

Case Management services are provided following the:

1. CFC High/Highest Needs Program Manual which outlines the reimbursable case management activities allowed in the program.
2. Case Management Standards provides details for Individual Case Management Standards, as well as specific agency requirements to be a CM agency for OAA and CFC in VT.
3. Agencies need to meet the requirements of the Case Management Agency Certification Procedures which are reviewed by the quality team at DAIL.

All Case Managers providing services under CFC or OAA follow the standards found in the Case Management Standards:

- To provide services in the least restrictive and most appropriate setting as possible in accordance of the individual's needs and preferences.

Respect the individual's rights strengths, values and preferences, encourage the participant to create, direct and participated in their individualized written plan and services.

Be knowledgeable about the full range of services available to an individual in their region.

Recognize self-neglecting behaviors and offer intervention when the situation jeopardizes the individual's well-being. Adults under age 60 referred to Adult Protective Services

Provide services efficiently, effectively and collaboratively to avoid duplication of services.

Respond to requests for information and/or assistance I a timely manner.

Assessment – At least annually or at times of significant change, assessment complete and accurate and in compliance with program guidelines (CFC assessment tool)

Identify long and short term goals

Planning

Monitoring and review

Documentation

Knowledgeable and comply with agency policy and standards – not limited to confidentiality, third –party referrals and conflict of interest.

Provide info regarding agency's grievance procedures.

CFC Case Management Activities Includes:

- A. Assessment – Comprehensive review of the individual circumstances, including but not limited to social, medical, functional, financial and environmental needs.
- B. Care-planning – formal process of identifying the needs of the individual as identified through the assessment process. Plan is developed to meet the identified needs and services to be delivered.
- C. Service Coordination – Process by which services are obtained for the individual through coordination with multiple resources and providers.
- D. Information and Referral – Process by which the individual is fully informed of available options and referrals are made as needed.
- E. Monitoring – Ongoing review of the individual's status, needs and service utilization.
- F. Consumer & Surrogate Employer Certification – process of assessing and reassessing an employer's certification for home-based consumer or surrogated directed option.
- G. Documentation – Completing all CFC forms, as well as applications for other services or public benefits as needed and documentation of ongoing case management activities.
- H. Travel – time to and from participant's home for visits or other face to face meetings, care planning meetings related to the individual's services.

High/Highest – 48 hours per year Moderate Needs Group – 12 hours per year.

Variances may be requested with documented justification.