaluation

Date: _____ **Service Area:** _____
Title/Topic: _____ **Speaker:** _____

1. **I am (select all that apply):**
   - ❑ a person age 60+
   - ❑ a person with a disability
   - ❑ an unpaid caregiver of a person age 60+ or a person with a disability
   - ❑ an employee of a human service agency, healthcare provider, or other professional
   - ❑ other: _____

2. **I live/work in the following PA county/counties:** _____

3. **This is my first time at a PA Link training.** **YES** **NO**

4. **Please circle the response that best reflects your evaluation of the training:**
   - **The speaker's knowledge of the subject was:**
     Excellent Good Fair Poor
   - **The materials provided were:**
     Excellent Good Fair Poor
   - **As a result of this training, my knowledge of the subject has improved?**
     Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree
   - **I would recommend this training to others?**
     Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

5. **Do you have any feedback regarding the venue or amenities?**

6. **What was particularly helpful about this training?**

7. **Is there anything about this training you would recommend changing?**

8. **On the back please circle additional topics you like to receive training on.**

9. **Other comments or feedback:** (if you would like to be contacted with an answer to any questions or requests for additional information, please include your email/phone)

Thank you for your attendance and feedback!

Appendix 9: Special Project Proposal

SPECIAL PROJECT PROPOSAL

PENNSYLVANIA Link TO AGING AND DISABILITY RESOURCES

ANTICIPATED / PROJECTED EXPENSES

EXPENSE ITEM	ESTIMATED COST
ADVERTISING / PROMOTION	$ -
COLLATERAL MATERIALS / PRINTED TAKEAWAYS	-
SPEAKER / PRESENTER STIPEND / FEE	-
OTHER	-
	-
WILL ADDITIONAL FUNDS BE REQUESTED? YES OR NO (If yes, write amount)	
ANTICIPATED TOTAL EXPENSES	$ -

WHAT IS THE NAME OF THE PROJECT? BRIEF DESCRIPTON OF PROJECT

-

WHO (WHICH POPULATIONS WILL BE BENEFIT FROM THE PROJECT?) (WHICH NETWORK PARTNER AGENCIES ARE COLLABORATING?)

-

WHEN WILL THE PROJECT HAPPEN?

-

WHERE WILL THE PROJECT HAPPEN?

-

WHY ARE YOU PROPOSING THE PROJECT? HOW WILL YOU MEASURE & SUSTAIN THE PROJECT?

Submitted by _____ Date Submitted _____
Service Area _____
Regional Coordinator's Signature _____ Date of Approval _____
** Additional information may be requested.

Appendix 10: PA Link Oversight Committee Written Guidelines

I. Purpose

The purpose of Oversight Committee #_____ is to plan, implement, review, and improve upon activities and functions of the PA Link to Aging and Disability Resources within (list out counties). This Oversight Committee should continually strive to attain fully functioning status as an ADRC. It should serve as a forum where the PA Link partner network, consumer representatives, and other community stakeholders can discuss community needs and gaps in service, and provide guidance on how to enhance the provision of long term services and supports.

II. Composition

The Oversight Committee should reflect composition required by the current Aging Program Directive. Each agency represented on the Oversight Committee should be called a Managing Partner. Each Managing Partner should designate a primary representative. This primary representative should participate in required meetings. If this primary representative changes, the Managing Partner should inform the Oversight Committee and Lead Coordinator of the change.

III. Proxy

(Discuss and reflect your position on the use of proxies.)
Sample phrasing: 'Managing Partners may not designate a proxy.' OR 'Managing Partners may designate a proxy who should participate in Oversight Committee meetings when the primay representative is unavailable.'

*If you do want to allow for proxies, you may want to discuss some of the following considerations and document your decisions: number of proxies that each Managing Partner can designate; how changes in proxy should be communicated to the Oversight Committee and Lead Coordinator; whether proxies should be included in all communications that go to primary representatives to ensure they are informed; if there is a maximum number of meetings in which a proxy can participate instead of the primary representative.

IV. Adding or Removing Managing Partners

(Discuss and reflect a procedure for Managing Partner resignation and for adding new Managing Partners. Additionally, decide whether or not your group wants a procedure in place for removing Managing Partners and/or more specifically, Primary Representatives. Document what you decide.)

*Points to consider:

-Adding– What process should be used for 'nominating' and approving new Managing Partners?
-Resigning – What if a Managing Partner wants to resign from the Committee? What would that process look like? How should the committee fill a hole (in terms of composition) caused by that resignation?
-Removing - What would be the criteria for removing a Managing Partner –what would they have to do, or not do, to be removed from the Committee? For example, missed X number/ percentage of meetings. How would the decision to remove them be communicated to them? What should the Oversight Committee do to ensure that the required composition is not affected due to that removal?

V. Required Meetings

Oversight Committee meetings should be held at the frequency and in the manner outlined in the current Aging Program Directive.

*Could add anything else it wants to say about required meetings. For example, a minimum number of required meetings in which the primary representative must participate.

VI. Scheduling Meetings

Oversight Committee meetings should be scheduled with the involvement of the Regional Coordinator and in advance for the entire Program Year. Meeting dates should be communicated to the Program Office no later than the Budget Proposal due date.

VII. Notification of Meetings

(Discuss and document a process for handling notification/reminders of meetings.)

Sample phrasing: 'The Lead Coordinator should notify the Managing Partners of the next Oversight Committee meeting via email at least ___weeks/days in advance. The agenda for the meeting should be attached to the email.'

VIII. Meeting Agenda

Each required meeting should address the minimum agenda requirements as outlined in the current Aging Program Directive.

*Local areas could add to the above statement if they wish. For example, if they want a process for Managing Partners to be able to submit agenda items to the Lead Coordinator for inclusion on the agenda – how would this be handled?

IX. Voting/Approval Method

(Discuss and reflect a decision on how your group should approve or vote on PA Link-related business – e.g. approving expenditures or activities, personnel issues, etc. The method is up to the local level, but each area must document the method they choose.)

Sample phrasing: 'Approval should require agreement from a simple majority/two-thirds majority of Managing Partners participating in the meeting.'

*If the local area wants to employ something more formal – e.g. Roberts Rules of Order – reference that decision here. Please note, that this type of formal process is not required by the Program Office.

X. Summarization and Distribution

The Lead Coordinator should prepare (a summary/minutes) of each meeting and should distribute electronically to the Managing Partners and the Regional Coordinator within (timeframe). The Lead Coordinator should maintain a file of Oversight Committee meeting (summaries/minutes) and should make them available to interested parties upon request.

XI. Subcommittees/Ad Hoc Committees

Subcommittees or Ad Hoc Committees should be created by the Oversight Committee as needed and should report to the Oversight Committee at required meetings. These committees may reflect representation from Managing Partners as well as the larger Partner Network or members of the community.

*If the Oversight Committee already has standing committees, reference those here.

XII. **Partner/Public Involvement**

(Discuss how your group should handle input from the larger partner network, or the public, and document that process in this section. Additionally, please discuss and document guidelines around the larger partner network, or members of the the public, attending Oversight Committee meetings. Please keep in mind that at all times, personnel matters should be discussed privately.)

*Some things to consider here:

-How should your Oversight Committee allow partners/the public to raise concerns or give input or suggestions for discusson at an upcoming meeting?

-If holding open meetings, in which anyone can attend - be clear about who can and cannot 'vote'/approve business discussed during the meetings

XIII. **Amendments**

(Create and document a process for amending these written guidelines.)

Sample phrasing: 'Changes and amendments to these written guidelines must be approved by a two-thirds vote of the Managing Partners present at the meeting at which they are discussed.'

Pennsylvania Link
Acknowledgement of Managing Partner Agency Guidelines

As the designated sole State Agency responsible for the implementation of specific objectives impacting the lives of older adults, the Pennsylvania Department of Aging aids in the facilitation of programs and directives as defined by the Older Americans Act.

"The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the U.S. Administration on Community Living (including AoA as of April 2012) and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points of entry into the long term supports and services system for older adults and people with disabilities. In a networked or virtual system such as the Pennsylvania Link, any Partner Agency can serve as that single point of entry thus creating a No Wrong Door System as defined by ACL.

"The goal is to have Aging and Disability Resource Centers in every community, serving as highly visible and trusted places where people of all incomes and ages can turn for information on the full range of long term support options and a single point of entry for access to public long term support programs and benefits."
Source: Federal ADRC website (http://www.adrc-tae.acl.gov).

PA Link partners

The Pennsylvania Link to Aging and Disability Resources, Pennsylvania's federal Aging and Disability Resource Center (ADRC) program, commonly known as PA Link, is a network of local, state and federal partners working together to help individuals of all ages, abilities, and incomes obtain the services and supports they need to remain as independent as possible in the setting of their choice. The agencies and organizations that work together in this effort are known as 'PA Link partners' The coordinated network of partners allows individuals, families and caregivers to initiate contact with any PA Link partner and access needed information, assistance and resources. The No Wrong Door approach attempts to minimize duplication of efforts by both individuals and providers. PA Link partners assist those who need information and access to home and community based services regardless of their age, ability or income.

The core components and criteria of a fully functional Aging and Disability Resource Center program include:

- Information, Referral and Assistance

- Person-Centered Counseling

- Streamlined Eligibility Determination for Public Programs

- Person-Centered Transition Support

- Key Referral Source and Stakeholder Involvement/Partnerships

- Quality Assurance and Continuous Improvement

Guidelines for Managing Partner Agencies

The Department has established guidelines to be considered by Managing Partner Agencies in providing access to services through the No Wrong Door approach.

Managing Partner Agencies are PA Link partners that serve on oversight committees for a PA Link Service Area. Managing Partner Agencies may:

1. Assign and maintain a staff person or persons with decision-making authority to be the point of contact for the PA Link and participate on the oversight committee.
2. Ensure the oversight committee in the respective Service Area includes representation from (at a minimum):
    a. Area Agency on Aging
    b. Center for Independent Living
    c. APPRISE/State Health Insurance Program (where not covered by the Area Agency on Aging)
    d. Intellectual Disabilities/ Developmental Disabilities
    e. Behavioral Health
    f. Substance Use
    g. Veterans service representation
    h. Consumer representation
3. Participate in quarterly meetings.
4. Serve as or designate a Quality Control/Review Board.
5. Serve as a No Wrong Door agency to ensure that individuals, families and caregivers receive a consistent consumer experience through a person-centered approach to get what they need – or at least the next step in planning.
6. Participate in the planning, implementing and measuring of program requirements.
7. Support the implementation, growth and progress of the core components.

The Aging and Disability Resource Office will provide funding, support, supervision, training, and technical assistance to help Service Area s achieve programmatic goals.

For the purposes of maintaining accuracy, should a Managing Partner Agency choose to terminate involvement in the oversight committee and/or the PA Link, it is preferable that the agency notify the Regional Coordinator in writing.

These are guidelines and do not take the place of any applicable state or Federal statutes or laws which would affect participation in the PA Link.

As the Executive Director (or equivalent) of the Managing Partner Agency, I have read, fully understand, the guidelines set forth in this document.

Agency Name: _____

_____ _____

Executive Director (or Equivalent) Printed Name **Date**

_____ _____

Executive Director (or Equivalent) Signature **Date**

Appendix 11: Report Timeframes

Quarterly Report

The Quarterly Report provides important insight into the activities and performance of the Link Service Area and is due to the Regional Coordinator as follows:

1st Qtr.	July - September	Report due on 3rd Friday of October
2nd Qtr.	October – December	Report due on 3rd Friday of January
3rd Qtr.	January – March	Report due on 3rd Friday of April
4th Qtr.	April – June	Report due on 3rd Friday of July

Partner List

An updated, complete partner list is due every quarter to the Regional Coordinator; same timeframe as above.

Person Centered Counselors by Service Area

An updated listing of Person-Centered Counselors by Agency noting the Lead Person-Centered Counselor is due every quarter to the Regional Coordinator; same timeframe as above.

Budget Proposal

Service Area Budget Proposal for the upcoming Fiscal Year is due to the Regional Coordinator by the end of the current FY.

Federal Reports

Federal Reports will be completed as necessary.

Additional Reports

Assigned as necessary.

*All report forms and any associated documents should be provided by the Regional Coordinator.

Appendix 12: Training Topics

Aging

- Area Agency on Aging / PA Department of Aging Services
- Aging with ID
- Living Independence for the Elderly Program (LIFE)
- Senior Center / Community Center Programs
- Skilled Nursing Facility (SNF) / Assisted Living Facilities (ALF) / Personal Care Home (PCH) / Domiciliary Care
- Adult Day Centers

Application Assistance / Insurance / Finances

- COMPASS
- Medicare / Medicaid
- Health Insurance
- LIHEAP and other utility assistance programs
- APPRISE / PACE / LIS / MSP
- SNAP and other nutrition assistance programs
- Budgeting / Money Management
- Waivers
- Special Needs Trust
- Long Term Care Insurance

Behavioral Health / Substance Use Disorder

- Behavioral Health / Mental Health diagnoses
- Hoarding
- Mental Health First Aid
- Suicide Prevention
- Trauma Informed Care
- Substance Use Disorder
- Opioid Dependency and Treatment
- Support Groups

Caregivers

- Caregiver Support Programs
- Respite
- Stress Reduction / Compassion Fatigue
- Support Groups

Disability

- Center for Independent Living Services
- Disability Issues / Sensitivity / ADA History
- Intellectual and Developmental Disability
- Office of Vocational Rehabilitation (OVR)
- Office of Deaf and Hard of Hearing (ODHH)
- Bureau of Blind and Vision Services (BBVS)

- Youth with special needs
- Employment programs
- Assistive Technology
- Home Modifications

Health Promotion and Awareness / Health Services
- Alzheimer's Disease and Related Dementias
- Chronic Disease (CHF, COPD, Diabetes, etc.)
- Wellness and Nutrition Programs
- Health Literacy
- Durable Medical Equipment
- Home Health and Hospice
- In-Home Services
- End-of-Life Planning

Housing and Transportation
- Options and programs for housing and transportation
- Homelessness programs

Legal/Protection
- Abuse / Neglect / Exploitation
- Adult Protective Services
- Older Adult Protective Services
- Child Protective Services
- Ombudsman
- Scams/Frauds
- Legal Aid Services
- Power of Attorney/Guardianship

Life Skills or Tools
- Advocacy (for yourself, a loved one, client/patient)
- Disaster / Emergency Preparedness
- Stress Reduction / Conflict Resolution
- Active Shooter / Workplace Safety
- Transition Support Services / Transition Assistance
- Person-Centered Approach
- Volunteer Opportunities

Veterans
- Reintegration Services
- Federal, State, and local systems and supports
- Post-Traumatic Stress Disorder
- Military Culture