NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

August 19, 2019
1:00 p.m. Central Time
Gold's Building – Room 534
1033 O Street, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 15 Chapters 1-6 of the Nebraska Administrative Code (NAC)-*Community Aging Services Act; Care Management Act; Long-Term Care Ombudsman Act.* These regulations govern the Area Agencies on Aging under Nebraska's Medicaid Program. The proposed changes set forth requirements for agency and care management designations, area plans and budgets, nutrition programs, and the Senior Companion Volunteer Program. The proposed regulations revise the Long-Term Care Ombudsman Program federal regulations, update terminology, and remove repeated statutory language in the regulations.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 15	Prepared by: Cynthia Brammeier
Chapter: 1, 2, 3, 4, 5, 6	Date prepared: 5/22/19
Subject: Aging Services	Telephone: 402-471-9155

Type of Fiscal Impact: None.

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: DHHS, MLTC, State Unit on Aging. No fiscal impact.

Political Subdivision: County and city governments, participating in aging programs. No fiscal impact.

Regulated Public: Area Agencies on Aging. No fiscal impact.

If indeterminable, explain why:

TITLE 15 AGING SERVICES

CHAPTER 1 DEFINITIONS

001. SCOPE AND AUTHORITY. These rules and regulations implement the Nebraska Community Aging Services Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 81-2201 to 81-2227, consistent with the Older Americans Act of 1965 (OAA).

002. DEFINITIONS. For purposes of this title, the following definitions apply:

002.01 ACT. The Act is the Nebraska Community Aging Services Act.

002.02 ANNUAL BUDGET. The annual budget is a document identifying fiscal year expenditures based on services to be provided in the Planning and Service Area, and corresponding service unit projections.

002.03 ASSESSMENT. An assessment is a comprehensive appraisal of individuals by making orderly and purposeful observations, conducting interviews, and recording the results of those observations and interviews on a standardized assessment document issued by the Department.

002.04 AUTHORITY AND CAPACITY. The authority and capacity is the power and right of an Area Agency on Aging to enforce, administer, and implement laws, rules, and regulations and programs for which it is responsible.

002.05 CARE MANAGEMENT. Care management is assisting a client to identify and utilize services needed to ensure that the client is receiving, when reasonably possible, the level of care that best matches his or her level of need.

002.06 CARE MANAGEMENT FEE SCALE. The Care Management fee scale is the document issued annually by the State Unit on Aging, using the Federal Poverty Level, for Area Agencies on Aging to determine the client fee for Care Management services based on family income. defined as follows:

(A) Family income is the total income the individual and spouse (if any) receives annually;
(B) Income is money received as profit from fees (net income after business expenses, before taxes) from a person's own business, professional practice, partnership, or farm;
(C) Income includes but is not limited to, regular payments such as social security, income from public assistance or welfare, interest, dividends, pensions, net rents, alimony, child support, or allotments;

(D) Income includes wages, salary, commission, bonuses, or tips from all jobs (before deductions from taxes), including sick leave pay; and
(E) For the purposes of this Title, family means an individual and his or her spouse.

002.07 CARE MANAGEMENT UNIT (CMU). The Care Management Unit is the organization which is created by, or which is contracting with, an Area Agency on Aging, or the public or private entity contracting with the Department, to provide Care Management program services as defined in the Act and this Title.

002.08 CERTIFIED CARE MANAGEMENT UNIT. Certified Care Management Unit is a Care Management Unit that has been found by the Department to meet the standards for certification under the Act.

002.09 CLIENT. Client is an eligible individual receiving services authorized by the Older Americans Act of 1965, or 15 Nebraska Administrative Code (NAC) services, also known as a participant.

002.10 CONTINUUM OF CARE. Continuum of care is a range of services designed to ensure that persons are receiving, when reasonably possible, the level of care that best matches their level of need.

002.11 CONTRIBUTION. A contribution is a donation of money, or anything of value, that is voluntarily given by an eligible individual to a service provider to be used toward the cost of the program or service received by the individual from the service provider.

002.12 DESIGNATION. Designation is the authorization granted by the Department to an entity to act as the Area Agency on Aging for a given Planning and Service Area.

002.13 DIRECT CARE PROGRAM. A direct care program is any program of an Area Agency on Aging, except the Care Management program, providing services to older eligible individuals.

002.14 ELIGIBLE INDIVIDUAL. Eligible individual is a person who resides in Nebraska and is either 60 years of age or older, or a caregiver, and meets program eligibility criteria within this Title.

002.15 ENVIRONMENTAL NEEDS. Environmental needs are factors required to maintain an individual in an appropriate and safe living arrangement.

002.16 FUNCTIONAL NEEDS. Functional needs are factors that affect an individual's ability to perform the activities of daily living and the instrumental activities of daily living.

002.17 GRANT. Grant is an award of financial assistance in the form of money, or of property in lieu of money, by the Department. See also Subawards.

002.18 GRANTEE. Grantee is any legal entity to which a grant is awarded and which is accountable to the Department for the use of the grant. The grantee includes the entire legal entity even if only a particular component of the entity is designated in the grant.

002.19 GRANTING AGENCY. Granting agency is the Department.

002.20 GRANT OR SUBAWARD AMENDMENT. Grant or subaward amendment is a change by an Area Agency on Aging that would:

(A) Alter the program scope, planned objectives, or the manner in which services are delivered;

(B) Provide financial assistance or payments to any entity not authorized by the original grant or contract; or,

(C) Alter the approved budget of the original grant or contract, except as authorized in directives issued by the Department.

002.21 INDIVIDUAL APPROVAL OR CLIENT APPROVAL. Individual approval or client approval is confirmation given after full disclosure, on a form by the eligible individual or the client, or their legal representative.

002.22 LONG-TERM CARE (LTC). Long-term care is caring for people who have unmet psycho-social, environmental, or functional needs and who need assistance in meeting these needs for a period of at least three months.

002.23 LONG-TERM CARE PLAN. Long-term Care Plan is a document prepared with a client by the Care Management Unit in compliance with 15 NAC 3.

002.24 LONG-TERM CARE PLANNING. Long-term care planning is the process used to prepare a Long-Term Care Plan.

002.25 MEAL. Meal is food served as the morning, mid-day, or evening meal. The meal must meet Older Americans Act of 1965, state, and local law requirements.

002.26 NUTRITION SCREENING. Nutrition screening is the completion of a nutrition screening checklist by eligible individuals to determine if they are at nutritional risk.

002.27 NUTRITION SERVICES INCENTIVE PROGRAM (NSIP). Nutrition Services Incentive Program provides funds that are distributed by the State Unit on Aging to the Area Agencies on Aging based on a ratio of the number of meals served the prior year to the total number of meals served throughout the state. Nutrition Services Incentive Program funds are primarily received in cash, however the State may choose to receive food commodities, cash, or a combination of both.

002.28 OLDER INDIVIDUALS, OLDER NEBRASKANS, OLDER POPULATION. Older individuals, older Nebraskans, and older population are persons who are 60 years of age or older.

002.29 PLAN OF OPERATION. Plan of Operation is a plan prepared in compliance with 15 NAC 3.

002.30 PERSON-CENTERED. Person-centered is as defined in Code of Federal Regulations (CFR) Title 42, Sec. 441.540.

002.31 POTENTIALLY HAZARDOUS FOODS. Potentially hazardous foods are foods that require time control, temperature control, or both, for safety to limit pathogenic microorganism growth or toxin formation.

002.32 PSYCHO-SOCIAL NEEDS. Psycho-social needs are basic needs which include, but are not limited to, social participation, orientation, understanding, and a sense of well-being.

002.33 REGISTERED DIETITIAN. Registered dietitian is a person registered by the Commission on Dietetic Registration.

002.34 REQUEST FOR PROPOSAL (RFP). Request for proposal is a document containing criteria which is used to solicit applications for a contract or subgrant from potential service providers.

002.35 SERVICE PROVIDER. Service provider is any entity that is obligated under law, subaward, or contract to provide community aging services to eligible individuals, in any Planning and Service Area.

002.36 SIGNIFICANT CHANGES IN HEALTH OR FUNCTIONAL STATUS. Significant changes in health or functional status are changes in a Care Management program client's health or abilities that requires admission to a hospital or a skilled nursing facility for inpatient care, or an increase in in-home services.

002.37 STATE PLAN. State Plan is a document developed, approved, and submitted to the Governor, and the Administration on Aging, a division of the Administration for Community Living, for the purposes of administering grant funds allocated to the state under the Older Americans Act of 1965. The State Plan must meet federal requirements outlined in the Older Americans Act of 1965, Title I, Sections, 306, 307, and 705.

002.38 SUBAWARD. Subaward is a document awarding financial assistance in the form of money, or of property in lieu of money, by the Department. See also Grant.

002.39 TAKE HOME MEAL. Take home meal is any meal sold at full price at a meal site, for eligible or ineligible individuals, who wish to take meals from the site.

002.40 TITLE III-C. Title III-C is as defined in Title III-C of the Older Americans Act of 1965.

Title 15 NAC 1

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Community Aging Services Act

Title 15 - NEBRASKA DEPARTMENT ON AGING

Chapter 1 - NEBRASKA COMMUNITY AGING SERVICES ACT

001 These rules and regulations implement Neb. Rev. Stat. Sec. 81-2201 to 81-2228 R.R.S., 1943 (The Act).

001.01 Definitions

001.01A Act shall mean the Nebraska Community Aging Services Act.

001.01B Annual Plan and Budget shall mean the document submitted by an Area Agency on Aging and approved by the Department which provides a detailed programmatic and budget narrative outlining the Area Agency on Aging's implementation of its Area Plan and Budget during the ensuing state fiscal year.

001.01C Area Agency on Aging shall mean the agency designated by the Department as responsible for the administration of the Area Plan and Budget and Annual Plan and Budget in each Planning and Service Area.

001.01D Area Plan and Budget shall mean the document submitted by an Area Agency on Aging and approved by the Department which outlines for a period of five years the Area Agency on Aging's comprehensive and coordinated program of Community Aging Services for the Planning and Service Area.

001.01E Authority and Capacity shall mean the power and right of an Area Agency on Aging to enforce, administer and implement laws, rules and regulations and programs for which it is responsible.

001.01F Committee shall mean the Department on Aging Advisory Committee.

001.01G Community Aging Services shall mean those activities and services which fulfill the goals of the Nebraska Community Aging Services Act and which are necessary to promote, restore, or support senior citizen self-sufficiency and independence. These may include, but not be limited to, congregate activities such as senior centers, group meals, volunteerism, adult day care, and recreation, and individual services such as specialized transportation, meals-on-wheels, home handyman, home health care, legal services, and counseling that relates to problems of aging or encourage access to aging services.

001.01H Community Focal Point shall mean a facility established to encourage the maximum collocation and coordination of services for

older individuals which do not exceed the geographic boundaries of a participating county.

001.01I Comprehensive and coordinated program of services shall mean a program of interrelated supportive and nutrition services as defined in 001.01G and which are designed to meet the needs of older persons in a planning and service area.

001.01J Contribution shall mean a donation of money or anything of value that is voluntarily given by a participant to a service provider.

001.01K Department shall mean the Department on Aging.

001.01L Designation shall mean the authorization granted by the Department to an entity to act as the Area Agency on Aging for a given Planning and Service Area.

001.01M Director shall mean the director of the Department on Aging appointed by the Governor, with the advice and consent of the Legislature, or such officer of the agency as he or she may designate to carry out in whole or in part the administration of the Act.

001.01N Grant shall mean an award of financial assistance in the form of money, or of property in lieu of money, by the Department.

001.01O Grantee shall mean any legal entity to which a grant is awarded and which is accountable to the Department for the use of the grant. The grantee is the entire legal entity even if only a particular component of the entity is designated in the grant.

001.01P Granting agency shall mean the Department.

001.01Q Greatest economic need shall mean the need resulting from an income level at or below the poverty level as established by the Office of Management and Budget.

001.01R Greatest social need shall mean the need caused by noneconomic factors, including physical and mental disabilities, language barriers, and cultural, social, or geographic isolation, including that caused by racial or ethnic status, which restricts an individual's ability to perform normal daily tasks or which threatens such a person's capacity to live independently or interferes with the exercise of rights and privileges.

001.01S In-home service shall mean the provision of health, medical or social services to an individual in his or her place of

residence, except if such residence is a hospital, nursing facility, penitentiary, or other institution licensed by the state.

001.01T Legal Assistance or legal services shall mean legal advice and education by an attorney, or by a nonlawyer where permitted by law and supervised by an attorney, to older individuals with economic or social needs.

001.01U Grant Award Amendment by an Area Agency on Aging shall mean a change that would:

1) alter the program scope, planned objectives, or the manner in which services are delivered; or

2) provide financial assistance or payments to any entity not authorized by the original grant or contract; or

3) alter the approved budget of the original grant or contract, except as authorized in directives issued by the Department.

001.01V Multipurpose senior center shall mean a community facility for the organization and provision of a broad spectrum of Community Aging Services.

001.01W Notification of Grant Award (NGA) shall mean the document issued by the Department awarding financial assistance for the provision of services and specifying the terms of the grant.

001.01X Older Americans Act shall mean the Older Americans Act, as amended 42 U.S.C. 3001 et seq. and its rules and regulations.

001.01Y Older Individual shall mean any person who is 60 years of age or older, or the spouse of an individual who is 60 years of age or older, except as related to employment programs, when an older person may be 55 years of age.

001.01Z Planning and Service Area (P.S.A.) shall mean a geographic area of a state for purposes of planning, development, delivery and overall administration of services under an Area Agency on Aging's Area Plan and Budget (see section 001.03).

001.01AA Request for Proposal (R.F.P) shall mean the document containing criteria which is used to solicit applications for a contract or subgrant from potential service providers.

001.01BB Service Provider shall mean any entity that is obligated under law or contract to provide community aging services to older persons in any Planning and Service Area.

001.01CC Senior service center shall mean a senior center or other community facility that provides ready access to a broad range of community aging services.

001.01DD State Plan shall mean the document developed, approved and submitted to the Governor for the purposes of administering grant funds allocated to the state under the Older Americans Act, as amended.

001.01EE Unit of General Purpose Local Government shall mean a political subdivision of the State whose authority is general and not limited to only one function or combination of related functions; or any Indian tribe, band, nation, or other organized group or community, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

001.02 Department on Aging Advisory Committee, a committee of 12 members appointed by the Governor, one from each of the PSAs in 001.03 and the remaining members from the state at large. In addition to advisory duties enumerated in Neb. Rev. Stat. Sec. 68-1104 and 81-2212 R.R.S. 1943, the Committee shall act as a panel for the hearing and resolution of any appeal requested by an Area Agency on Aging should the Department disapprove the Area Plan and Budget or amendments thereto. Such an appeal shall follow the Appeal Process outlined in Section 001.05 of these rules and regulations.

001.03 Designation and Continued Designation. The Department shall designate and determine continued designation of an Area Agency on Aging for each of the Planning and Service Areas created by section 81-2213 (6) of the Act.

001.03A Prior to initial designation the Department shall:

001.03A1 Provide written notice to the county government in the PSA of the pending designation no less than 60 days before taking action.

001.03A2 Conduct an on-site assessment to determine that the agency being considered for designation as an Area Agency on Aging has the authority and capacity to perform the functions of an Area Agency on Aging as specified by the Act, these rules and regulations, and the Older Americans Act, as amended.

001.03A2a The Department shall determine authority of an Area Agency on Aging through a review that shall include, but not be limited to, the following:

1) An Interlocal Cooperation Act agreement signed by the chief elected officials of participating counties within its PSA.

2) Authority to accept and utilize funds for aging services as specified by the Act, these rules and regulations, and the Older Americans Act, as amended.

3) Authority to develop and implement policies and procedures for administration, services and program development, program records, data collection and planning. Such policies and procedures, including the following, are to be in writing and on file:

a) A statement that the Agency is an Equal Opportunity Employer with an Affirmative Action Plan

b) By-laws for the Governing Board

c) By-laws for an Advisory Committee

d) Use of property (real, personal, etc.)

e) Confidentiality and storage of confidential material

f) Personnel Policies which include: Job descriptions for each Area Agency employee, Code of Ethics, Leave, Travel, Discipline, Performance Evaluation, Hiring/Termination, Grievance procedures, and accounting and financial management.

4) Collected and evaluated views of Units of General Purpose Local Government gathered in public hearing in the PSA prior to seeking designation.

5) Evidence that the views of older persons have been considered and evidence of support from older persons in the PSA.

6) Evidence of support from Units of General Purpose Local Government and human service agencies and community organizations in the PSA.

7) Authority to be an advocate for older persons in the PSA.

001.03A2b The Department shall determine capacity of an Area Agency on Aging through a review that shall include, but not be limited to, an evaluation of the record of its performance in:

1) the planning, organizing, staffing, directing and supervision of a comprehensive and coordinated program of services for older Nebraskans;

2) monitoring, evaluating and commenting on policies, programs, hearings and community actions which affect older persons;

3) conducting public hearings, studies, and assessments of the needs of older persons;

4) representing the interest of older persons;

5) conducting activities in support of the Department's Long-Term Care Ombudsman and Legal Services program as required by the Older Americans Act, as amended;

6) coordinating planning with other agencies and organizations to promote programs and opportunities which benefit older persons;

7) providing technical assistance to providers of services and to multipurpose senior centers in the planning and service area;

8) establishing effective and efficient procedures for the coordination between the programs assisted by the Department and other programs available to older Nebraskans;

9) carrying out the intention of the Act and these rules and regulations and the Older Americans Act, as amended, and its rules and regulations.

001.03B Conduct a public hearing to consider the views of Units of General Purpose Local Governments in each of the PSAs.

001.03C Each designated Area Agency shall be proposed and supported by the chief elected officials of the Units of General Purpose Local Governments formed under the Interlocal Cooperation Act.

001.03D After a review of the proposed agency and an assessment of its authority and capacity to function as an Area Agency on Aging, the Department shall either issue designation as an Area Agency on Aging or issue a denial of designation in writing to the Governing Board.

001.03E If a letter of denial is sent, the Department shall state the reasons for denial and provide a minimum of 30 working days for the Governing Board to respond and correct the reasons for denial.

001.03F The Department shall reconsider determination of approval or denial of designation or continued designation upon submittal of new materials. If a second denial is made, the Department shall notify the Governing Board in writing, stating reasons for the denial. After a second denial, the Department may seek a new office or agency to apply for designation as outlined in these rules and regulations.

001.03G A designated Area Agency on Aging is subject to an on-site assessment at least once every 3 years. The on-site assessment will determine if the Area Agency continues to have the authority and capacity to carry out the functions of an area agency as set out in the Act, these rules and regulations and the Older Americans Act, as amended.

001.03G1 Such a review shall include an evaluation of the agency's performance in carrying out its responsibilities and functions under the Act, these rules and regulations, including subsections 001.03A2a and 001.03A2b, the Older Americans Act, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B; an evaluation of the agency's goals and objectives under its approved Annual Plan and Budget and five-year Area Plan and Budget; on-site visits, client interviews, desktop monitoring of area agency performance and fiscal reports, and reviews of area agency plans.

001.04 Withdrawal of designation.

001.04A The Department may suspend or withdraw designation for any of the following reasons:

1) The designated Area Agency on Aging voluntarily withdraws as the designated Area Agency on Aging.

2) There is a change in the Area Agency's authority and capacity to perform the functions of an Area Agency on Aging according to the Act, these rules and regulations, the Older Americans Act, as amended, or its rules and regulations, attached and incorporated herein by reference as Attachment B.

3) Malfeasance in the administration of the Area Agency's area plan and failure by the governing unit to take corrective action within a reasonable time.

4) The Area Agency does not implement an approved Annual Plan or Budget or five-year Area Plan and Budget.

5) The Area Agency refuses to serve older persons in the Planning and Service Area with a program of services as outlined in the Agency's Annual Plan and Budget or Area Plan and Budget.

6) The resources allocated by the Department or any other State or Federal source are being used in violation of the Act, these rules and regulations, the Older Americans Act, as amended, or its rules and regulations, attached and incorporated herein by reference as Attachment B.

7) The Area Agency does not obtain approval for an amendment to its Annual Plan and Budget or Area Plan and Budget prior to implementing a change.

8) The Area Agency does not meet the conditions of the Notification of Grant Award issued by the Department.

9) The Area Agency does not comply with the Act, these rules and regulations, the Older Americans Act, as amended, or its rules and regulations, attached and incorporated herein by reference as Attachment B.

001.04B If the Department determines that there is cause to withdraw the designation of an Area Agency on Aging, the Director will notify the Governing Board of the Area Agency in writing of the areas of non-compliance and the action or actions needed to be taken by the Area Agency in order to be in compliance and to continue designation.

001.04B1 The Governing Board of the Area Agency will have 30 working days from service of such notice to respond to the Department with a plan of corrective action to maintain its designation. The plan of corrective action must describe the steps to be taken, the expected outcomes for each action, and the maximum time frame in order to be in compliance.

001.04B2 The plan of corrective action must be approved by the Department before it is implemented.

OO1.04C The Director will issue to the Governing Board a written notice of withdrawal of designation when an area agency on aging fails to comply with the plan of corrective action or when the Department and an area agency on aging fails to reach agreement on a corrective plan of action.

001.04D An Area Agency that fails to respond to the written notice of non-compliance or to a written notice of intent to withdraw designation, or that fails to implement an approved plan of corrective action to regain compliance within the time frame agreed upon by the Department, may have all or a portion of the grant award withheld and may have its designation withdrawn following notice by the Department and completion of the appeal process (see 001.05), if the Agency chooses to appeal.

001.04E Upon withdrawal or denial of designation the Department may temporarily perform all or part of the functions and responsibilities of the Area Agency on Aging or may designate another agency to perform such functions and responsibilities identified by the Department until the designation of a new Area Agency on Aging; or, when it deems necessary, may temporarily deliver services to assure continuity of programming.

001.05 Appeal Process. A decision by the Department to withdraw or deny designation or continued designation may be appealed to the Director by the Area Agency on Aging. The appeal will follow the procedures of the Administrative Procedures Act, Neb. Rev. Stat. Sec. 84-914 (R.R.S., 1943).

001.05A Rules of Evidence

1) The Director may admit and give probative effect to evidence which possesses probative value commonly accepted by reasonably prudent persons in the conduct of their affairs.

2) The Director shall give effect to the rules of privilege recognized by law.

3) The Director may exclude incompetent, irrelevant, immaterial, and unduly repetitious evidence.

4) The Director may administer oaths, issue subpoenas, compel the attendance of witnesses and the production of any papers, books, accounts, documents, and testimony, and cause the depositions of witnesses residing either within or without the state to be taken in the manner prescribed by law for taking depositions in civil actions in the district court.

5) All evidence including records and documents in the possession of the Department of which it desires to avail itself shall be offered and made a part of the record in the case. No other factual information or evidence shall be considered in the determination of the case. Documentary evidence may be received in the form of copies or excerpts or by incorporation by reference.

6) Every party shall have the right of cross-examination of witnesses who testify and shall have the right to submit rebuttal evidence.

7) The Director may take notice of judicially cognizable fact and in addition may take notice of general, technical, or scientific facts within its specialized knowledge. Parties shall be notified either before or during the hearing or by reference in preliminary reports or otherwise of the materials so noticed. They shall be afforded an opportunity to contest the facts so noticed. An agency may utilize its experience, technical competence, and specialized knowledge in the evaluation of the evidence presented to it.

8) Any party to a formal hearing before the Director, from which a decision may be appealed to the courts of this state, may request that the Director be bound by the rules of evidence applicable in district court by delivering to the Department at least 3 days prior to the holding of such hearing a written request therefor. Such request shall include the requesting party's agreement to be liable for the payment of costs incurred thereby and upon any appeal or review thereof, including the cost of court reporting services which the requesting party shall procure for the hearing. All cost of a formal hearing shall be paid by the party or parties against whom a final decision is rendered.

001.05B An Area Agency on Aging or provider aggrieved by a decision of the Department to withdraw or deny designation or continued designation as an Area Agency on Aging shall exercise the right of appeal by filing a notice of appeal with the Director of the Department within 10 working days after service of notice by the Department.

001.05C The Director shall set the date, time, and place of the hearing within 5 working days of receiving an appeal request from an aggrieved Area Agency on Aging or provider.

001.05D The Director shall appoint an impartial hearing officer to conduct the hearing.

001.05E The hearing officer shall rule on motions and objections and may cross-examine any witnesses. The hearing officer shall prepare written recommendations regarding findings of fact and conclusions of law and submit the same to the Director within 20 working days of the conclusion of the hearing.

001.05F A representative may appear on behalf of the Area Agency on Aging. There shall be opportunity to present witnesses and documentary evidence under the provisions of Neb. Rev. Stat. Sec. 84-914, R.R.S. 1943.

001.05G The Director shall issue a written decision which shall be accompanied by findings of fact and conclusions of law. The findings of fact shall be based on the evidence submitted at the hearing pursuant to Neb. Rev. Stat. Sec. 84-914, R.R.S. 1943.

001.05H The Director shall transmit the written decision to the parties to the proceeding by certified or registered mail within 30 working days of the hearing.

001.05I Appeals to the District Court from any order or decision of the Director shall follow the statutory requisites set forth in Neb. Rev. Stat. Sec. 84-917 R.R.S. 1943 unless specifically provided for otherwise in statute.

001.05J The Director may terminate formal hearing procedures at any point if the Department and Area Agency on Aging or the provider that requested the hearing negotiate a written agreement that resolves the issues or issues which led to the hearing.

001.06 Governing Units of Area Agencies on Aging

001.06A Each governing unit shall establish written policies and procedures for the selection, appointment and annual performance rating of its chief executive officer and staff including minimum qualifications of education, training, and experience for its chief executive officer.

001.06B Each governing unit shall provide for the employment of sufficient staff to carry out the area agency's approved Area Plan and Budget and Annual Plan and Budget.

001.06C Each governing unit shall approve an Annual Plan and Budget and a five-year Area Plan and Budget which shall be in compliance with this Act, its rules and regulations, the Older Americans Act, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B. The Annual Plan and Budget must be submitted to the Department by July 1 of each year.

001.06D Each governing unit shall approve such contracts and agreements as are necessary to carry out the functions of the Area Agency on Aging.

001.06E The governing unit shall establish and consult with an area advisory council on needs, services, and policies affecting older persons in the area.

001.06E1 The advisory council shall establish bylaws specifying its role and function, number and selection of members, and term of membership and frequency of meetings.

001.06E1a The Council shall meet at least quarterly.

001.06E1b Composition of Council. As described in Section 1321.57(b) of the attached rules and regulations of the Older Americans Act, Attachment B, the council shall include individuals and representatives of community organizations who will help to enhance the leadership role of the area agency in developing community-based systems of services. The advisory council shall be made up of:

1) More than 50 percent older persons, including minority individuals who are participants or who are eligible to participate in programs under this part;

2) Representatives of older persons;

3) Representatives of health care provider organizations, including providers of veterans' health care, if appropriate;

4) Representatives of supportive services providers organizations;

5) Persons with leadership experience in the private and voluntary sectors;

6) Local elected officials; and

7) The general public.

001.06E2 The advisory council may include a representative of developmental disability organizations within the PSA of the Area Agencies on Aging.

001.07 Area Plan and Budget. Each Area Agency on Aging shall submit to the Department for approval an Area Plan and Budget that covers a period of 5 years from the date of approval. The Area Plan and Budget, which shall outline a comprehensive and coordinated program of community aging services for older persons within the PSA, shall be in compliance with the Act and its rules and regulations and with the Older Americans Act, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B. Each Area Plan and Budget shall include, but not be limited to, the following items:

001.07A A statement of mission;

001.07B A narrative and statement of goals and objectives including a time frame and plan for implementation;

001.07C Provisions of the Act and the Older Americans Act, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B;

001.07D A statement describing how the Area Agency on Aging develops, administers, and supports the comprehensive coordinated program of community aging services in its PSA

001.07E A statement describing how the Area Agency on Aging monitors and evaluates the activities of service providers.

001.07F A statement describing how the Area Agency on Aging provides technical assistance to service providers.

001.07G A budget to implement the Area Plan.

001.07H Procedures to evaluate compliance with the Area Plan and Budget on an annual basis.

001.07I Documentation to substantiate the following assurance items subject to review by the Department during assessment:

1) The program is administered in accordance with the Act, these rules and regulations, and the Area Plan.

2) Policies, procedures and methods as are necessary for the proper and efficient administration of the Plan in accordance with the Act, these regulations, and the Area Plan.

3) Uniform administrative requirements and cost principles are in compliance with the relevant provisions of applicable regulations of the Department.

4) Sufficient fiscal control and accounting procedures are maintained to assure proper disbursement of and accounting for funds under this Plan. Records shall be maintained which identify adequately the source and application of funds for grant or subgrant support activities.

5) Providers of service under the Area Plan operate fully in conformance with all applicable Federal, State, and local fire, health, safety and sanitation and other standards prescribed in law or regulations. The Area Agency provides that where the State or local public jurisdictions require licensure for the provision of services, agencies providing such services shall be licensed.

6) Such standards and procedures as are necessary to meet the requirements provided in Neb. Rev. Stat. Sec. 81-2214.02, R.R.S. 1943 regarding safeguarding confidential information.

7) The Area Agency shall furnish such reports and evaluations to the Department as may be required to be in compliance with the Act, its rules and regulations, the Older Americans Act, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B.

8) Each program funded through the Area Agency on Aging operates its program or activity in a manner accessible to handicapped persons.

9) That benefits and services available under the Area Plan are provided in a non-discriminatory manner.

10) A third party blanket liability coverage is in force, sufficient to protect it in case of accident on project premises.

11) A statement acknowledging responsibility for: the subgranting and subcontract of Area Agency on Aging funds, the fiscal accountability for these funds, the meeting of all State requirements and any conflicts of interest arising from any grants, contracts, subgrants, or subcontracts under this Area Plan.

12) A statement that the Area Agency has and will maintain on file the Interlocal Cooperation Agreement and By-Laws under which it operates and will make those available on request.

001.07J Disasters. Each Area Agency on Aging shall have on file a current plan for services to the elderly during disasters, including, but not limited to, tornado (high winds), chemical, nuclear, flood and blizzards. The plan will show the coordination with Civil Defense and Red Cross and its pyramid alert system, including notification of the Department's disaster coordinator.

001.07K Providing services. Each Area Agency on Aging shall submit in its plan a description and/or explanation of:

1) A reasonable and objective method for determining the needs of all eligible residents of all geographic areas in the PSA for allocating resources to meet those needs.

2) A reasonable and objective method for establishing priorities for service and such methods are in compliance with the Act.

3) A method to assure that Older Americans Act and Community Aging Services Act funds are used to serve only those individuals and groups eligible under these Acts and their rules and regulations.

4) How the plan addresses the needs of older individuals with the greatest economic need and the greatest social need.

5) A plan to coordinate and utilize as much as possible the services and resources of other appropriate public and private agencies and organizations.

6) A plan that provides that in the operations and programs conducted under this Area Plan by the Area Agency or any contractors, any contributions received will be collected in a manner which provides the client maximum confidentiality.

001.07L Community Focal Point. Each Area Agency on Aging shall designate at least one community focal point within the boundaries of each participating county in its planning and service area.

001.07L1 Each Area Agency on Aging shall maintain an accurate listing of the Community Focal Points, shall provide the Department with the listing, and shall update that listing on a continuous basis.

001.07M The Area Agency will make available in its offices during ordinary business hours the Area Plan and Budget, Annual Plan and Budget, all periodic reports, and all policies governing the administration of the program in the area, for review upon request by interested persons.

001.07N Confidentiality of Records and Information. The Area Plan and Budget will contain written policies and procedures governing the confidentiality and information of all clients of the Area Agency. No client record or information of sensitive or confidential nature will be disclosed or released to any other party except with the written consent of the client or his/her legal representative, unless the disclosure is required by court order or is necessary for program monitoring by authorized federal, state, or local monitoring agencies, including the Department.

001.07O Contribution for Services. The Area Plan and Budget will contain policies and procedures to ensure that those using services funded in whole or in part with Older Americans Act funds are provided a free and voluntary opportunity to contribute to the cost of the services and their privacy is protected with respect to their contribution. Such policies and procedures shall include but not be limited to:

001.07O1 A posted notice of the cost of each service in all congregate facilities.

001.07O2 A means of providing contributions with anonymity.

001.07O3 The availability of envelopes for confidential contributions for services provided in the home.

001.07O4 Written listings of total costs of services, recommended contributions, and fee schedules shall be presented in such a manner as not to be mistaken for a bill or invoice for services rendered.

001.07P Expansion. Each Area Plan and Budget shall include policies and procedures for expansion of activities in the PSA including services and/or programs in unreached areas and new or expanded services and/or programs in areas currently receiving services.

001.07Q Reduction. Each Area Plan and Budget shall include policies and procedures for reducing services in the PSA when federal, state, or local funding sources are decreased or are no longer adequate to continue the current level of activity.

001.07R Eligibility. Area Plans and Budgets shall describe procedures for determining eligibility for receiving Community Aging Services. Determination shall take into account:

001.07R1 For congregate activities, the area's community and older citizens' needs, resources, and standards and the recommendations of the area advisory council; and

001.07R2 For individual services, an assessment of an individual's or family's circumstances and the development of a service plan.

001.07R3 There shall be no requirements as to duration of residence or citizenship as a condition of participation in the Area Agency's program.

001.07S Use of Senior Centers. The Area Agency on Aging shall be responsible for the following requirements regarding the length of time a senior center shall be used as an aging service center when funds granted by the Department are used in its acquisition, renovation, or construction, pursuant to the Older Americans Act:

001.07S1 A facility purchased for use as a senior center shall be used for at least 10 years from the date of acquisition.

001.07S2 A facility constructed for use as a senior center shall be used for at least 20 years from the date of completion of construction.

001.07S3 Facilities which involve renovation costs of more than $20,000 of state/federal money or more than 50 percent of the fair market value shall be used for at least 10 years.

001.07T Review and Approval. Upon review and approval, the Department will notify the Governing Board of the Area Agency on Aging of acceptance or non-acceptance of the Area Plan and Budget.

001.07U Plan amendment. Amendments to the Area Plan and Budget must be approved by the Department prior to implementation. Implementation of an amendment without prior approval shall constitute non-compliance and may be cause for withdrawal of designation.

001.07U1 Amendments to Area Plans and Budgets. Any request for approval of amendment must be accompanied by:

1) Reason for the requested change;

2) Proposed amended budget;

3) Proposed amended level of service or goals and objectives;

4) Any pages of the Annual Plan and Budget (and the Area Plan and Budget) that are altered as a result of the changes;

5) Records of public hearings on any changes which are substantial or which adjust scope or direction.

001.07V If, after review, the Department finds that the proposed Area Plan and Budget fails to address the Act, these rules and regulations, the Older Americans Act, as amended, or its rules and regulations, attached and incorporated herein by reference as Attachment B, the Department shall return the proposed Area Plan and Budget to the Area Agency on Aging for revision.

001.07V1 The notice of revision will state items to be revised.

001.07V2 The Area Agency on Aging will have 45 days to resubmit the revised Area Plan and Budget to the Department.

001.07W Failure to have an approved or conditionally approved Area Plan and Budget shall constitute non-compliance with the Act and these rules and regulations and shall be cause for withdrawal of designation.

001.07X Ninety (90) days prior to the expiration of an Area Plan and Budget, the Area Agency on Aging shall submit a new or revised Area Plan and Budget to cover the next five year period. Prior to submission of a new Area Plan and Budget, the Area Agency shall:

1) hold at least one public hearing within its PSA to gather comments on the proposed Area Plan and Budget; and

2) make available draft copies of the Area Plan and Budget to service providers and other agencies and local governments in the PSA for comment; and

3) revise draft responding to comments of the public, service providers and other agencies and local governments, insofar as they are consistent with the Act and these regulations; and

4) have approval of the Area Plan and Budget by the Governing Board of the Area Agency on Aging.

001.08 Annual Plan and Budget. Each Area Agency on Aging shall submit to the Department for approval an Annual Plan and Budget. The Annual Plan and Budget shall provide detailed programmatic narrative and budget narrative describing how the Area Agency on Aging will implement goals and objectives of its Area Plan and Budget during the ensuing fiscal year.

001.08A The Annual Plan and Budget shall contain at least the following:

001.08A1 A report of performance on goals and objectives of the area plan;

001.08A2 Statements of program objectives to be accomplished within the one-year plan period.

001.08A3 Budget narratives which shall:

1) Explain the relationship between objectives and budgets;

2) Provide cost itemization of equipment with cumulative cost of $5,000 or more and expenditures involving renovation, construction, and data processing equipment;

3) Identify any proprietary/for profit contracts.

001.08A4 An indication of planned expansion or reduction activities.

001.08B The Department shall review the Annual Plan and Budget prior to approval. The review will include but not be limited to:

1) a review of Area Agency objectives and their relationships to the plan and budget;

2) a review of the last assessment of the Area Agency on Aging including progress made on any deficiencies found during that assessment;

3) evidence of coordination with other agencies;

4) targeting of resources to socially and economically needy, low-income minority, rural older persons and Native Americans;

5) maintenance of effort as described in Section 001.11 of these regulations;

6) a match of no less than 25% of such approved plan and budget from local sources; and

7) compliance with the Act, these Rules and Regulations and the Older Americans Act, as amended, and its rules and regulations, as attached and incorporated herein by reference as Attachment B.

001.08C Upon approval, the Department shall issue a Notification of Grant Award (NGA) to the Area Agency on Aging. Acceptance of the NGA by the Governing Board of the Area Agency on Aging is required before the Annual Plan and Budget is effective.

001.08D If, after review, the Department determines revisions must be made in the submitted Annual Plan and Budget in order to be in compliance with 001.08A and 001.08B of these regulations, a notice of revision will be mailed to the Area Agency on Aging, stating items to be revised.

001.08E An Area Agency on Aging will have 15 days to resubmit a revised Annual Plan and Budget.

001.08F If the Department fails to approve an Annual Plan and Budget before the start of a new fiscal year, the Department may do any of the following:

1) Issue an NGA providing conditional approval, setting the conditions and date for compliance;

2) Approve the continued operation by the Area Agency on Aging under the previously approved Annual Plan and Budget until a revised Annual Plan and Budget is approved, but in no case for more than 180 days.

001.08G Amendments of Annual Plan. The Department must approve amendments prior to implementation. Failure to apply for an amendment of the Annual Plan and Budget, or to receive approval for an amendment, shall constitute non-compliance and shall be cause for withdrawal of designation. Any request for approval of amendment must be accompanied by:

1) Reason for the requested change;

2) Proposed amended budget;

3) Proposed amended service or action statement;

4) Any pages of the Annual Plan and Budget (and the Area Plan and Budget) that are altered as a result of the changes;

5) Records of public hearings on any changes which are substantial or with a change in scope or direction.

001.09 Reporting Requirements. Each Area Agency on Aging shall submit required program and financial reports to comply with state requirements and federal requirements in 45 CFR Part 74 and Part 92, as referenced in Attachments A and C, incorporated herein by reference.

001.09A Each Area Agency on Aging shall use the Nebraska Department on Aging Service Reporting System, a computer program developed by the Department in 1989 to generate required data reports. Reports shall be submitted by due dates determined by the Department.

001.09B Each Area Agency on Aging shall be responsible for obtaining and reporting necessary information from those sub-grantees and service providers with whom they have sub-grants or contracts.

001.09C Each Area Agency on Aging shall obtain and file with the Department an audit report in compliance with OMB Circular 128, contained in Attachment A, incorporated herein by reference, by September 30th of each year. The audit shall be conducted in accordance with generally accepted auditing standards.

001.10 Grants/Reimbursement. The Department shall reimburse through a grant to each Area Agency on Aging 75% of the actual cost of providing activities and services as described in its approved Plan and Budget, which are eligible for funding under Neb. Rev. Stat. Sec. 81-2222, R.R.S. 1943.

001.10A Such reimbursements shall be made from:

1) State funds appropriated to the Department under the Act; and

2) Federal funds allocated to the Department, including funds allocated under the Older Americans Act, as amended.

001.10B If appropriated state or federal funds are insufficient to finance the approved budget for each Area Agency on Aging, the reimbursement to each Agency shall be proportionately reduced.

001.10C If an Area Agency on Aging chooses to exceed the approved budget, the Department shall not reimburse costs in excess of the approved budget.

001.10D To qualify for reimbursement, an Area Agency on Aging shall provide no less than 25 percent of the approved budget from local sources, which shall include but not be limited to:

1) Local public tax dollars, federal revenue sharing trust funds and local government in-kind donations in the form of rent, building space, utilities, utility repair, paving, sewer fees, equipment, labor materials, supplies, etc., provided they are program related.

2) Local "other" donations in the form of labor, materials, supplies, acceptable safe food, transportation services, furniture, equipment, provided they are program related, and cash.

3) Participant contributions and fees.

001.11 Maintenance of effort. Area Agencies on Aging receiving state funds under the Act shall expend, as a minimum, in their budgets, the same level of local public tax dollars as was expended under the Annual Plan and Budget for the year ending June 30, 1981.

TITLE 15 AGING SERVICES

CHAPTER 2 DESIGNATION, AREA PLAN, AND BUDGET

001. SCOPE AND AUTHORITY. These rules and regulations implement Nebraska Revised Statute (Neb. Rev. Stat.) §§ 81-2201 to 81-2227 (the Act) and the Older Americans Act of 1965 (OAA).

002. DEFINITIONS. Definitions are located in this Title, Chapter 1.

003. DESIGNATION AND CONTINUED DESIGNATION. A proposed Area Agency on Aging must comply with applicable legal requirements to be designated, and an existing Area Agency on Aging must continue to comply with applicable legal requirements to continue to be designated, according to the Act and the Older Americans Act of 1965 (OAA).

003.01 AUTHORITY. A proposed Area Agency on Aging must demonstrate its authority to be designated to the State Unit on Aging, which includes providing to the State Unit on Aging copies of the following documents:

(A) An Interlocal Cooperation Act agreement signed by the chief elected officials of participating counties within its Planning and Service Area;

(B) Authority to accept and utilize funds for aging services as specified by the Act, this Title, and the Older Americans Act of 1965;

(C) Authority to develop and implement policies and procedures for administration, services and program development, program records, data collection, and planning. Policies and procedures, including the following, are to be in writing and on file:

(i) A statement that the Agency is an Equal Opportunity Employer with an Affirmative Action Plan;

(ii) By-laws for the Governing Unit;

(iii) By-laws for an Advisory Committee;

(iv) Use of property;

(v) Confidentiality and storage of confidential material; and

(vi) Personnel policies which include: job descriptions for each Area Agency employee, code of ethics, leave, travel, discipline, performance evaluation, hiring and termination, grievance procedures, and accounting and financial management;

(D) Collected and evaluated views of units of general purpose local government gathered in public hearing in the Planning and Service Area prior to seeking designation;

(E) Evidence that the views of older persons have been considered and evidence of support from older persons in the Planning and Service Area;

(F) Evidence of support from Units of General Purpose Local Government and human service agencies and community organizations in the Planning and Service Area; and
(G) Authority to be an advocate for older persons in the Planning and Service Area.

003.02 CAPACITY REVIEW. A proposed Area Agency on Aging must demonstrate its capacity to be designated to the State Unit on Aging, which includes providing to the State Unit on Aging documents demonstrating its capacity to carry out the following:
(A) The planning, organizing, staffing, directing, and supervision of a comprehensive and coordinated program of services for older Nebraskans;
(B) Monitoring, evaluating and commenting on policies, programs, hearings, and community actions which affect older persons;
(C) Conducting public hearings, studies, and assessments of the needs of older persons;
(D) Representing the interest of older persons;
(E) Conducting activities in support of the Department's Long-Term Care Ombudsman and Legal Services program as required by the Older Americans Act of 1965;
(F) Coordinating planning with other agencies and organizations to promote programs and opportunities which benefit older persons;
(G) Providing technical assistance to providers of services and to multipurpose senior centers in the Planning and Service Area;
(H) Establishing effective and efficient procedures for the coordination between the programs assisted by the Department and other programs available to older Nebraskans; and
(I) Carrying out the intention of the Act and these rules and regulations and the Older Americans Act of 1965, and its rules and regulations.

003.03 PUBLIC HEARING. A proposed Area Agency on Aging must conduct a public hearing to consider the views of units of general purpose local governments in its planning and service area.

003.04 PROPOSAL AND SUPPORT. A proposed Area Agency on Aging must obtain within its planning and service area the support of the chief elected officials of the units of general purpose local governments formed under the Interlocal Cooperation Act (Neb. Rev. Stat. §§ 13-801 – 13-827).

003.05 ON-SITE ASSESSMENT. A proposed or designated Area Agency on Aging must allow the State Unit on Aging to conduct assessments, including on-site assessments, which may include an evaluation of the proposed or designated Area Agency on Aging's performance in carrying out responsibilities and functions, an evaluation of goals and objectives under any approved plan or budget, onsite visits, client interviews, a review of performance and fiscal reports, and a review of any plan.

004. WITHDRAWAL OF DESIGNATION.

004.01 REASONS FOR WITHDRAWAL. The Department may revoke an Area Agency on Aging's designation, and may accordingly withhold all or a portion of a grant award, for any of the following reasons:
(A) Voluntarily withdrawal;
(B) Adverse change in authority or capacity to perform;

(C) Malfeasance in, or failure of, administration;
(D) Failure to implement an approved plan or budget;
(E) Refusal to serve older persons in the planning and service area with a program of services as outlined in an approved plan or budget;
(F) Misappropriation of funds;
(G) Failure to obtain approval, in advance, for any proposed amendment to an approved plan or budget;
(H) Failure to meet the conditions of the subaward from the State Unit on Aging; or
(I) Failure to comply with applicable law, including the Act, this Title, or the Older Americans Act of 1965.

004.02 RECONSIDERATION. If its proposed designation is denied, a proposed Area Agency on Aging may submit a request for reconsideration within 30 days of the date that the State Unit on Aging issued its denial, which shall include sufficient reasons why designation should occur and supporting documentation.

If an existing designation is revoked, an Area Agency on Aging may submit a request for reconsideration within 30 days of the date that the State Unit on Aging issued its revocation, which shall include sufficient reasons why designation should not be revoked, supporting documentation, and a proposed plan of corrective action that indicates an understanding and acknowledgment of the reason(s) for the designation revocation, describes the steps to be taken to remedy the reason(s), indicates the expected outcome(s) for each proposed remediation step, and describes the time frame to which the Area Aging on Aging would expect to be held to remedy the reason(s) for the designation revocation, if the State Unit on Aging were to reconsider revocation and accept the proposed corrective action plan. The Area Agency on Aging must not implement a proposed plan prior to the granting of its request for reconsideration and approval of the proposed corrective plan by the State Unit on Aging.

004.03 FAILURE OF SECOND CHANCE. If an Area Agency on Aging fails to comply with a corrective action plan that was approved by the State Unit on Aging, the Area Agency on Aging will have its designation revoked by the State Unit on Aging.

004.04 APPEAL PROCESS. A decision by the Department to deny or revoke designation may be appealed in writing to the director of the State Unit on Aging within 10 days of the date the denial or revocation notice was sent. Appeal and hearing procedures are governed by the Administrative Procedures Act, Neb. Rev. Stat. Sec. 84-917 and 465 NAC 6.

005. GOVERNANCE.

005.01 SUFFICIENT STAFFING. An Area Agency on Aging must provide for the employment of sufficient staff to carry out its approved plan and budget.

005.02 PLAN AND BUDGET APPROVAL. An Area Agency on Aging must submit a budget to the State Unit on Aging no later than May 1 of each year.

005.03 THIRD-PARTY SERVICES APPROVAL. An Area Agency on Aging must approve appropriate subawards, contracts and agreements that are necessary to carry out its functions

005.04 ADVISORY COUNCIL CONSULATATION. An Area Agency on Aging must establish and consult with an area advisory council on needs, services and policies affecting older persons in the area.

005.05 ADVISORY COUNCIL BYLAWS. The advisory council must establish bylaws specifying its role and function, number and selection of members, and term of membership and frequency of meetings. The council must meet at least quarterly.

005.06 COMPOSITION OF COUNCIL. The advisory council may include a representative of developmental disability organizations within the planning and service area. The council must include individuals and representatives of community organizations to enhance the leadership role of the Area Agency on Aging in developing community-based systems of services. The advisory council must be made up of:

(A) More than 50 percent older persons, including minority individuals who are participants or who are eligible to participate in programs under this Title;
(B) Representatives of older persons;
(C) Representatives of health care provider organizations, including providers of veterans' health care, if appropriate;
(D) Representatives of supportive services providers' organizations;
(E) Persons with leadership experience in the private and voluntary sectors;
(F) Local elected officials; and
(G) The general public.

006. AREA PLAN. An Area Agency on Aging must submit to the State Unit on Aging for approval an Area Plan that covers a period of two, three, or four years (as indicated by the State Unit on Aging) from the date of approval. The Area Plan, which must outline a comprehensive and coordinated program of community aging services for older persons within the planning and service area, must be in compliance with applicable law, including the Act, this Title, and with the Older Americans Act of 1965. A proposed Area Plan must include the following items:

(A) A statement of mission;
(B) A narrative and statement of goals and objectives, including a time frame and plan for implementation;
(C) A statement indicating an intent to comply with applicable law, including the Act, this Title, and with the Older Americans Act of 1965;
(D) A statement describing how the Area Agency on Aging develops, administers and supports the comprehensive coordinated program of community aging services in its Planning and Service Area;
(E) A statement describing how the Area Agency on Aging monitors and evaluates the activities of service providers;
(F) A statement describing how the Area Agency on Aging provides technical assistance to service providers;
(G) Procedures to evaluate compliance with the Area Plan and budget;
(H) Documentation to substantiate the following items:
    (i) The program is administered in accordance with applicable law and the approved Area Plan;
    (ii) Policies, procedures and methods that are necessary for the proper and efficient administration of the Area Plan exist in writing and are followed;

(iii) Uniform administrative requirements and cost principles are in compliance with the relevant provisions of applicable law;

(iv) Sufficient internal control and accounting procedures are maintained in accordance with generally accepted accounting principles (GAAP) to ensure proper disbursement of and accounting for funds under the approved plan. Fiscal records must be maintained for three years from the date of final payment, except records that fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) must be maintained for six full years from the date of final payment. (Health Insurance Portability and Accountability Act [HIPAA] procedures must be compliant with Code of Federal Regulations (CFR) 45 Sec.160, Sec.162, and Sec.164.) Records must identify adequately the source and application of funds for grant or subaward support activities;

(v) Providers of service under the Area Plan operate fully in conformance with all applicable federal, state, and local fire, health, safety and sanitation and other standards prescribed in law or regulations. The Area Agency on Aging requires that when the state or local public jurisdictions require licensure for the provision of services, agencies providing the services must be licensed;

(vi) Standards and procedures that are necessary to meet the requirements provided in Neb. Rev. Stat. § 81-2214.02, regarding safeguarding confidential information exist in writing and are followed;

(vii) The Area Agency on Aging furnishes reports and evaluations to the State Unit on Aging as requested and as required by law;

(viii) Each program funded through the Area Agency on Aging operates its program or activity in a manner accessible to persons with disabilities;

(ix) Benefits and services available under the Area Plan are provided in a non-discriminatory manner;

(x) A third-party blanket liability coverage is in force, reasonably sufficient to cover an accident on project premises;

(xi) A statement acknowledging responsibility for: the subgranting and subcontract of Area Agency on Aging funds, the fiscal accountability for these funds, the meeting of all state requirements and the avoidance of any conflicts of interest arising from any grants, contracts, subgrants, or subcontracts under the plan; and

(xii) A statement that the Area Agency on Aging has a copy of the Interlocal Cooperation Agreement and bylaws under which it operates, maintains it, and that is available on request.

006.01 DISASTERS. An Area Agency on Aging must have a current plan for services, a copy of which is available on request, to the elderly during disasters, including, but not limited to, a tornado (high winds), chemical event , nuclear event, flood, and blizzard. The plan must show the coordination with Civil Defense and Red Cross and its pyramid alert system, including notification of the Department's disaster coordinator.

006.02 PROVIDING SERVICES. An Area Agency on Aging must submit in its plan a description or explanation, or both, of:

(A) A reasonable and objective method for determining the needs of all eligible residents of all geographic areas in the Planning and Service Area for allocating resources to meet those needs;

(B) A reasonable and objective method for establishing priorities for service and how the methods are in compliance with the Act;
(C) A method to ensure that Older Americans Act of 1965 and Community Aging Services Act funds are used to serve only those individuals and groups eligible under these Acts and their rules and regulations;
(D) How the plan addresses the needs of older individuals with the greatest economic need and the greatest social need;
(E) A plan to coordinate and utilize as much as possible the services and resources of other appropriate public and private agencies and organizations; and
(F) A plan that provides that in the operations and programs conducted by the Area Agency on Aging or service providers, any contributions received are to be collected in a manner which provides the client maximum confidentiality.

006.03 COMMUNITY FOCAL POINT. An Area Agency on Aging must designate at least one community focal point within the boundaries of each participating county in its planning and service area.

006.04 COMMUNITY FOCAL POINT LIST. An Area Agency on Aging must maintain an accurate listing of the community focal points, must provide the Department with the listing, and must update that listing as needed.

006.05 AVAILABILITY OF DOCUMENTS. An Area Agency on Aging must make available in its offices during ordinary business hours its Area Plan and budget, all periodic reports, and all policies governing the administration of the program in the area, for review by interested persons.

006.06 CONFIDENTIALITY OF RECORDS AND INFORMATION. An Area Agency on Aging must include written policies and procedures in its plan governing the confidentiality and information of all clients. No client record or information of sensitive or confidential nature is to be disclosed or released to any other party except with the written consent of the client, unless the disclosure is required by applicable law.

006.07 CONTRIBUTION FOR SERVICES. An Area Agency on Agency must include policies and procedures in its plan to ensure that those using services funded in whole, or in part, with Older Americans Act of 1965 funds are provided a free and voluntary opportunity to contribute to the cost of the services and ensure that their privacy is protected with respect to their contribution. Policies and procedures must include, but not be limited to:
(A) A means of providing contributions with anonymity;
(B) The availability of envelopes for confidential contributions for services provided in the home; and
(C) Written listings of total costs of services, suggested contributions, and cost-sharing fee schedules presented in a manner not to be mistaken for a bill or invoice for services rendered.

006.08 EXPANSION. An Area Agency on Aging must include policies and procedures in its plan for expansion of activities in the planning and service area, including services or programs, or both, in unreached areas and new or expanded services or programs, or both, in areas currently receiving services.

006.09 REDUCTION. An Area Agency on Aging must include policies and procedures in its plan for reducing services in the planning and service area if federal, state, or local funding sources are decreased or are no longer adequate to continue the current level of activity.

006.10 ELIGIBILITY. An Area Agency on Aging must describe procedures in its plan for determining eligibility for receiving federal and state funded services. Determination must take into account:

(A) For congregate activities, the area's community and older citizens' needs, resources, and standards and the recommendations of the area advisory council; and
(B) For individual services, an assessment of an individual's or family's circumstances and the development of a service plan.

006.11 USE OF SENIOR AND MULTI-PURPOSE CENTERS. An Area Agency on Aging must follow any requirements regarding the length of time a senior center must be used as an aging service center when funds granted by the State Unit on Aging are used in its acquisition, renovation, or construction, pursuant to the Older Americans Act of 1965, Section 312.

006.12 AMENDMENTS TO AREA PLANS AND BUDGETS. Any request for approval of an amendment must be accompanied by:

(A) Reason(s) for the requested change;
(B) Proposed amended budget;
(C) Proposed amended level of service or goals and objectives;
(D) Any pages of the Area Plan or budget, or both, that are altered as a result of the proposed change(s); and
(E) Records of public hearings on any changes which are substantial or which adjust scope or direction.

006.13 PLAN DEFICIENCIES. An Area Agency on Aging must revise the proposed Area Plan if the State Unit on Aging finds that the proposed plan fails to comply with the Act, this Title, or the Older Americans Act of 1965, or its rules and regulations.

006.14 NOTICE OF REVISION. The Notice of Revision states the items to be revised.

006.15 PLAN RESUBMISSION. The Area Agency on Aging must resubmit the revised Area Plan to the Department within 45 days from the postmark of the Notice of Revision.

006.16 NON-COMPLIANCE. Failure to have an approved, or conditionally approved, Area Plan constitutes non-compliance with the Act and these rules and regulations and will require withdrawal of designation.

006.17 NEW OR REVISED PLAN. Ninety days prior to the expiration of an Area Plan, the Area Agency on Aging must submit a new or revised Area Plan to cover the next two, three, or four year period. Prior to submission of a new Area Plan, the Area Agency must:

(A) Hold at least one public hearing within its Planning and Service Area to gather comments on the proposed Area Plan;
(B) Make available draft copies of the Area Plan to service providers and other agencies and local governments in the Planning and Service Area for comment;

(C) Revise draft Area Plan responding to comments of the public, service providers, and other agencies and local governments, insofar as they are consistent with the Act and this Title; and
(D) Obtain approval of the Area Plan by the Governing Unit of the Area Agency on Aging.

007. ANNUAL BUDGET. Each Area Agency on Aging must submit to the Department for approval an annual budget. The budget must detail how the Area Agency on Aging implements goals and objectives during the ensuing fiscal year. The annual budget must:

(A) Tie taxonomy services between service unit projections and budgets;
(B) Provide cost itemization of equipment with cumulative cost of $5,000 or more and expenditures involving renovation, construction, and data processing equipment;
(C) Identify any proprietary or for profit contracts;
(D) Identify all subgrantees and contractors who receive Older Americans Act of 1965 funds, including dollar amounts for each; and
(E) Provide an indication of planned expansion or reduction activities.

007.01 DEPARTMENT REVIEW. The Department will review the annual budget prior to approval. The review will include, but not be limited to:

(A) A review of Area Agency objectives and their relationships to the Area Plan and budget;
(B) A review of the last assessment of the Area Agency on Aging including progress made on any deficiencies found during that assessment;
(C) Evidence of coordination with other agencies;
(D) Targeting of resources to socially and economically needy, low-income minority, rural older persons and Native Americans;
(E) A match of no less than 25% of the approved Area Plan and budget from local sources; and
(F) Compliance with the Act, these Rules and Regulations and the Older Americans Act of 1965, and its rules and regulations.

007.02 SUBAWARD ISSUANCE. The Governing Unit of the Area Agency on Aging must accept the subaward or grant before the annual budget is effective, once approved and issued by the Department. Acceptance of the subaward or grant is accomplished by the return of an executed subaward or grant.

007.03 NOTICE OF REVISION. An Area Agency on Aging will receive a notice of revision, which states the items to be revised, if, after review, the Department determines revisions to the submitted annual budget are required to be in compliance with the Act, this Title, the Older Americans Act of 1965, or its rules and regulations.

007.04 RESUBMISSION. An Area Agency on Aging must resubmit a revised annual budget within 15 days from the postmark of the rejection by the Department of the annual budget.

007.05 DEPARTMENT OPTIONS. If the Department does not approve an annual budget before the start of a new fiscal year, the Department may do any of the following:

(A) Issue a subaward or grant providing conditional approval, setting the conditions and date for compliance; or

(B) Approve the continued operation by the Area Agency on Aging under the previously approved Area Plan or budget, or both until a revised annual budget is approved, but in no case for more than 180 days.

007.06 AMENDMENTS OF ANNUAL BUDGET. Before an Area Agency on Aging can implement its budget, the Area Agency on Aging must obtain the approval of the budget from the Department. Failure to apply for an amendment of the annual budget, or to receive approval for an amendment, constitutes non-compliance and is cause for withdrawal of designation. Any request for approval of amendment must be accompanied by:

(A) Reason for the requested change;
(B) Proposed amended budget;
(C) Proposed amended service or action statement;
(D) Any pages of the Area Plan and budget that are altered as a result of the changes; and
(E) Records of public hearings on any changes which are substantial or with a change in scope or direction.

008. REPORTING REQUIREMENTS. Each Area Agency on Aging must submit required program and financial reports to comply with state requirements and federal requirements in 45 CFR Part 74 and 2 CFR 200, respectively.

008.01 SERVICE REPORTING SYSTEM. Each Area Agency on Aging must use the Aging designated Service Reporting System. Service units, activities, and reports must be entered or submitted by the Area Agency on Aging by due dates set by the Department.

008.02 THIRD PARTY REPORTING. Each Area Agency on Aging must obtain and report necessary information from those sub-recipients and service providers with whom they have subawards or contracts.

008.03 AUDITS. Each Area Agency on Aging must obtain and file with the Department an audit report in compliance with the Office of Management and Budget (OMB) CFR 200 Part F. The audit must be conducted in accordance with generally accepted auditing standards.

009. GRANTS AND REIMBURSEMENT. Each Area Agency on Aging is reimbursed, through a subaward, up to 75 percent of the actual cost of providing activities and services as described in its approved Area Plan and budget that are eligible for funding under Neb. Rev. Stat. Sec. 81-2222.

009.01 SOURCES. The reimbursements are made from:

(A) State funds appropriated to the Department under the Act; and
(B) Federal funds allocated to the Department, including funds allocated under the Older Americans Act of 1965.

009.02 INSUFFICIENT FUNDING. If appropriated state or federal funds are insufficient to finance the approved budget for each Area Agency on Aging, the reimbursement to each Agency is proportionately reduced.

009.03 EXCEEDING APPROVED BUDGET. If an Area Agency on Aging chooses to exceed the approved budget, the Department cannot reimburse costs in excess of the approved budget.

009.04 REIMBURSEMENT QUALIFICATION. To qualify for reimbursement, an Area Agency on Aging must provide no less than 25 percent of the approved budget from local sources, which must include but not be limited to:

(A) Local public tax dollars, federal revenue sharing trust funds and local government in-kind donations in the form of rent, building space, utilities, utility repair, paving, sewer fees, equipment, labor materials, and supplies, provided they are program related; and

(B) Local "other" donations in the form of cash, labor, materials, supplies, acceptable safe food, transportation services, furniture, equipment, provided they are program related.

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Care Management Units

Chapter 2 - CARE MANAGEMENT UNITS

001 These rules and regulations implement Neb. Rev. Stat. Sec. 81-2229 - Sec. 81-2236, R.R.S. 1943 (the Act) which directs the establishment of a statewide system of Care Management Units through the Area Agencies on Aging.

001.01 DEFINITIONS

001.01A Area Agency on Aging shall mean an agency designated by the Nebraska Department on Aging in compliance with Neb. Rev. State Sec, 81-2201 - 81-2228, R.R.S. 1943.

001.01B Assessment shall mean the comprehensive appraisal of individual clients by making orderly and purposeful observations, conducting interviews, and recording the results of those observations and interviews on a standardized assessment document issued by the Department.

001.01C Care Management shall mean assisting a client to identify and utilize services needed to assure that the client is receiving, when reasonably possible, the level of care that best matches his or her level of need. The Care Management Unit through its Care Management Unit Supervisor and staff of care managers assists clients with services as specified in the Act, including ongoing consultation, assessment, Long-Term Care Plan development, and referral for clients in need of long-term care; coordination of the Long-Term Care Plan; monitoring of the delivery of services for clients, and review of the client's Long-Term Care Plan.

001.01D Care management Unit shall mean the organization which is created by, or which is contracting with an Area Agency on Aging, or the public or private entity contracting with the Department to provide care management services as defined in the Act and these rules and regulations.

001.01E Care Management Unit Supervisor shall mean the person who supervises a Care Management Unit.

001.01F Case Management is a term which is interchangeable in meaning with Care Management.

001.01G A Certified Care Management Unit is a Care Management Unit that has been found by the Department to meet the standards for certification under the Act.

001.01H Client shall mean a person in need of care management services or the legal representative of such person.

001.01I Continuum of Care shall mean the range of services designed to ensure that persons are receiving, when reasonably possible, the level of care that best matches their level of need.

001.01J Department shall mean the Nebraska Department on Aging.

001.01K Direct Care Program shall mean any program of an Area Agency on Aging, except care management, providing services to older individuals.

001.01L Eligible individual for services shall mean a person, primarily an individual 60 years-of-age or older, who resides in Nebraska, and who is in need of Long-Term Care as defined in Subsection 001.01P of these rules and regulations.

001.01M Environmental needs shall mean those factors required to maintain an individual in an appropriate and safe living arrangement.

001.01N Functional needs shall mean those factors that affect the individual's ability to perform the activities of daily living and the instrumental activities of daily living.

001.01O Individual approval or client approval shall mean confirmation given after full disclosure, usually a signature on a form by the client or client's legal representative.

001.01P Long-Term Care shall mean the caring for people who have unmet psycho-social, environmental or functional needs and who need assistance in meeting these needs for a three-month or longer time.

001.01Q Long-Term Care Plan shall mean a document prepared with a client by the Care Management Unit in compliance with Section 6, Subsection 6 of these rules and regulations.

001.01R Long-Term Care Planning shall mean the process used to prepare a Long-Term Care Plan.

001.01S Plan of Operation shall mean a plan prepared in compliance with Section 6 of these rules and regulations.

001.01T Psycho-Social needs shall mean those basic needs which include, but are not limited to, social participation, orientation, understanding, and a sense of well-being.

001.01U Older individuals, older Nebraskans, or older population are terms that shall mean persons who are 60 years of age or older.

001.01V Uniform Data Collection System shall mean the Nebraska Care Management Information System which is a computer software package adapted in 1988 for Nebraska from the "Client Oriented Case Management and Service Reporting System for the Aging Network" designed by the Long Term Care Gerontology Center in Kansas City, Kansas, and issued by the Department to certified care management units to collect and process data from the Nebraska Long Term Care Assessment Document made a part of these rules as Attachment B and financial data needed to calculate reimbursement for casework time units as provided in Section 8 of these rules and regulations and the Act.

002 CERTIFICATION PROCEDURES. Within 60 days of the adoption and promulgation of these rules and regulations, each Area Agency on Aging shall submit to the Department a Plan of Operation to either provide and supervise or subcontract for at least one certifies Care Management Unit to provide all eligible individuals residing in its planning and service area with long-term care management services.

002.01 The Plan of Operation shall comply with these rules and regulations for Care Management Units, and include all the elements specified in Section 006 below.

002.02 The Plan of Operation shall be submitted to the Nebraska Department on Aging, P. O. Box 95044, Lincoln, Nebraska.

002.03 An Area Agency on Aging may create more than one certified Care Management Unit to serve its planning and service area by submitting a Plan of Operation for each Care Management Unit for which it plans to provide and supervise or subcontract.

002.04 Within 30 days of receipt of the Plan of Operation, the Department shall complete its review and notify the governing board of the Area Agency on Aging of the Department's approval or denial of Certification. If Certification is denied, the Department shall provide the reasons for denial to the governing board of the Area Agency on Aging.

002.04A The Department may deny certification for any or all of the following reasons:

002.04A1 Failure to submit a complete Plan of Operation as outlined in these rules and regulations.

002.04A2 Failure to provide a Plan of Operation reasonably calculated to achieve the intent of the Act.

002.04A3 Failure to provide in the initial Plan of Operation a reasonable time frame for providing the opportunity for care management services to all eligible individuals within the planning and service area of an Area Agency on Aging.

002.04A4 Failure to operate a Care Management Unit separately from a Direct Care Program of an Area Agency on Aging.

002.04A5 Putting into effect any change to the Plan of Operation without prior approval from the Department.

002.05 The Area Agency on Aging shall have 30 days from the date it receives notice of the initial denial by the Department to submit a revised Plan of Operation.

002.06 Within 30 days of the receipt of a revised Plan of Operation, the Department shall notify the governing board of the Area Agency on Aging of its acceptance or denial of the revised Plan of Operation and reasons for denial.

002.06A During the initial Certification process, an Area Agency on Aging may not file a request for an appeal hearing until it has submitted a revised Plan of Operation as stated in the Act, and has received notice of denial of the revised Plan of Operation from the Department. The appeal hearing procedure is described in Section 3 of these rules and regulations.

002.07 If the Area Agency does not submit a revised Plan of Operation within 30 days of the denial, or if the revised Plan of Operation is denied by the Department, the Department may request proposals from and contract with another public or private entity to serve that planning and service area, providing such entity meets the provision for certification.

003 NOTICE OF APPROVAL AND CERTIFICATION; APPEAL RIGHTS. The Department shall forward a notice of approval of a Plan of Operation and Certification of a Care Management Unit to the Area Agency on Aging governing board or, as appropriate, to the governing board of a contracted public or private entity. Public notice of the Certification decision by the Department shall be made after the applicant has been informed of the decision.

003.01 A Care Management Unit provider aggrieved by a decision of the Department to deny approval of a Plan of Operation or Certification of a Care Management Unit shall have the right to appeal, and may exercise the right to appeal by filing a notice of appeal within ten working days of receiving notice of denial.

003.01A The Department shall set the date, time, and place of the hearing within five working days of receiving a request from an aggrieved applicant or provider. The hearing shall take place within thirty calendar days of the request.

003.01B The Department shall appoint an impartial hearing officer to conduct the hearing.

003.01C The hearing officer shall rule on motions and objections and may cross-examine any witnesses. The hearing officer shall prepare written findings of fact and conclusions of law and submit the same to the Director of the Department within twenty working days of the conclusions of the hearing. The Director of the Department either shall be in attendance or shall review the record of the hearing.

003.01D A representative may appear on behalf of the provider or the provider may be represented by counsel. There shall be opportunity to present witnesses and documentary evidence under the provision of Neb.Rev.Stat. Sec. 84-914, R.R.S. 1943.

003.01E The Director shall make a decision which shall be in writing and shall be accompanied by findings of fact and conclusions of law. The findings of fact shall be based on the evidence submitted at the hearing pursuant to Neb.Rev.Stat. Sec. 84-914, R.R.S. 1943.

003.01F The Department shall transmit the written decision to interested parties by certified or registered mail within thirty working days of the hearing.

003.01G Appeals to the District Court from any order or decision of the Department shall follow the statutory requisites set forth in Neb. Rev. Stat. Section 84-917 R.R.S. 1943 unless specifically provided for otherwise by statute.

003.01H The Department may terminate formal hearing procedures at any point if the Department and provider that requested the hearing negotiate a written agreement that resolves the issue(s) which led to the hearing.

003.02 If the Department has not certified another public or private agency, a provider whose Certification is denied may reapply for Certification ninety working days after the date of completion of the appeal process.

003.03 Approval of a Plan of Operation and Certification of Care Management Unit is valid for two years from the date granted unless revoked by the Department at an earlier date.

004 REVOCATION OF CERTIFICATION

004.01 The Department may revoke Certification at any time for any of the following reasons:

004.01A There is a change in ownership of the company or organization operating a Care Management Unit without the prior approval of the Department.

004.01B The Care Management Unit clients are being inadequately served; or that the resources allocated to the Care Management Unit by the Department or any other State or Federal source are being used in violation of the Act or of these rules and regulations.

004.01C The Care Management Unit fails to perform according to the approved Plan of Operation.

004.01D The Care Management Unit fails to provide services to all eligible persons in the planning and service area of the Area Agency on Aging as required by the Act, these rules and regulations and the Plan of Operation.

004.01E The Care Management Unit is not a separate operation from a Direct Care Program of the Area Agency on Aging.

004.01F The Care Management Unit fails to obtain approval from the Department for a change in its Plan of Operation.

004.01G The Care Management Unit is in violation of any of these rules and regulations or of the Act.

004.02 The Department shall notify the governing board of an Area Agency on Aging or other contractor of its intent to revoke Certification.

004.02A A Care Management Unit provider aggrieved by a decision of the Department to revoke Certification of a Care Management Unit shall be entitled to an appeal as described in Section 3 of these rules and regulations.

004.02B A provider whose Certification is revoked may reapply for Certification ninety working days after the date of revocation becomes final. For purposes of this subsection, revocation does not become final until the time for all appeals under the Administrative Procedures act has expired.

004.03 During the process of appeal of a revocation of Certification, a Care Management Unit may continue to serve those clients already being served, but may not take in new clients without the direct or contracted supervision of the Department.

004.03A The Department shall suspend reimbursement payments to the Care Management Unit for those clients it continues to serve during the process of appeal. If reimbursement is suspended and a decision to revoke Certification becomes final, the suspended reimbursement amount shall not be paid to the Care Management Unit. If upon conclusion of all hearings and appeals the Certification is not revoked, suspended reimbursement shall then be paid to the Care Management Unit.

005 RECERTIFICATION

005.01 An application for recertification must be submitted to the Department 90 to 120 calendar days prior to the expiration of each two-year certification period.

005.01A Failure to file for recertification will cause Certification to expire at the end of the two-year Certification period.

005.02 The application for recertification shall be submitted on the form issued by the Department and made a part of these rules and regulations as Attachment A.

005.03 Each application for recertification will be reviewed by the Department on the basis of the results of periodic reviews and of an on-site inspection including but not limited to a review of files and records and visits with clients and cooperating agencies to determine compliance with these rules and regulations and the Plan of Operation.

005.04 Notice of approval or denial of recertification will be issued by the Department prior to the expiration of the current Certification period.

005.04A The basis for approval or denial of recertification will be the same as in Section 2, Subsection 4A and Section 4. Subsection 1 of these rules and regulations, and will be based upon the results of the review conducted in Subsection 3 of this section and an evaluation of the performance of the Care Management Unit in meeting its goals and objectives outlined in its approved Plan of Operation.

005.04B In case of a denial, appeal procedures will be the same as those specified in Section 3 of these rules and regulations.

006 PLAN OF OPERATION

006.01 Each Plan of Operation for a Care Management Unit shall provide the following information.

006.01A A statement of the philosophy, and goals and objectives of the Care Management Unit. The goals and objectives shall include a timetable for making care management services available in an entire planning and service area of an Area Agency on Aging.

006.01A1 The statement of philosophy shall detail the approach to be used by the Care Management Unit is a) involving all support systems of a client, including family members, neighbors, or friends, b) utilizing all available care resources including community-based services and institutionalization; c) coordinating the delivery of a continuum of services; and d) assuring that persons are receiving, when reasonably possible, the level of care that best matches their level of need.

006.01B A statement of the procedures to receive input from local citizens in the formulation and implementation of the Plan of Operation, and the procedures to be used to inform eligible individuals on a regular schedule and in a comprehensive manner about Care Management Unit services.

006.01C A statement of methods to evaluate the attainment of program goals and objectives for the Care Management Unit, and how the evaluation findings will be documented and resolved.

006.01D A written representation that the Care Management Unit shall be operated separately from Direct Care Programs of an Area Agency on Aging.

006.01E Each Care Management Unit's Plan of Operation shall outline procedures for utilizing an interdisciplinary approach to care management.

006.01F A statement of criteria to be used to determine the priority of service to eligible clients in the event funds are insufficient to meet all the client needs of a Care Management Unit.

006.01G A statement detailing the grievance procedure available to clients of the Care Management Unit and the process to be used to resolve client complaints.

006.01H An annual budget of income and expenses for the Care Management Unit shall coincide with the state fiscal year and shall include units of services to be provided, and details of costs of a casework time unit as explained in Section 8 of these rules and regulations and the Act.

006.01H1 Each Area Agency on Aging shall report to the Department at the time of submission of the initial Plan of Operation the dollar value of funds appropriated under the Nebraska Community Aging Services Act and used for Care Management Service prior to August 30, 1987.

006.01H2 Each Care Management Unit shall have a procedure approved by the Department in its Plan of Operation for recording on a timesheet or other document the actual casework time units and Care Management Unit services provided each client.

006.02 Each Plan of Operation shall provide written policies and procedures for the administrative and programmatic operation of the Care Management Unit based upon the following minimum standards.

006.02A PERSONNEL POLICIES AND PROCEDURES. The Care Management Unit shall have a job description for each position as well as written personnel policies and procedures for hiring and selection, compensation, evaluation, disciplinary action and grievance, and supervision and training of employees, contractors, volunteers, students and/or interns. The personnel policies and procedures shall include:

006.02A1 An Equal Opportunity Policy that includes nondiscrimination on the basis of race, disability, color, sex, affiliation or age, and an Affirmative Action statement.

006.02A2 An organization chart which identifies the responsibility of each position in the Care Management Unit.

006.02A3 A policy that Care Management services for clients as outlined in 001.01C of these rules and regulations are the exclusive responsibility of the Care Management Unit Supervisor or care manager; except that a supervisor or care manager may delegate to staff of the Care Management Unit the performance of the services of referral, coordination of the Long-Term Care Plan, and monitoring of the delivery of services to clients if supervision is provided by the supervisor or care manager.

006.02B The designation of a Care Management Unit Supervisor responsible to implement the Plan of Operation and to supervise the activities of the staff and contractors.

006.02C The Care Management Unit Supervisor and care managers shall have the following minimum qualifications:

006.02C1 A current Nebraska license as a registered nurse, or baccalaureate or graduate degree in the human services field, or certification under the Nebraska Social Work Law; and

006.02C2 At least two years of experience in long-term care, gerontology or community health.

006.02C3 In addition, a Care Management Unit Supervisor shall have at least two years of supervisory or management experience.

006.02D ORGANIZATION. Each Plan of Operation shall provide information about the organization of the Care Management Unit as follows:

006.02D1 An organizational chart which shows that the Care Management Unit is operated separately from any Area Agency on Aging Direct Care Programs or from any Direct Care programs of another provider of a Care Management Unit.

006.02D2 An organizational chart showing the line of authority between the Care Management Unit Supervisor and the Area Agency on Aging or other public or private entity operating said unit.

006.02D3 A description of the process that a Care Management Unit will use to monitor contractors.

006.02D4 Each Care Management Unit shall maintain accounting records as necessary for presentation of financial statements in accordance with generally accepted accounting principles.

006.02D5 Each Care Management Unit shall obtain and file with the Department an audit report by September 30th of each year. The audit shall be conducted in accordance with generally accepted auditing standards resulting in an opinion of the financial statements of Subsection 006.02D4.

006.02E CLIENT RIGHTS. The Care Management Unit shall have written policies and procedures on client rights, and those rights shall be given to the client prior to the assessment. As used in this section, client shall mean the person receiving services or his or her legal representative. Written policies and procedures shall include as a minimum the following:

006.02E1 Each client has the right to accept or reject care management services.

006.02E2 Each client has the right to be consulted in the development and to approve or disapprove his or her Long-Term Care Plan.

006.02E3 Each client has the right to choose available services and providers of services.

006.02E4 Each client has the right to receive care management services without regard to race, color, sex, national origin, religion, or disability.

006.02E5 Each client has the right to be informed of the name of the care manager responsible for his/her case.

006.02E6 Each client has the right to receive a description of available care management services, fees charged, and billing mechanisms.

006.02E7 Each client has the right to have access to his or her care management service file and record unless access is restricted by law or a State or Federal regulation.

006.02E8 Each client has the right to register complaints and the right to file grievances without discrimination or reprisal from the Care Management Unit.

006.02F CONFIDENTIALITY. The Care Management Unit shall have written policies and procedures which govern confidentiality of case records and information including the following:

006.02F1 Procedures for maintaining confidentiality in releasing information to other agencies or professionals and in obtaining information from outside agencies or professionals. Forms for such release and receipt of client information must be part of the policies and procedures.

006.02F2 Methods and procedures used to secure and to control access to records.

006.02F3 Procedures to be followed by staff and/or contractors when participating in Long-Term Care Plan conferences or consultations involving outside agencies or professionals.

006.02F4 Procedures to put all release forms and/or other documents legally approving the release of information in the client file or record.

006.02F5 Procedures for maintaining confidentiality of case records in use and in storage, including computerized case data.

006.03 CLIENT FILES Each Plan of Operation shall include policies and procedures for establishment of client files and records which shall include all documents relating to the client.

006.02A The Department shall have authority to inspect and review client files and records to evaluate performance and achievement of the Care Management Unit and to verify and audit the services provided and information published by the Care Management Unit.

006.04 TRAINING. A training plan which shall include as a minimum:

006.04A An orientation training for employees, contractors, volunteers, students or interns commensurate with their responsibilities in the Care Management Unit.

006.04B Required participation by the Care Management Unit Supervisor in training provided by the Department.

006.04C A schedule for in-service training, which shall include, but not be limited to, policies and procedures of the Care Management Unit, and techniques, methods, and research on Care Management.

006.05 STANDARDIZED LONG-TERM CARE ASSESSMENT DOCUMENT. Each Plan of Operation shall provide for the use of the standardized long-term care assessment document issued by the Department and made a part of these rules and regulations as Attachment B.

006.05A Each care manager shall be trained by the Care Management Unit Supervisor prior to using the assessment document.

006.06 LONG-TERM CARE PLAN. Each Plan of Operation shall have written policies and procedures concerning Long-Term Care Plan development.

006.06A Each Long-Term Care Plan will be developed in consultation with the client after an assessment; and with the client's approval, the client's family will be consulted in the plan development.

006.06B Each Long-Term Care Plan shall outline procedures for utilizing an interdisciplinary approach to care management which involves input from a variety of professionals, agencies, which may be already involved with the client, and support systems which may be available to the client.

006.06C Each Long-Term Care Plan will utilize and coordinate available and appropriate public and private resources so that persons receive, when reasonably possible, the level of care that best matches their level of need.

006.06C1 Services which are needed but not available will be recorded in the Long-Term Care plan, as well as those rejected by the client.

006.06D As a minimum, the Long-Term Care Plan should:

006.06D1 Establish individual goals and objectives agreed to by the client.

006.06D2 Establish a time frame for implementation of the Long-Term Care Plan.

006.06D3 Define the services which are needed, including any equipment or supplies.

006.06D4 Define who will provide each service.

006.06D5 Specify the availability of services, supplies and/or equipment.

006.06D6 Specify the costs and methods of service delivery.

006.06D7 Provide for reassessment upon change in client status.

006.06E MONITORING. The Plan of Operation shall provide written policies and procedures which detail the Care Management Unit's system for periodic monitoring of the delivery of services to the client. The purpose of periodic monitoring is to reasonably insure the continued appropriateness and effectiveness of the services being delivered as outlined in the Long Term Care Plan.

006.06F REVIEW. The review of the client's Long-Term Care Plan is to determine its continued appropriateness and shall occur at least annually.

006.06G ON-GOING CONSULTATION. There shall be ongoing consultation, including the regular exchange of ideas and comments between the client and the Care Management Unit.

006.07 ACCESSIBILITY OF SERVICES. Each Plan of Operation shall provide for development of a comprehensive directory of available public and private resources that documents Continuum of Care services, including both form and informal community-based services and institutions for use in referral activities of the Care Management Unit.

006.08 UNIFORM DATA COLLECTION. Each Plan of Operation shall provide for use of the Nebraska Care Management Information System as defined in Section 1 of these rules and regulations and which will be provided by the department to the Care Management Unit upon Certification.

006.08A Each Care Management Unit will have access to a compatible computer in order to use the Nebraska Care Management Unit Information System, and will be responsible for data entry and verification for quarterly and annual reports.

006.09 PERIODIC REVIEW. The Department shall conduct periodic review of each Care Management Unit for the purpose of evaluating the Care Management Unit's compliance with the Act and these rules and regulations.

006.09A In conducting a periodic review, the Department shall have access to files and records of the Care Management Unit and the files and records of the provider, supervisor or contractor of a Care Management Unit.

006.09B The Department shall use the results of a periodic review in the process of determining if Certification of a Care Management Unit shall continue.

006.10 AMENDMENT OF THE PLAN OF OPERATION. A certified Care Management Unit shall not change its Plan of Operation or its practice under such plan unless the proposed amendment has been submitted to and approved by the Department.

007 FEE SCALE. Each Care Management Unit shall use the fee scale as adopted and promulgated by the Department and set out in 007.03.

007.01 The fee scale will be based on family income defined as follows:

007.01A Family income is the total income the individual and spouse (in any) receives annually.

007.01B Income is money received as profit from fees (net income after business expenses, before taxes) from a person's own business, professional practice, partnership or farm.

007.01C Income shall include but not be limited to, regular payments such as social security, income from public assistance or welfare, interest, dividends, pensions, net rents, alimony, child support, or allotments.

007.01D Income includes wages, salary, commission, bonuses, or tips from all jobs (before deductions from taxes), including sick leave pay.

007.01E For the purposes of these rules and regulations, family shall mean an individual and his or her spouse.

007.02 The Department adopts as its poverty index the poverty income guidelines issued by the U.S. Department of Health and Human Services and published annually in the Federal Register.

007.03 A client whose family income is below 300% of the poverty level in the index issued by the Department will pay from 0 to 90 percent of the fee for the Care Management Unit services based on the following fee scale.

FAMILY INCOME EXPRESSED AS A PERCENT OF POVERTY	CLIENTS SHARE OF THE FEE FOR SERVICES
0 - 149 percent	0 percent
150 - 166	10
167 - 182	20
183 - 199	30
200 - 216	40
217 - 232	50
233 - 249	60
250 - 266	70
267 - 282	80
283 - 299	90
300+	100

007.04 The Care Management Unit shall inform the individual of the fee for services prior to the delivery of services. Monthly statements of the services rendered and prior balance receivable, charges at full fee, sliding fee scale adjustments, payments received and ending balance receivable shall be sent to each client.

008 REIMBURSEMENT. The Department may reimburse a Care Management Unit for costs not paid for by the client or through other sources.

008.01 Reimbursement by the Department shall be based upon actual casework time units.

008.01A A casework time unit is one hour of reimbursable service by a Care Management Unit supervisor or care manager for a client. The reimbursable services are consultation, assessment, care plan development and coordination, referral of a client to other agencies and services, and care plan review and monitoring.

008.02 The value of a casework time unit shall be calculated by adding all expenses for personnel, administration and planning, client eligibility review, contractual services, and necessary supportive services and other necessary actual and indirect costs of the Care Management Unit, and dividing by the number of actual casework time units to be delivered by a Care Management Unit during the fiscal year as approved by the Department in the budget for the Care Management Unit.

008.03 The reimbursable amount of a casework time unit is based upon the difference between actual value of a casework time unit less fees collected from the client, payments from Medicaid and other third-party payers, and other sources of income to the Care Management Unit as specified in the Act.

008.04 The maximum reimbursable dollar amount per casework time unit is $54, but in no case shall the maximum reimbursement exceed the cost of an actual casework time unit minus costs paid by an individual or through other reimbursement specified in the Act.

008.05 The Department shall provide reimbursement only up to the limit of funds appropriated to the Department under the Act and may not exceed the approved budget and projected actual casework time units in a Care Management Unit's Plan of Operation.

008.06 In requesting reimbursement, the Care Management Unit grants authority to the Department to verify the service delivered to the client by inspecting individual client files and records which must be maintained in the client files and records which must be maintained in the Care Management Unit office, to verify costs allocated to the casework time unit, and to verify total income from an individual or client and from other sources.

008.06A The Department will not reimburse a Care Management Unit for any costs for which the Unit receives payment from an individual or client; or from other reimbursement by state or federal government programs or third-party payers; or from funds appropriated under the Nebraska Community Aging Services Act prior to the effective date of the Act, or from any other sources.

008.07 An Area Agency on Aging which fails to maintain the level of spending on Care Management services equal to the funds appropriated under the Nebraska Community Aging Services Act prior to the effective date of the Act, or to maintain the level of spending from other replacement funds are provided in the Act, shall be ineligible for reimbursement under this Act.

Title 15 NAC 2
Attachment A

Date Received
by Department
on Aging:

Nebraska Department on Aging
APPLICATION
For
Recertification
of a Care Management Unit

Applicant Name: _____
Address: _____
City, State, Zip: _____
Name of Person to Contact about application, Address and Telephone if different than above:

_____

_____

DIRECTIONS FOR APPLICATION FOR RECERTIFICATION

1) Complete this form, attach necessary information, and submit it to the Nebraska Department on Aging, P. O. Box 95044, Lincoln, NE 68509, anytime between 120 and 90 calendar days before the expiration of certification.

2) A. If the Provider is a corporation, attach a resolution that has been adopted by the Governing Unit of the Care Management Unit's Provider Organization approving Application for Recertification; and

Provider for the signature of the chairperson of the Governing Unit to the statement below:

I,
chairperson of the
(name of agency)
certify that the Governing Board has authorized application for recertification of the Care Management Unit within Planning and Service Area _____.
(appropriate letter designation)

Date: _____ Signature:
Title:

APPLICATION
For
Recertification
of a Care Management Unit (continued)

B. If the Provider of a Care Management Unit is a sole proprietorship or partnership, provide for the signature of the duly authorized person to the statement below:

I,

(name and title)

of

Certify that I am the authorized agent of the above organization and am authorized to apply for recertification of the Care Management Unit within Planning and Service Area

(put appropriate letter designation here)

Date: _____ Signature:

Title:

3) Attach to this application form any change proposed to the Care Management Unit's current certified Plan of Operation which is to be effective with Recertification, along with explanation supporting the reasons for any proposed change.

TITLE 15 AGING SERVICES

CHAPTER 3 CARE MANAGEMENT UNITS

001. SCOPE AND AUTHORITY. These rules and regulations implement Nebraska Revised Statute (Neb. Rev. Stat.) §§ 81-2229 - 81-2235, the Act, which directs the establishment of a statewide system of Care Management Units through the Area Agencies on Aging.

002. DEFINITIONS. Care Management definitions are located in this Title, Chapter 1.

003. CERTIFICATION PROCEDURES. The Plan of Operation must comply with this Title for Care Management Units, and include all the elements specified in Section 4 below.

003.01 PLAN OF OPERATION SUBMISSION. The Care Management Unit must submit the Plan of Operation to the State Unit on Aging, as prescribed by the Department.

003.02 MULTIPLE CERTIFICATIONS. An Area Agency on Aging may create more than one certified Care Management Unit to serve its Planning and Service Area by submitting a Plan of Operation for each Care Management Unit for which it plans to provide and supervise or subaward.

004. PLAN OF OPERATION. Each Plan of Operation for a Care Management Unit must provide the following information:

004.01 REQUIREMENTS. A statement of the philosophy and goals and objectives of the Care Management Unit. The goals and objectives must include a timetable for making care management services available in an entire Planning and Service Area of an Area Agency on Aging.

004.02 APPROACH OF CARE MANAGEMENT UNIT. The statement of philosophy must detail the approach to be used by the Care Management Unit is:

(A) Involving all support systems of a client, including family members, neighbors, or friends;
(B) Utilizing all available care resources including community-based services and institutionalization;
(C) Coordinating the delivery of a continuum of services;
(D) Assuring that persons are receiving, when reasonably possible, the level of care that best matches their level of need; and
(E) Person centered.

004.03 CITIZEN INPUT. A statement of the procedures to receive input from local citizens in the formulation and implementation of the Plan of Operation, and the procedures to be used to inform eligible individuals on a regular schedule and in a comprehensive manner about Care Management Unit services.

004.04 PROGRAM EVALUATION. A statement of methods to evaluate the attainment of program goals and objectives for the Care Management Unit, and how the evaluation findings are documented and resolved.

004.05 SEPARATE OPERATION. A written representation that the Care Management Unit is operated separately from Direct Care Programs of an Area Agency on Aging.

004.06 INTERDISCIPLINARY APPROACH. The Care Management Unit's Plan of Operation must outline procedures for utilizing an interdisciplinary approach to care management.

004.07 SERVICE PRIORITY. A statement of criteria to be used to determine the priority of service to eligible clients in the event funds are insufficient to meet all the client needs of a Care Management Unit.

004.08 GREVIANCE PROCEDURE. A statement detailing the grievance procedure available to clients of the Care Management Unit and the process to be used to resolve client complaints.

004.09 ANNUAL BUDGET. An annual budget of income and expenses for the Care Management Unit that coincides with the state fiscal year and must include units of services to be provided, and details of costs of a casework time unit as explained in Section 8 of these rules and regulations and the Act.

004.10 RECORDING OF SERVICES. The Care Management Unit must have a procedure approved by the State Unit on Aging in its Plan of Operation for recording on a timesheet or other document the actual casework time units and Care Management Unit services provided each client.

004.11 OPERATIONS PROCEDURES. Each Plan of Operation must provide written policies and procedures for the administrative and programmatic operation of the Care Management Unit based upon the following minimum standards.

004.11(A) PERSONNEL POLICIES AND PROCEDURES. The Care Management Unit must have a job description for each position as well as written personnel policies and procedures for hiring and selection, compensation, evaluation, disciplinary action and grievance, and supervision and training of employees, contractors, volunteers, students, and interns. The personnel policies and procedures must include:

(i) An Equal Opportunity Policy that includes nondiscrimination on the basis of race, disability, color, sex, affiliation or age, and an Affirmative Action statement;

(ii) An organization chart which identifies the responsibility of each position in the Care Management Unit; and

(iii) A policy that Care Management services for clients as outlined in this Title of these rules and regulations are the exclusive responsibility of the Care Management Unit

Supervisor or care manager; except that a supervisor or care manager may delegate to staff of the Care Management Unit assistance with the performance of the services of referral, coordination of the Long-Term Care Plan, assessment and monitoring of the delivery of services to clients if supervision is provided by the supervisor or care manager.

004.11(B) DESIGNATION OF SUPERVISOR. The designation of a Care Management Unit Supervisor responsible to implement the Plan of Operation and to supervise the activities of the Care Management Unit.

004.11(C) QUALIFICATIONS. The Care Management Unit Supervisor and care managers must have the following minimum qualifications:

(i) A current Nebraska license as a registered nurse, or baccalaureate or graduate degree in the human services field, or certification as a social worker or master social worker under the Mental Health Practice Act;

(ii) At least an equivalency of two years of related, professional experience; paid or unpaid; (employment; college internships; volunteering at philanthropic, community and social organizations) in long-term care, gerontology or community health. Candidates will receive credit for all qualified experience; and

(iii) In addition, a Care Management Unit Supervisor shall have at least an equivalency of two years of related, professional supervisory or management experience.

004.11(D) ORGANIZATION. Each Plan of Operation must provide information about the organization of the Care Management Unit as follows:

(i) An organizational chart which shows that the Care Management Unit is operated separately from any Area Agency on Aging Direct Care Programs or from any Direct Care programs of another provider of a Care Management Unit;

(ii) An organizational chart showing the line of authority between the Care Management Unit and the Area Agency on Aging or other public or private entity operating the unit;

(iii) A description of the process that the Care Management Unit uses to monitor sub grantees;

(iv) Each Care Management Unit must maintain accounting records as necessary for presentation of financial statements in accordance with generally accepted accounting principles; and

(v) Each Care Management Unit must obtain and file with the State Unit on Aging an annual audit report in compliance with the Office of Management and Budget (OMB) Code of Federal Regulations (CFR) 200 Part F. The audit must be conducted in accordance with generally accepted auditing standards resulting in an opinion of the financial statements.

004.11(E) CLIENT RIGHTS. The Care Management Unit must have written policies and procedures on client rights, and those rights must be given to the client prior to the assessment. Written policies and procedures must include as a minimum the following:

(i) Each client has the right to accept or reject care management services;

(ii) Each client has the right to be consulted in the development and to approve or disapprove his or her Long-Term Care Plan;

(iii) Each client has the right to choose available services and providers of services;

(iv) Each client has the right to receive care management services without regard to race, color, sex, national origin, religion, or disability;

(v) Each client has the right to be informed of the name of the care manager responsible for their case;

(vi) Each client has the right to receive a description of available care management services, fees charged, and billing mechanisms;

(vii) Each client has the right to have access to his or her care management service file and record unless access is restricted by applicable law or a state or federal regulation; and

(viii) Each client has the right to register complaints and the right to file grievances without discrimination or reprisal from the Care Management Unit.

004.11(F) CONFIDENTIALITY. The Care Management Unit must have written policies and procedures which govern confidentiality of case records and information including the following:

(i) Procedures for maintaining confidentiality in releasing information to other agencies or professionals and in obtaining information from outside agencies or professionals. Forms for the release and receipt of client information must be part of the policies and procedures;

(ii) Methods and procedures used to secure and to control access to records;

(iii) Procedures to be followed by the Care Management Unit and contractors when participating in Long-Term Care Plan conferences or consultations involving outside agencies or professionals;

(iv) Procedures to put all release forms and other documents legally approving the release of information in the client file or record;

(v) Procedures for maintaining confidentiality of case records in use and in storage, including computerized case data; and

(vi) Procedures must be compliant with CFR 45 Sec.160, Sec.162, Sec.164, and all applicable law.

004.12 CLIENT FILES. Each Plan of Operation must include policies and procedures for establishment of client files and records which includes all documents relating to the client.

004.12(A) REVIEW OF CLIENT FILES. The Care Management Unit must permit the State Unit on Aging to inspect and review client files and records to evaluate performance and achievement of the Care Management Unit and to verify and audit the services provided and information published by the Care Management Unit.

004.13 TRAINING. Each Plan of Operation must include a training plan including at a minimum:

(A) An orientation training for employees, contractors, volunteers, students or interns commensurate with their responsibilities in the Care Management Unit;

(B) Required participation by the Care Management Unit in training provided by the State Unit on Aging; and

(C) A schedule for in-service training, which must include, but not be limited to, policies and procedures of the Care Management Unit, and techniques, methods, and research on Care Management.

004.14 STANDARDIZED LONG-TERM CARE ASSESSMENT DOCUMENT. Each Plan of Operation must provide for the use of the standardized long-term care assessment document, as prescribed by the Department.

004.14(A) TRAINING. Each care manager must be trained by the Care Management Unit Supervisor prior to using the assessment document.

004.14(B) ASSESSMENT COMPLETION. This assessment document is to be completed in its entirety and to be used with the initial assessment and development of the Long-Term Care Plan as well as with subsequent annual reassessments and reviews of the Long-Term Care Plan.

004.15 LONG-TERM CARE PLAN. Each Plan of Operation must have written policies and procedures concerning Long-Term Care Plan development.

004.15(A) REQUIREMENTS. Each Long-Term Care Plan must outline procedures for utilizing an interdisciplinary, person centered, approach to care management which involves input from a variety of professionals, agencies, which may be already involved with the client, and support systems which may be available to the client.

004.15(B) SERVICES NOT UTILIZED. Services which are needed but not available must be recorded in the Long-Term Care Plan, as well as those rejected by the client.

004.15(C) REQUIREMENTS. As a minimum, the Long-Term Care Plan must:

(i) Establish individual goals and objectives agreed to by the client;
(ii) Establish a time frame for implementation of the Long-Term Care Plan;
(iii) Define the services which are needed, including any equipment or supplies;
(iv) Define who provides each service;
(v) Specify the availability of services, supplies and equipment;
(vi) Specify the costs and methods of service delivery; and
(vii) Provide for reassessment upon change in client status.

004.15(D) MONITORING. The purpose of periodic monitoring is to reasonably ensure the continued appropriateness and effectiveness of the services being delivered as outlined in the Long-Term Care Plan.

004.15(E) REVIEW. The review of the client's Long-Term Care Plan is to determine its continued appropriateness and must occur at least annually and upon significant change in client status.

004.15(F) ON-GOING CONSULTATION. There must be ongoing consultation, including the regular exchange of ideas and comments between the client and the Care Management Unit.

004.15(F)(i) CLIENT CONTACT. The Care Management Unit must have ongoing contact with each client to ensure that their service needs are being met. This includes a minimum of quarterly client contact with at least two face-to-face visits per year, one

of which is to complete an annual client reassessment using the State Unit on Aging's standardized assessment document, and review and update to the Plan of Care.

004.15(F)(ii) CLIENT CONTACT AFTER SIGNIFICANT CHANGE. Client contact, for purposes of reassessment and updating the Plan of Care, must also be made within 10 calendar days of notification of client returning to non-institutional setting of choice for continued Care Management services, after a significant change in health or functional status.

004.16 ACCESSIBILITY OF SERVICES. Each Plan of Operation must provide for development of a comprehensive directory of available public and private resources that documents Continuum of Care services, including both formal and informal community-based services and institutions for use in referral activities of the Care Management Unit.

004.17 UNIFORM DATA COLLECTION. Each Plan of Operation must provide for use of the Aging Designated Service Reporting System as defined in Section 1 of these rules and regulations and which must be provided by the State Unit on Aging to the Care Management Unit upon Certification.

004.17(A) DATA ENTRY. Each Care Management Unit must have access to a compatible computer in order to use the Aging Designated Service Reporting System and is responsible for data entry and verification for quarterly and annual reports.

004.18 PERIODIC REVIEW. The Care Management Unit must cooperate fully during periodic reviews, including on-site assessments, for the purpose of evaluating compliance with the Act and this Title to retain Certification.

004.18(A) ACCESS TO FILES AND RECORDS. In conducting a periodic review, the Care Management Unit must provide access to the State Unit on Aging to files and records of the Care Management Unit as well as the files and records of the provider or contractor of a Care Management Unit.

004.19 AMENDMENT OF THE PLAN OF OPERATION. A certified Care Management Unit must not change its Plan of Operation or its practice under the Plan unless the Area Agency on Aging's proposed amendment submission has been approved by the State Unit on Aging.

004.20 DURATION OF CERTIFICATION. Approval of a Plan of Operation and Certification of Care Management Unit is valid for four years from the date granted unless revoked by the State Unit on Aging at an earlier date.

005. DENIAL OF PLAN OF OPERATION AND CERTIFICATION OF A CARE MANAGEMENT UNIT. The State Unit on Aging may deny certification for any or all of the following reasons:

(A) Failure of the Area Agency on Aging to submit a complete Plan of Operation as outlined in these rules and regulations;
(B) Failure of the Area Agency on Aging to provide a Plan of Operation reasonably calculated to achieve the intent of the Act;

(C) Failure of the Area Agency on Aging to provide in the initial Plan of Operation a reasonable time frame for providing the opportunity for care management services to all eligible individuals within the Planning and Service Area of an Area Agency on Aging; or
(D) The Area Agency on Aging putting into effect any change to the Plan of Operation without prior approval from the State Unit on Aging.

005.01 PLAN OF OPERATION RESUBMISSION. The Area Agency on Aging may submit a revised Plan of Operation within 30 days of the date that the State Unit on Aging mails or otherwise notifies the Area Agency on Aging of the denial of certification.

006. APPEAL PROCESS. A decision by the Department to revoke or deny Certification of a Care Management Unit may be appealed by the Area Agency on Aging by filing a notice of appeal with the Director of the Department within 10 days after postmark of notice by the Department. The appeal follows the procedures of the Administrative Procedures Act, Neb. Rev. Stat. Sec. 84-917.

007. REAPPLICATION FOR CERTIFICATION. If the State Unit on Aging has not yet certified another agency as the Care Management Unit for the geographic area for which a provider has had its certification revoked or denied, the provider may reapply for certification 90 days after the date of the revocation or denial of certification. Revocation becomes final after all appeals under the Administrative Procedures act have expired.

008. REVOCATION OF CERTIFICATION. The State Unit on Aging may revoke Certification of a Care Management Unit at any time for any of the following reasons:
(A) There is a change in ownership of the company or organization operating a Care Management Unit without the prior approval of the State Unit on Aging;
(B) The Care Management Unit clients are being inadequately served; or that the resources allocated to the Care Management Unit by the State Unit on Aging or any other state or federal source are being used in violation of the Act or of these rules and regulations;
(C) The Care Management Unit fails to perform according to the approved Plan of Operation;
(D) The Care Management Unit fails to provide services to all eligible persons in the Planning and Service Area of the Area Agency on Aging as required by the Act, these rules and regulations and the Plan of Operation;
(E) The Care Management Unit is not a separate operation from a Direct Care Program of the Area Agency on Aging;
(F) The Care Management Unit fails to obtain approval from the State Unit on Aging for a change in its Plan of Operation; or
(G) The Care Management Unit is in violation of any of these rules and regulations, the Act, or any other applicable law.

008.01 SERVING CLIENTS DURING APPEAL. During an appeal of a revocation of Certification, a Care Management Unit may continue to serve existing clients. New clients cannot be accepted without prior approval of the State Unit on Aging.

008.01(A) SUSPENSION OF PAYMENTS. A Care Management Unit will not receive reimbursement payments for any time period its certification as a Care Management Unit is suspended or revoked. Suspension of reimbursement payments will continue during the pendency of any appeal of the suspension of reimbursement payments. To the extent

that a suspension is not ultimately upheld in an appeal process, reimbursement payments otherwise due for the time period at issue will be paid.

009. RECERTIFICATION. A Care Management Unit that seeks recertification must submit an application for recertification to the State Unit on Aging at least 90 calendar days prior to the expiration of each certification period.

009.01 APPLICATION FOR RECERTIFICATION. The Area Agency on Aging must submit an application for recertification on the form issued by the State Unit on Aging, as prescribed by the Department.

009.02 REVIEW OF APPLICATION FOR RECERTIFICATION. An application for recertification will be reviewed on the basis of the results of periodic reviews and onsite inspections, including but not limited to a review of files and records and visits with clients and cooperating agencies to determine compliance with these rules and regulations and the Plan of Operation.

009.03 CERTIFICATION EXPIRATION. Failure to file for recertification results in Certification expiration at the end of the current Certification period.

009.04 APPROVAL OR DENIAL OF RECERTIFICATION. The basis for approval or denial of recertification is set forth in Section 006, Subsections 1 – 4, and Section 008, Subsections 1 - 7 of this section of this Title, and is based upon the results of the review conducted in Subsection 2 of this section and an evaluation of the performance of the Care Management Unit in meeting its goals and objectives outlined in its approved Plan of Operation.

009.05 APPEAL PROCEDURES. In case of a denial, appeal procedures are set forth in Section 7.

010. FEE SCALE. Each Care Management Unit must use the fee scale as prescribed by the Department.

010.01 POVERTY INDEX. The State Unit on Aging adopts as its poverty index the poverty income guidelines issued by the U.S. Department of Health and Human Services.

010.02 FEE FOR SERVICES. The Care Management Unit shall inform the individual of the fee for services prior to the delivery of services. Monthly statements of the services rendered and prior balance receivable, charges at full fee, sliding fee scale adjustments, payments received and ending balance receivable shall be sent to each client.

010.03 PAYMENT OF FEE. A client whose family income is below 300% of the poverty level in the index issued by the Department must pay from 0 to 90 percent of the fee for the Care Management Unit services based on the fee scale as prescribed by the Department.

011. REIMBURSEMENT. The Department may reimburse a Care Management Unit for costs not required to be paid for by the client and not paid through other sources.

011.01 REIMBURSABLE SERVICES. A casework time unit is one hour of reimbursable service by a Care Management Unit for a client. The reimbursable services are consultation, assessment, Care Plan development and coordination, referral of a client to other agencies and services, and Care Plan review and monitoring.

011.02 VALUE OF TIME UNITS. The value of a casework time unit is calculated by dividing all expenses by the number of actual casework time units to be delivered by a Care Management Unit during the fiscal year as approved by the State Unit on Aging in the budget for the Care Management Unit.

011.03 REIMBURSABLE TIME. The reimbursable amount of a casework time unit is based upon the difference between actual value of a casework time unit less fees required to be paid for by the client, payment from Medicaid and other third-party payers, and other sources of income to the Care Management Unit as specified in the Act.

011.04 MAXIMUM REIMBURSABLE AMOUNT. The maximum reimbursable dollar amount per casework time unit follows the fee schedule as prescribed by the Department, however, the maximum reimbursement must not exceed the cost of an actual casework time unit minus costs required to be paid for by the client or through other reimbursement specified in the Act.

011.05 REIMBURSEMENT LIMIT. The State Unit on Aging provides reimbursement only up to the limit of funds appropriated to the State Unit on Aging under the Act and may not exceed the approved budget and projected actual casework time units in a Care Management Unit's Plan of Operation.

011.06 VERIFICATION OF SERVICES DELIVERED. In requesting reimbursement, the Care Management Unit grants authority to the State Unit on Aging to verify the service delivered to the client by inspecting individual client files and records which must be maintained in the client files and records which must be maintained in the Care Management Unit office, to verify costs allocated to the casework time unit, and to verify total income from an individual or client and from other sources.

011.06(A) NON REIMBURSABLE UNITS OR COSTS. A Care Management Unit may seek reimbursement from the State Unit on Aging for otherwise allowable costs, except for costs required to be paid by the client or those that are paid by another person or entity.

Table of Contents
Care Management Units

Chapter 2 - CARE MANAGEMENT UNITS

001 These rules and regulations implement Neb. Rev. Stat. Sec. 81-2229 - Sec. 81-2236, R.R.S. 1943 (the Act) which directs the establishment of a statewide system of Care Management Units through the Area Agencies on Aging.

001.01 DEFINITIONS

001.01A Area Agency on Aging shall mean an agency designated by the Nebraska Department on Aging in compliance with Neb. Rev. State Sec, 81-2201 - 81-2228, R.R.S. 1943.

001.01B Assessment shall mean the comprehensive appraisal of individual clients by making orderly and purposeful observations, conducting interviews, and recording the results of those observations and interviews on a standardized assessment document issued by the Department.

001.01C Care Management shall mean assisting a client to identify and utilize services needed to assure that the client is receiving, when reasonably possible, the level of care that best matches his or her level of need. The Care Management Unit through its Care Management Unit Supervisor and staff of care managers assists clients with services as specified in the Act, including ongoing consultation, assessment, Long-Term Care Plan development, and referral for clients in need of long-term care; coordination of the Long-Term Care Plan; monitoring of the delivery of services for clients, and review of the client's Long-Term Care Plan.

001.01D Care management Unit shall mean the organization which is created by, or which is contracting with an Area Agency on Aging, or the public or private entity contracting with the Department to provide care management services as defined in the Act and these rules and regulations.

001.01E Care Management Unit Supervisor shall mean the person who supervises a Care Management Unit.

001.01F Case Management is a term which is interchangeable in meaning with Care Management.

001.01G A Certified Care Management Unit is a Care Management Unit that has been found by the Department to meet the standards for certification under the Act.

001.01H Client shall mean a person in need of care management services or the legal representative of such person.

001.01I Continuum of Care shall mean the range of services designed to ensure that persons are receiving, when reasonably possible, the level of care that best matches their level of need.

001.01J Department shall mean the Nebraska Department on Aging.

001.01K Direct Care Program shall mean any program of an Area Agency on Aging, except care management, providing services to older individuals.

001.01L Eligible individual for services shall mean a person, primarily an individual 60 years-of-age or older, who resides in Nebraska, and who is in need of Long-Term Care as defined in Subsection 001.01P of these rules and regulations.

001.01M Environmental needs shall mean those factors required to maintain an individual in an appropriate and safe living arrangement.

001.01N Functional needs shall mean those factors that affect the individual's ability to perform the activities of daily living and the instrumental activities of daily living.

001.01O Individual approval or client approval shall mean confirmation given after full disclosure, usually a signature on a form by the client or client's legal representative.

001.01P Long-Term Care shall mean the caring for people who have unmet psycho-social, environmental or functional needs and who need assistance in meeting these needs for a three-month or longer time.

001.01Q Long-Term Care Plan shall mean a document prepared with a client by the Care Management Unit in compliance with Section 6, Subsection 6 of these rules and regulations.

001.01R Long-Term Care Planning shall mean the process used to prepare a Long-Term Care Plan.

001.01S Plan of Operation shall mean a plan prepared in compliance with Section 6 of these rules and regulations.

001.01T Psycho-Social needs shall mean those basic needs which include, but are not limited to, social participation, orientation, understanding, and a sense of well-being.

001.01U Older individuals, older Nebraskans, or older population are terms that shall mean persons who are 60 years of age or older.

001.01V Uniform Data Collection System shall mean the Nebraska Care Management Information System which is a computer software package adapted in 1988 for Nebraska from the "Client Oriented Case Management and Service Reporting System for the Aging Network" designed by the Long Term Care Gerontology Center in Kansas City, Kansas, and issued by the Department to certified care management units to collect and process data from the Nebraska Long Term Care Assessment Document made a part of these rules as Attachment B and financial data needed to calculate reimbursement for casework time units as provided in Section 8 of these rules and regulations and the Act.

002 CERTIFICATION PROCEDURES. Within 60 days of the adoption and promulgation of these rules and regulations, each Area Agency on Aging shall submit to the Department a Plan of Operation to either provide and supervise or subcontract for at least one certifies Care Management Unit to provide all eligible individuals residing in its planning and service area with long-term care management services.

002.01 The Plan of Operation shall comply with these rules and regulations for Care Management Units, and include all the elements specified in Section 006 below.

002.02 The Plan of Operation shall be submitted to the Nebraska Department on Aging, P. O. Box 95044, Lincoln, Nebraska.

002.03 An Area Agency on Aging may create more than one certified Care Management Unit to serve its planning and service area by submitting a Plan of Operation for each Care Management Unit for which it plans to provide and supervise or subcontract.

002.04 Within 30 days of receipt of the Plan of Operation, the Department shall complete its review and notify the governing board of the Area Agency on Aging of the Department's approval or denial of Certification. If Certification is denied, the Department shall provide the reasons for denial to the governing board of the Area Agency on Aging.

002.04A The Department may deny certification for any or all of the following reasons:

002.04A1 Failure to submit a complete Plan of Operation as outlined in these rules and regulations.

002.04A2 Failure to provide a Plan of Operation reasonably calculated to achieve the intent of the Act.

002.04A3 Failure to provide in the initial Plan of Operation a reasonable time frame for providing the opportunity for care management services to all eligible individuals within the planning and service area of an Area Agency on Aging.

002.04A4 Failure to operate a Care Management Unit separately from a Direct Care Program of an Area Agency on Aging.

002.04A5 Putting into effect any change to the Plan of Operation without prior approval from the Department.

002.05 The Area Agency on Aging shall have 30 days from the date it receives notice of the initial denial by the Department to submit a revised Plan of Operation.

002.06 Within 30 days of the receipt of a revised Plan of Operation, the Department shall notify the governing board of the Area Agency on Aging of its acceptance or denial of the revised Plan of Operation and reasons for denial.

002.06A During the initial Certification process, an Area Agency on Aging may not file a request for an appeal hearing until it has submitted a revised Plan of Operation as stated in the Act, and has received notice of denial of the revised Plan of Operation from the Department. The appeal hearing procedure is described in Section 3 of these rules and regulations.

002.07 If the Area Agency does not submit a revised Plan of Operation within 30 days of the denial, or if the revised Plan of Operation is denied by the Department, the Department may request proposals from and contract with another public or private entity to serve that planning and service area, providing such entity meets the provision for certification.

003 NOTICE OF APPROVAL AND CERTIFICATION; APPEAL RIGHTS. The Department shall forward a notice of approval of a Plan of Operation and Certification of a Care Management Unit to the Area Agency on Aging governing board or, as appropriate, to the governing board of a contracted public or private entity. Public notice of the Certification decision by the Department shall be made after the applicant has been informed of the decision.

003.01 A Care Management Unit provider aggrieved by a decision of the Department to deny approval of a Plan of Operation or Certification of a Care Management Unit shall have the right to appeal, and may exercise the right to appeal by filing a notice of appeal within ten working days of receiving notice of denial.

003.01A The Department shall set the date, time, and place of the hearing within five working days of receiving a request from an aggrieved applicant or provider. The hearing shall take place within thirty calendar days of the request.

003.01B The Department shall appoint an impartial hearing officer to conduct the hearing.

003.01C The hearing officer shall rule on motions and objections and may cross-examine any witnesses. The hearing officer shall prepare written findings of fact and conclusions of law and submit the same to the Director of the Department within twenty working days of the conclusions of the hearing. The Director of the Department either shall be in attendance or shall review the record of the hearing.

003.01D A representative may appear on behalf of the provider or the provider may be represented by counsel. There shall be opportunity to present witnesses and documentary evidence under the provision of Neb.Rev.Stat. Sec. 84-914, R.R.S. 1943.

003.01E The Director shall make a decision which shall be in writing and shall be accompanied by findings of fact and conclusions of law. The findings of fact shall be based on the evidence submitted at the hearing pursuant to Neb.Rev.Stat. Sec. 84-914, R.R.S. 1943.

003.01F The Department shall transmit the written decision to interested parties by certified or registered mail within thirty working days of the hearing.

003.01G Appeals to the District Court from any order or decision of the Department shall follow the statutory requisites set forth in Neb. Rev. Stat. Section 84-917 R.R.S. 1943 unless specifically provided for otherwise by statute.

003.01H The Department may terminate formal hearing procedures at any point if the Department and provider that requested the hearing negotiate a written agreement that resolves the issue(s) which led to the hearing.

003.02 If the Department has not certified another public or private agency, a provider whose Certification is denied may reapply for Certification ninety working days after the date of completion of the appeal process.

003.03 Approval of a Plan of Operation and Certification of Care Management Unit is valid for two years from the date granted unless revoked by the Department at an earlier date.

004 REVOCATION OF CERTIFICATION

004.01 The Department may revoke Certification at any time for any of the following reasons:

004.01A There is a change in ownership of the company or organization operating a Care Management Unit without the prior approval of the Department.

004.01B The Care Management Unit clients are being inadequately served; or that the resources allocated to the Care Management Unit by the Department or any other State or Federal source are being used in violation of the Act or of these rules and regulations.

004.01C The Care Management Unit fails to perform according to the approved Plan of Operation.

004.01D The Care Management Unit fails to provide services to all eligible persons in the planning and service area of the Area Agency on Aging as required by the Act, these rules and regulations and the Plan of Operation.

004.01E The Care Management Unit is not a separate operation from a Direct Care Program of the Area Agency on Aging.

004.01F The Care Management Unit fails to obtain approval from the Department for a change in its Plan of Operation.

004.01G The Care Management Unit is in violation of any of these rules and regulations or of the Act.

004.02 The Department shall notify the governing board of an Area Agency on Aging or other contractor of its intent to revoke Certification.

004.02A A Care Management Unit provider aggrieved by a decision of the Department to revoke Certification of a Care Management Unit shall be entitled to an appeal as described in Section 3 of these rules and regulations.

004.02B A provider whose Certification is revoked may reapply for Certification ninety working days after the date of revocation becomes final. For purposes of this subsection, revocation does not become final until the time for all appeals under the Administrative Procedures act has expired.

004.03 During the process of appeal of a revocation of Certification, a Care Management Unit may continue to serve those clients already being served, but may not take in new clients without the direct or contracted supervision of the Department.

004.03A The Department shall suspend reimbursement payments to the Care Management Unit for those clients it continues to serve during the process of appeal. If reimbursement is suspended and a decision to revoke Certification becomes final, the suspended reimbursement amount shall not be paid to the Care Management Unit. If upon conclusion of all hearings and appeals the Certification is not revoked, suspended reimbursement shall then be paid to the Care Management Unit.

005 RECERTIFICATION

005.01 An application for recertification must be submitted to the Department 90 to 120 calendar days prior to the expiration of each two-year certification period.

005.01A Failure to file for recertification will cause Certification to expire at the end of the two-year Certification period.

005.02 The application for recertification shall be submitted on the form issued by the Department and made a part of these rules and regulations as Attachment A.

005.03 Each application for recertification will be reviewed by the Department on the basis of the results of periodic reviews and of an on-site inspection including but not limited to a review of files and records and visits with clients and cooperating agencies to determine compliance with these rules and regulations and the Plan of Operation.

005.04 Notice of approval or denial of recertification will be issued by the Department prior to the expiration of the current Certification period.

005.04A The basis for approval or denial of recertification will be the same as in Section 2, Subsection 4A and Section 4. Subsection 1 of these rules and regulations, and will be based upon the results of the review conducted in Subsection 3 of this section and an evaluation of the performance of the Care Management Unit in meeting its goals and objectives outlined in its approved Plan of Operation.

005.04B In case of a denial, appeal procedures will be the same as those specified in Section 3 of these rules and regulations.

006 PLAN OF OPERATION

006.01 Each Plan of Operation for a Care Management Unit shall provide the following information.

006.01A A statement of the philosophy, and goals and objectives of the Care Management Unit. The goals and objectives shall include a timetable for making care management services available in an entire planning and service area of an Area Agency on Aging.

006.01A1 The statement of philosophy shall detail the approach to be used by the Care Management Unit is a) involving all support systems of a client, including family members, neighbors, or friends, b) utilizing all available care resources including community-based services and institutionalization; c) coordinating the delivery of a continuum of services; and d) assuring that persons are receiving, when reasonably possible, the level of care that best matches their level of need.

006.01B A statement of the procedures to receive input from local citizens in the formulation and implementation of the Plan of Operation, and the procedures to be used to inform eligible individuals on a regular schedule and in a comprehensive manner about Care Management Unit services.

006.01C A statement of methods to evaluate the attainment of program goals and objectives for the Care Management Unit, and how the evaluation findings will be documented and resolved.

006.01D A written representation that the Care Management Unit shall be operated separately from Direct Care Programs of an Area Agency on Aging.

006.01E Each Care Management Unit's Plan of Operation shall outline procedures for utilizing an interdisciplinary approach to care management.

006.01F A statement of criteria to be used to determine the priority of service to eligible clients in the event funds are insufficient to meet all the client needs of a Care Management Unit.

006.01G A statement detailing the grievance procedure available to clients of the Care Management Unit and the process to be used to resolve client complaints.

006.01H An annual budget of income and expenses for the Care Management Unit shall coincide with the state fiscal year and shall include units of services to be provided, and details of costs of a casework time unit as explained in Section 8 of these rules and regulations and the Act.

006.01H1 Each Area Agency on Aging shall report to the Department at the time of submission of the initial Plan of Operation the dollar value of funds appropriated under the Nebraska Community Aging Services Act and used for Care Management Service prior to August 30, 1987.

006.01H2 Each Care Management Unit shall have a procedure approved by the Department in its Plan of Operation for recording on a timesheet or other document the actual casework time units and Care Management Unit services provided each client.

006.02 Each Plan of Operation shall provide written policies and procedures for the administrative and programmatic operation of the Care Management Unit based upon the following minimum standards.

006.02A PERSONNEL POLICIES AND PROCEDURES. The Care Management Unit shall have a job description for each position as well as written personnel policies and procedures for hiring and selection, compensation, evaluation, disciplinary action and grievance, and supervision and training of employees, contractors, volunteers, students and/or interns. The personnel policies and procedures shall include:

006.02A1 An Equal Opportunity Policy that includes nondiscrimination on the basis of race, disability, color, sex, affiliation or age, and an Affirmative Action statement.

006.02A2 An organization chart which identifies the responsibility of each position in the Care Management Unit.

006.02A3 A policy that Care Management services for clients as outlined in 001.01C of these rules and regulations are the exclusive responsibility of the Care Management Unit Supervisor or care manager; except that a supervisor or care manager may delegate to staff of the Care Management Unit the performance of the services of referral, coordination of the Long-Term Care Plan, and monitoring of the delivery of services to clients if supervision is provided by the supervisor or care manager.

006.02B The designation of a Care Management Unit Supervisor responsible to implement the Plan of Operation and to supervise the activities of the staff and contractors.

006.02C The Care Management Unit Supervisor and care managers shall have the following minimum qualifications:

006.02C1 A current Nebraska license as a registered nurse, or baccalaureate or graduate degree in the human services field, or certification under the Nebraska Social Work Law; and

006.02C2 At least two years of experience in long-term care, gerontology or community health.

006.02C3 In addition, a Care Management Unit Supervisor shall have at least two years of supervisory or management experience.

006.02D ORGANIZATION. Each Plan of Operation shall provide information about the organization of the Care Management Unit as follows:

006.02D1 An organizational chart which shows that the Care Management Unit is operated separately from any Area Agency on Aging Direct Care Programs or from any Direct Care programs of another provider of a Care Management Unit.

006.02D2 An organizational chart showing the line of authority between the Care Management Unit Supervisor and the Area Agency on Aging or other public or private entity operating said unit.

006.02D3 A description of the process that a Care Management Unit will use to monitor contractors.

006.02D4 Each Care Management Unit shall maintain accounting records as necessary for presentation of financial statements in accordance with generally accepted accounting principles.

006.02D5 Each Care Management Unit shall obtain and file with the Department an audit report by September 30th of each year. The audit shall be conducted in accordance with generally accepted auditing standards resulting in an opinion of the financial statements of Subsection 006.02D4.

006.02E CLIENT RIGHTS. The Care Management Unit shall have written policies and procedures on client rights, and those rights shall be given to the client prior to the assessment. As used in this section, client shall mean the person receiving services or his or her legal representative. Written policies and procedures shall include as a minimum the following:

006.02E1 Each client has the right to accept or reject care management services.

006.02E2 Each client has the right to be consulted in the development and to approve or disapprove his or her Long-Term Care Plan.

006.02E3 Each client has the right to choose available services and providers of services.

006.02E4 Each client has the right to receive care management services without regard to race, color, sex, national origin, religion, or disability.

006.02E5 Each client has the right to be informed of the name of the care manager responsible for his/her case.

006.02E6 Each client has the right to receive a description of available care management services, fees charged, and billing mechanisms.

006.02E7 Each client has the right to have access to his or her care management service file and record unless access is restricted by law or a State or Federal regulation.

006.02E8 Each client has the right to register complaints and the right to file grievances without discrimination or reprisal from the Care Management Unit.

006.02F CONFIDENTIALITY. The Care Management Unit shall have written policies and procedures which govern confidentiality of case records and information including the following:

006.02F1 Procedures for maintaining confidentiality in releasing information to other agencies or professionals and in obtaining information from outside agencies or professionals. Forms for such release and receipt of client information must be part of the policies and procedures.

006.02F2 Methods and procedures used to secure and to control access to records.

006.02F3 Procedures to be followed by staff and/or contractors when participating in Long-Term Care Plan conferences or consultations involving outside agencies or professionals.

006.02F4 Procedures to put all release forms and/or other documents legally approving the release of information in the client file or record.

006.02F5 Procedures for maintaining confidentiality of case records in use and in storage, including computerized case data.

006.03 CLIENT FILES Each Plan of Operation shall include policies and procedures for establishment of client files and records which shall include all documents relating to the client.

006.02A The Department shall have authority to inspect and review client files and records to evaluate performance and achievement of the Care Management Unit and to verify and audit the services provided and information published by the Care Management Unit.

006.04 TRAINING. A training plan which shall include as a minimum:

006.04A An orientation training for employees, contractors, volunteers, students or interns commensurate with their responsibilities in the Care Management Unit.

006.04B Required participation by the Care Management Unit Supervisor in training provided by the Department.

006.04C A schedule for in-service training, which shall include, but not be limited to, policies and procedures of the Care Management Unit, and techniques, methods, and research on Care Management.

006.05 STANDARDIZED LONG-TERM CARE ASSESSMENT DOCUMENT. Each Plan of Operation shall provide for the use of the standardized long-term care assessment document issued by the Department and made a part of these rules and regulations as Attachment B.

006.05A Each care manager shall be trained by the Care Management Unit Supervisor prior to using the assessment document.

006.06 LONG-TERM CARE PLAN. Each Plan of Operation shall have written policies and procedures concerning Long-Term Care Plan development.

006.06A Each Long-Term Care Plan will be developed in consultation with the client after an assessment; and with the client's approval, the client's family will be consulted in the plan development.

006.06B Each Long-Term Care Plan shall outline procedures for utilizing an interdisciplinary approach to care management which involves input from a variety of professionals, agencies, which may be already involved with the client, and support systems which may be available to the client.

006.06C Each Long-Term Care Plan will utilize and coordinate available and appropriate public and private resources so that persons receive, when reasonably possible, the level of care that best matches their level of need.

006.06C1 Services which are needed but not available will be recorded in the Long-Term Care plan, as well as those rejected by the client.

006.06D As a minimum, the Long-Term Care Plan should:

006.06D1 Establish individual goals and objectives agreed to by the client.

006.06D2 Establish a time frame for implementation of the Long-Term Care Plan.

006.06D3 Define the services which are needed, including any equipment or supplies.

006.06D4 Define who will provide each service.

006.06D5 Specify the availability of services, supplies and/or equipment.

006.06D6 Specify the costs and methods of service delivery.

006.06D7 Provide for reassessment upon change in client status.

006.06E MONITORING. The Plan of Operation shall provide written policies and procedures which detail the Care Management Unit's system for periodic monitoring of the delivery of services to the client. The purpose of periodic monitoring is to reasonably insure the continued appropriateness and effectiveness of the services being delivered as outlined in the Long Term Care Plan.

006.06F REVIEW. The review of the client's Long-Term Care Plan is to determine its continued appropriateness and shall occur at least annually.

006.06G ON-GOING CONSULTATION. There shall be ongoing consultation, including the regular exchange of ideas and comments between the client and the Care Management Unit.

006.07 ACCESSIBILITY OF SERVICES. Each Plan of Operation shall provide for development of a comprehensive directory of available public and private resources that documents Continuum of Care services, including both form and informal community-based services and institutions for use in referral activities of the Care Management Unit.

006.08 UNIFORM DATA COLLECTION. Each Plan of Operation shall provide for use of the Nebraska Care Management Information System as defined in Section 1 of these rules and regulations and which will be provided by the department to the Care Management Unit upon Certification.

006.08A Each Care Management Unit will have access to a compatible computer in order to use the Nebraska Care Management Unit Information System, and will be responsible for data entry and verification for quarterly and annual reports.

006.09 PERIODIC REVIEW. The Department shall conduct periodic review of each Care Management Unit for the purpose of evaluating the Care Management Unit's compliance with the Act and these rules and regulations.

006.09A In conducting a periodic review, the Department shall have access to files and records of the Care Management Unit and the files and records of the provider, supervisor or contractor of a Care Management Unit.

006.09B The Department shall use the results of a periodic review in the process of determining if Certification of a Care Management Unit shall continue.

006.10 AMENDMENT OF THE PLAN OF OPERATION. A certified Care Management Unit shall not change its Plan of Operation or its practice under such plan unless the proposed amendment has been submitted to and approved by the Department.

007 FEE SCALE. Each Care Management Unit shall use the fee scale as adopted and promulgated by the Department and set out in 007.03.

007.01 The fee scale will be based on family income defined as follows:

007.01A Family income is the total income the individual and spouse (in any) receives annually.

007.01B Income is money received as profit from fees (net income after business expenses, before taxes) from a person's own business, professional practice, partnership or farm.

007.01C Income shall include but not be limited to, regular payments such as social security, income from public assistance or welfare, interest, dividends, pensions, net rents, alimony, child support, or allotments.

007.01D Income includes wages, salary, commission, bonuses, or tips from all jobs (before deductions from taxes), including sick leave pay.

007.01E For the purposes of these rules and regulations, family shall mean an individual and his or her spouse.

007.02 The Department adopts as its poverty index the poverty income guidelines issued by the U.S. Department of Health and Human Services and published annually in the Federal Register.

007.03 A client whose family income is below 300% of the poverty level in the index issued by the Department will pay from 0 to 90 percent of the fee for the Care Management Unit services based on the following fee scale.

FAMILY INCOME EXPRESSED AS A PERCENT OF POVERTY	CLIENTS SHARE OF THE FEE FOR SERVICES
0 - 149 percent	0 percent
150 - 166	10
167 - 182	20
183 - 199	30
200 - 216	40
217 - 232	50
233 - 249	60
250 - 266	70
267 - 282	80
283 - 299	90
300+	100

007.04 The Care Management Unit shall inform the individual of the fee for services prior to the delivery of services. Monthly statements of the services rendered and prior balance receivable, charges at full fee, sliding fee scale adjustments, payments received and ending balance receivable shall be sent to each client.

008 REIMBURSEMENT. The Department may reimburse a Care Management Unit for costs not paid for by the client or through other sources.

008.01 Reimbursement by the Department shall be based upon actual casework time units.

008.01A A casework time unit is one hour of reimbursable service by a Care Management Unit supervisor or care manager for a client. The reimbursable services are consultation, assessment, care plan development and coordination, referral of a client to other agencies and services, and care plan review and monitoring.

008.02 The value of a casework time unit shall be calculated by adding all expenses for personnel, administration and planning, client eligibility review, contractual services, and necessary supportive services and other necessary actual and indirect costs of the Care Management Unit, and dividing by the number of actual casework time units to be delivered by a Care Management Unit during the fiscal year as approved by the Department in the budget for the Care Management Unit.

008.03 The reimbursable amount of a casework time unit is based upon the difference between actual value of a casework time unit less fees collected from the client, payments from Medicaid and other third-party payers, and other sources of income to the Care Management Unit as specified in the Act.

008.04 The maximum reimbursable dollar amount per casework time unit is $54, but in no case shall the maximum reimbursement exceed the cost of an actual casework time unit minus costs paid by an individual or through other reimbursement specified in the Act.

008.05 The Department shall provide reimbursement only up to the limit of funds appropriated to the Department under the Act and may not exceed the approved budget and projected actual casework time units in a Care Management Unit's Plan of Operation.

008.06 In requesting reimbursement, the Care Management Unit grants authority to the Department to verify the service delivered to the client by inspecting individual client files and records which must be maintained in the client files and records which must be maintained in the Care Management Unit office, to verify costs allocated to the casework time unit, and to verify total income from an individual or client and from other sources.

008.06A The Department will not reimburse a Care Management Unit for any costs for which the Unit receives payment from an individual or client; or from other reimbursement by state or federal government programs or third-party payers; or from funds appropriated under the Nebraska Community Aging Services Act prior to the effective date of the Act, or from any other sources.

008.07 An Area Agency on Aging which fails to maintain the level of spending on Care Management services equal to the funds appropriated under the Nebraska Community Aging Services Act prior to the effective date of the Act, or to maintain the level of spending from other replacement funds are provided in the Act, shall be ineligible for reimbursement under this Act.

Date Received
by Department
on Aging:

Nebraska Department on Aging
APPLICATION
For
Recertification
of a Care Management Unit

Applicant Name: _____
Address: _____
City, State, Zip: _____
Name of Person to Contact about application, Address and Telephone if different than above:

_____

_____

DIRECTIONS FOR APPLICATION FOR RECERTIFICATION

1) Complete this form, attach necessary information, and submit it to the Nebraska Department on Aging, P. O. Box 95044, Lincoln, NE 68509, anytime between 120 and 90 calendar days before the expiration of certification.

2) A. If the Provider is a corporation, attach a resolution that has been adopted by the Governing Unit of the Care Management Unit's Provider Organization approving Application for Recertification; and

Provider for the signature of the chairperson of the Governing Unit to the statement below:

I,
chairperson of the
(name of agency)
certify that the Governing Board has authorized application for recertification of the Care Management Unit within Planning and Service Area _____.
(appropriate letter designation)

Date: _____ Signature:
Title:

APPLICATION
For
Recertification
of a Care Management Unit (continued)

B. If the Provider of a Care Management Unit is a sole proprietorship or partnership, provide for the signature of the duly authorized person to the statement below:

I,

(name and title)

of

Certify that I am the authorized agent of the above organization and am authorized to apply for recertification of the Care Management Unit within Planning and Service Area

(put appropriate letter designation here)

Date: _____ Signature:

Title:

3) Attach to this application form any change proposed to the Care Management Unit's current certified Plan of Operation which is to be effective with Recertification, along with explanation supporting the reasons for any proposed change.

Chapter 3 LONG-TERM CARE OMBUDSMAN PROGRAM

3-001 SCOPE AND AUTHORITY: These rules and regulations implement Nebraska Revised Statutes Section 81-2237 to 81-2264, which directs the establishment of a statewide long-term care ombudsman program. Other authorities for the program are: (1) Older Americans Act of 1965, as amended, 42 U.S.C. 3001 et seq., specifically, 42 U.S.C. Sections 3058f-3058h; (2) 42 CFR Sections 483.10 through 483.13; and (3) The Nebraska Nursing Home Act, Rev. Statutes of Nebraska, Article 60, Section 71-6019.

3-002 DEFINITIONS:

Adult Protective Services means the Adult Protective Services program of the Division of Aging and Disability Services of the Nebraska Department of Health and Human Services.

Agency means any entity seeking designation or redesignation by the Department to operate and administer a local long-term care ombudsman program in accordance with Neb. Rev. Stat. 81-2237 to 81-2264 and with these rules and regulations.

Conflict of interest means the existence of any interest which impairs an individual's ability to carry out his or her official duties in an impartial manner.

Continuing care community means any facility which provides care to an older individual pursuant to an agreement effective for life, at the same or another location, housing, and at a minimum, access to health-related services, i.e., priority for nursing home admission or assistance in the activities of daily living, except convenience services such as meals and housekeeping, or a system of managed health care.

Department means the Nebraska Department of Health and Human Services.

Director means the Director of the Nebraska Department of Health and Human Services.

Local long-term care ombudsman program means the public or private and non-profit entity designated by the Department to provide long-term care ombudsman services as defined in the Act and in accordance with these rules and regulations.

Long-term care facility means those facilities defined in Nebraska Revised Statutes, Section 71-2017.01, which are licensed or otherwise regulated to provide continuous care to persons age 60 or older. These facilities include:

1. A nursing facility licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a nursing facility or a

skilled nursing facility to provide nursing care and related services for patients who require medical or nursing care or rehabilitation services;

2. A licensed or unlicensed boarding home in which is provided for a period exceeding 24 consecutive hours to four or more individuals, not related to the owner, occupant, manager, or administrator thereof, who are capable of managing their own affairs, at least two of the following for compensation:
    a. Sleeping and other living accommodations;
    b. A dining room, cafe, or common kitchen for the use of the individuals in connection therewith; and
    c. Domestic services requested by the guest.

   Boarding home shall not include hotels, motels, homes operated by religious or fraternal organizations, dormitories at educational institutions, whether public or private, or any of the excluded categories listed in Neb. Rev. Stat., Section 76-1408;
3. Any other adult care home licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a center for the developmentally disabled, or any other licensed or unlicensed facility which provides nursing care, personal assistance, rehabilitative services or supervision for a period exceeding 24 consecutive hours to two or more individuals not related to the owner, occupant, manager, or administrator thereof.
    a. Assisted Living Facility in which are provided for a period exceeding twenty-four consecutive hours, through ownership, contract, or preferred provider arrangements, accommodation, board and an array of services for assistance with or provision of personal care activities of daily living, health maintenance activities, or other supporting services, for four or more nonrelated individuals who have been determined to need or want these services.
    b. Center for the developmentally disabled means any residential facility, place, or building, not licensed as a hospital, which is used to provide accommodation, board, and training, advice, counseling, diagnosis, treatment, care, including medical care when appropriate, or services primarily or exclusively to four or more persons residing in the facility who are developmentally disabled, which term shall include those persons suffering from mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions which require care similar to the care required for persons suffering from such aforementioned conditions, if such conditions meet the definition of developmental disability provided in Neb. Rev. Stat. Section 71-2017.01(20). The term "Center for the Developmentally Disabled" shall include a group residence.
    c. Group residence means any group of rooms located within a building or structure forming a habitable unit with living, sleeping,

cooking, and eating facilities for four or more developmentally disabled persons, operated by the same or identical lessee, owner, or management.

4. Swing bed in an acute care facility or extended care facility means any bed licensed for treatment of individuals requiring short-term acute care treatment or extended care.
5. An adult day care facility means any institution, facility, place, or building which provides nursing care, personal assistance, rehabilitative services, or supervision on a regular, continuing basis for less than a 24-hour period.

Office means the Office of the State Long-Term Care Ombudsman as established by the Department.

Older Americans Act means the Older Americans Act of 1965, as amended 42 U.S.C. 3001 et seq., and its rules and regulations.

Older individual means an individual who is sixty years of age or older.

Ombudsman advocate means an employee or a volunteer of the Office, other than the State Long-Term Care Ombudsman, or of a local program, who is trained and certified by the Office of the State Long-Term Care Ombudsman to carry out duties in accordance with these rules and regulations.

State long-term care ombudsman means the employee or employees appointed by the Director to be responsible for the implementation of the Long-Term Care Ombudsman Program in accordance with Neb. Rev. Stat. Sections 81-2237 to 81-2264 and these rules and regulations.

3-003 DESIGNATION PROCEDURES: Within 60 days of the issuance of a Request for Proposal, agencies, including any interested Area Agency on Aging, shall submit to the Department a proposed Plan of Operation to provide the services of a local long-term care ombudsman program within a planning and service area as described in Neb. Rev. Stat. Section 81-2213(6).

3-003.01 The Plan of Operation shall comply with the Act and these rules and regulations.

3-003.02 The Plan of Operation shall be submitted to the Nebraska Department of Health and Human Services, Division of Aging and Disability Services, P.O. Box 95044, Lincoln, Nebraska.

3-003.03 Within 30 days of receipt of the Plan of Operation, the Department shall complete its review and notify the agency of the Department's approval or denial of designation. If designation is denied, the Department shall provide the reasons for denial.

3-003.03A The Department may deny designation for any or all of the following reasons:

1. Failure to submit a complete Plan of Operation as outlined in these rules and regulations;
2. Failure to provide a Plan of Operation which is in conformance with the intent of the Act; or
3. Failure to provide in the initial Plan of Operation a reasonable time frame for providing local long-term care ombudsman services.

3-003.03B The Department may provisionally designate a local long-term care ombudsman program for no more than 90 days provided -

1. The local long-term care ombudsman program has complied substantially with the requirements of Neb. Rev.Stat. Sections 81-2237 to 81-3364 and these rules and regulations;
2. There is a strong likelihood that the sponsoring agency will be able to correct any areas of non-compliance within 60 days; and
3. No person has been or is likely to be placed in a position where his or her life, livelihood, health, or property is placed in jeopardy by the continued operation of the local long-term care ombudsman program during the period the local long-term care ombudsman program is provisionally certified.

3-003.04 The agency shall have 30 days from the date it receives notice of the initial denial by the Department to submit a revised Plan of Operation.

3-003.05 Within 30 days of the receipt of a revised Plan of Operation, the Department shall notify the agency of its acceptance or denial of the revised Plan of Operation and reasons for denial.

3-003.05A During the initial designation process, an agency may not file a request for an appeal hearing until it has submitted a revised Plan of Operation and has received notice of denial of the revised Plan of Operation from the Department. The appeal hearing procedure is described in 15 NAC 3-004.01.

3-003.06 Standards: In order to be designated as a long-term care ombudsman program, the agency shall meet the following standards:

3-003.06A Demonstrate the capacity to carry out the duties and responsibilities of the local long-term care ombudsman program in accordance with these rules and regulations;

3-003.06B Possess the capacity to develop policies and procedures that conform to all applicable federal and state statutes, regulations, and policies.

3-004 NOTICE OF APPROVAL AND DESIGNATION; APPEAL RIGHTS: The Department shall forward a notice of approval of a Plan of Operation and designation of a local long-term care ombudsman program to the administrator of the agency. Public notice of the designation decision by the Department shall be made after the agency has been informed of the decision.

3-004.01 An agency for a local long-term care ombudsman program which has been aggrieved by a decision of the Department to deny approval of a Plan of Operation or designation of a long-term care ombudsman program shall have the right to appeal, and may exercise the right of appeal by filing notice of appeal within ten working days of receiving notice of denial.

3-004.01A The Department shall set the date, time and place of the hearing within five working days of receiving a request from an aggrieved agency. The hearing shall take place within 30 calendar days of the request.

3-004.01B The Department shall appoint an impartial hearing officer to conduct the hearing.

3-004.01C The hearing officer shall rule on motions and objections and may cross-examine any witnesses. The hearing officer shall prepare proposed written findings of fact and conclusions of law and submit the same to the Director and the State Long-Term Care Ombudsman within 20 working days of the conclusion of the hearing. The Director and the State Long-Term Care Ombudsman shall be in attendance or shall review the record of the hearing.

3-004.01D A representative may appear on behalf of the agency or the agency may be represented by counsel. There shall be opportunity to present witnesses and documentary evidence under the provision of Neb. Rev. Stat. Section 84-914.

3-004.01E The Director shall make a decision which shall be in writing and shall be accompanied by findings of fact and conclusions of law. The findings of fact shall be based on the evidence submitted at the hearing pursuant to Neb. Rev. Stat. Section 84-914.

3-004.01F The Department shall transmit the written decision to interested parties by certified or registered mail within 30 working days of the hearing.

3-004.01G Appeals to the District Court of any order or decision of the Department shall follow the statutory requisites set forth in Neb. Rev. Stat. Section 84-917 unless specifically provided for otherwise in statute.

3-004.01H The Department may terminate formal hearing procedures at any point if the Department and the agency that requested the hearing negotiate a written agreement that resolves the issue(s) which led to the hearing.

3-004.02 Approval of a Plan of Operation and designation of a local long-term care ombudsman program is valid for two years from October 1 and ending on September 30 unless revoked by the Department at an earlier date or the Department specifies a beginning date for the designation period after October 1 in the Request for Proposals.

3-004.02A The Department may specify in its Request for Proposals that the period of designation of any local long-term care ombudsman program shall begin and end in either an odd-numbered year or an even-numbered year.

3-005 REVOCATION OF DESIGNATION: The Department may revoke designation at any time for one or more of the following reasons:

1. There is a change in status or ownership of the agency operating a local long-term care ombudsman program without prior approval of the Department.
2. The resources allocated to the local long-term care ombudsman program by the Department or any other state or federal source are being used in violation of the Act, the Older Americans Act of 1965, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B of Title 15, or of these rules and regulations.
3. The local long-term care ombudsman program fails to perform according to the approved Plan of Operation.
4. The local long-term care ombudsman program fails to obtain approval from the Department for a change in its Plan of Operation in accordance with 15 NAC 3-007.
5. Disclosure of any conflict of interest.
6. The local long-term care ombudsman program is in violation of any of the Older Americans Act of 1965, as amended, and its rules and regulations, attached and incorporated herein by reference as Attachment B of Title 15, the Act, or these rules and regulations.

3-005.01 The Department shall notify the administrator of the local long-term care ombudsman program of its intent to revoke designation. A local long-term care ombudsman program aggrieved by a decision of the Department to revoke designation shall be entitled to an appeal as described in 15 NAC 3-004.01.

3-005.02 A local long-term care ombudsman program whose designation is revoked, and which has appealed such revocation, may have its designation reinstated when, in the judgment of the Department, the conditions leading to revocation have been corrected.

3-005.03 A local long-term care ombudsman program whose designation has been revoked may reapply for designation as a local long-term care ombudsman program 90 working days after the date upon which revocation becomes final, if the Department has not approved the Plan of Operation of another agency.

3-005.04 When revocation of designation of a local long-term care ombudsman program becomes final, the program shall maintain any and all records and files relating to any complaint received by or investigation conducted by the local long-term care ombudsman program pursuant to the Act for two years, during which time the Office shall have access to those records and files. After two years, the Office shall determine how the records and files are to be maintained.

3-005.05 During the process of appeal of a revocation of designation, a local long-term care ombudsman program may continue to serve those clients already being served, unless confidentiality has been violated or the health and safety of clients is compromised. The local long-term care ombudsman program may not take in new clients without prior approval.

3-005.06 When designation of a local long-term care ombudsman program has been revoked, the Office of the State Long-Term Care Ombudsman will provide ombudsman services in the affected planning and service area until another agency has been designated to provide such services.

3-006 REDESIGNATION: An application for redesignation must be submitted by the agency to the Department 60 calendar days prior to the expiration of each two-year designation period. Failure to file for redesignation will cause designation to expire at the end of the two-year designation period.

3-006.01 The application for redesignation shall be submitted according to the designation process as outlined in 15 NAC 3-003.

3-006.02 The Department will consider the following in determining redesignation:

1. Annual review and an on-site inspection including, but not limited, to a review of files and records and visits with clients and cooperating agencies to determine compliance with these rules and regulations and the Plan of Operation.
2. Documentation of the following regarding each ombudsman advocate in their program:
    a. Compliance with their ombudsman advocate contract during the past year;

b. Evidence of 12 hours of training received during the period of designation; and
c. Satisfactory performance as an ombudsman advocate, including attending training and submitting monthly reports.

3. Evaluation of the performance of the local long-term care ombudsman program in meeting its goals and objectives as outlined in its approved Plan of Operation.

3-006.03 Notice of approval or denial of redesignation will be issued by the Department prior to the expiration of the current designation period.

3-006.04 In case of a denial, appeal procedures will be the same as those specified in 15 NAC 3-004.

3-006.05 Within 15 days of completing any program review, the Department shall provide the local long-term care ombudsman program and the agency with written notification of the results. The new designation period shall begin on October 1.

3-007 PLAN OF OPERATION: Each Plan of Operation for a local long-term care ombudsman program shall provide the following information:

3-007.01 A description of the area to be served within a planning and service area. No local program shall include within its service area any facility being served by another designated program.

3-007.02 A statement of philosophy and goals and objectives of the program.

3-007.03 A statement of the procedures to be used to recruit and support volunteer ombudsman advocates.

3-007.04 A statement of methods to evaluate the attainment of program goals and objectives for the program.

3-007.05 If more than one local long-term care ombudsman program is to be established in the planning and service area, a statement detailing how the programs will coordinate services and avoid duplication of effort.

3-007.06 An annual budget of income and expenses for the program coincident with the state fiscal year.

3-007.07 Assurance that the program will comply with all requirements of the Department, including training of all representatives of the Office, confidentiality of records, and reporting.

3-007.08 Assurance that no person shall investigate any complaint filed with the Office unless such person is certified by the Office.

3-007.09 Assurance that the program has the ability to pursue appropriate remedies to resolve complaints, including but not limited to:

3-007.09A Representing residents in administrative hearings and appeals before state and federal agencies, including the Nebraska Department of Health and Human Services, the Nebraska Department of Health and Human Services Regulation and Licensure, the Nebraska Department of Health and Human Services Finance and Support, and the United States Department of Health and Human Services;

3-007.09B Making referrals and recommending specific courses of action, referring situations to public and private agencies such as the Nebraska Department of Health and Human Services Adult Protective Services Program, the Nebraska Department of Health and Human Services Regulation and Licensure, Legal Services Corporations, county attorneys' offices, the Nebraska Attorney General's office, state and federal courts, and other agencies;

3-007.09C Serving as an agent for residents in negotiations with long-term care facilities, public and private agencies, family members, and other individuals and agencies to the extent permitted by state and federal law.

3-007.10 Written policies and procedures for the administrative and programmatic operation of the program based upon the following minimum standards.

3-007.10A Personnel Policies and Procedures: The program shall have a job description for each position, as well as written personnel policies and procedures for hiring and selection, compensation, evaluation, disciplinary action and grievance, and supervision and training of employees, contractors, volunteers, students and/or interns. The personnel policies and procedures shall include:

1. The following minimum requirements qualifications for individuals serving in the capacity of long-term care ombudsman advocates for the State or local long-term care ombudsman programs:

    a. An understanding of long-term care issues;
    b. Experience in the fields of aging and health care;
    c. Worked with and been involved in volunteer programs;
    d. Good verbal, listening, and writing skills;
    e. Commitment to serve a minimum of three hours per week in the performance of their duties, including at least two hours per week in a long-term care facility;
    f. No known conflict of interest which would interfere with their objective performance as an ombudsman advocate;

g. g Understanding of and agreement to follow the ombudsman rules of confidentiality;
h. Agreement to follow the policies and procedures of the State and local long-term care ombudsman program and accept the direction of the Ombudsman Advocate Coordinator.
i. Compliance with the Office's reporting needs to collect and analyze data relating to complaints and conditions in long-term care facilities.
j. Certification by the Department's Office of the Long-Term Care Ombudsman.

2. An Equal Opportunity Policy that includes nondiscrimination on the basis of race, disability, color, sex, affiliation, or age, and an Affirmative Action statement.
3. An organizational chart which identifies the responsibility of each position in the program.
4. Means to ensure that no officer, employee, volunteer, or other representative of the Office, including staff of local long-term care ombudsman programs and ombudsman advocates, shall be subject to a conflict of interest which would impair the ability of said person to carry out his or her official duties in an impartial manner. A conflict of interest shall exist when:
    a. An ombudsman advocate investigates any complaint in a facility in which he or she was previously employed or affiliated;
    b. An ombudsman advocate investigates any complaint in a facility owned or operated by the same person, corporation, partnership, or other entity which owned or operated any facility in which he or she was previously employed or affiliated within the previous two years prior to being employed by or affiliated with the Office of the Long-Term Care Ombudsman or local long-term care ombudsman program;
    c. An officer, employee, volunteer, or ombudsman advocate is affiliated with or has a financial interest in a provider of long-term care services or a membership organization of long-term care providers; or
    d. An ombudsman advocate investigates any complaint in a facility in which an immediate member of the family of the long-term care ombudsman advocate resides or is employed.

3-007.10B Program Staffing Requirements: At a minimum, the local long-term care ombudsman program staff shall consist of one individual available to conduct ombudsman advocate activities, manage the program on a day-

to-day basis, and coordinate and supervise ombudsman advocates, and adequate support staff.

3-007.10C Policies and procedures addressing:

1. Complaint handling, including complaint priority system and types of complaints to be handled by the local office, ombudsman advocates and those to be referred to the Office of the State Long-Term Care Ombudsman;
2. Case assignment;
3. Access to and treatment of confidential information, including the confidentiality of case records;
4. Recruiting, screening, training and supervising ombudsman advocates;
5. Types of information that can be provided by the local office and ombudsman advocates, e.g., survey information, program options, service alternatives;
6. Participation in the Nebraska Department of Health and Human Services Regulation and Licensure survey and certification process as defined in 42 CFR Part 483, Subpart B, attached and incorporated herein by reference as Attachment D of Title 15; specifying when to attend an exit conference, a statement of the information the ombudsman will give to the survey team; and notification to the Nebraska Department of Health and Human Services Regulation and Licensure of the program's policy in this regard.

3-007.11 Fiscal Accountability: Each Program shall maintain accounting records as necessary for preparation of financial statements in accordance with generally accepted accounting principles.

3-007.11A Each Program shall obtain and file with the Department an audit report by September 30th of each year. The audit shall be conducted in accordance with generally accepted accounting standards.

3-007.12 Complaint Investigation and Resolution: Local programs shall investigate and resolve to the best of their ability all complaints received by or on behalf of older individuals who reside in long-term care facilities which are not reportable under the Adult Protective Services Act.

3-007.12A The Office and designated local programs shall represent the interests and wishes of older individuals who are residents of long-term care facilities, even if they are contrary to the interests and wishes of any person who files a complaint with the Office of local program on behalf of such older individuals.

3-007.12B Local policies and procedures shall include, but not be limited to, the following:

1. Intake: During the initial contact with the complainant, the long-term care ombudsman advocate shall advise the complainant of the Program's policies with respect to confidentiality and shall attempt to obtain the following information:
    a. Complainant's name, location, and relationship to the resident (if applicable);
    b. Affected resident's name, age, and location (if applicable);
    c. A clear, specific statement of the problem; and
    d. An understanding of the complainant's desired outcome.
2. Investigation: Upon receipt of a complaint, the long-term care ombudsman advocate shall initiate an investigation, either personally or by referral to another investigative/regulatory agency, to determine the validity of the complaint, the expressed wishes of the resident/client in questions, and the intervention needed to resolve the complaint.
    a. Required information shall be entered in the computerized master file as developed by the Office of the State Long-Term Care Ombudsman (if the local long-term care ombudsman program has access to a computer system) and a permanent written complaint file shall be created for each resident/client using the forms and procedures established by the Office.
    b. The investigation shall begin within 20 working days after a complaint is received. Exceptions may be granted if the best interests of the resident would be served or if other constraints would make a timely response difficult, but shall require the approval of the State Long-Term Care Ombudsman.
    c. An investigation involving a specific resident shall be concluded at any time if the resident so requests.
    d. An anonymous complaint will be investigated by a long-term care ombudsman advocate to the extent possible from the information provided by the complainant.
    e. If the State Long-Term Care Ombudsman, the local long-term care ombudsman or ombudsman advocate does not investigate a complaint, the complainant shall be notified of the decision not to investigate and the reasons for the decision.
    f. A resident shall be presumed competent to make decisions affecting his/her welfare unless he/she has been determined otherwise by a court of law.
    g. The State Long-Term Care Ombudsman, local long-term care ombudsman or ombudsman advocate may refer the

complaint to another agency for investigation or may contact another agency for assistance in the investigation if the long-term care ombudsman or ombudsman advocate believes such action will result in successful resolution of the complaint If such action is considered, the resident/client will be informed of the intended action. The resident/client retains the right to accept or reject such action.

3. Complaint Resolution: Once the investigation is completed, the long-term care ombudsman or ombudsman advocate shall develop and implement a plan of intervention designed to resolve the complaint. The plan shall be documented in the resident/client's permanent written complaint file.
    a. If the complaint alleges noncompliance with facility standards or regulations, the long-term care ombudsman or ombudsman advocate may report or facilitate reporting to the Division of Investigations in the Nebraska Department of Health and Human Services Regulation and Licensure, Nebraska Fire Marshall, or other regulatory agency with appropriate jurisdiction. Such referral will be documented in the resident/client's permanent written complaint file.
    b. Any state agency responding to a complaint against a long-term care facility or an individual employed by a long-term care facility that was referred to them by the Office or the local long-term care ombudsman program shall forward to the Office or local program copies of related inspection reports, plans of correction, and notice of any citations and sanctions levied against the long-term care facility or the individual.
4. Follow-up: Follow-up contacts to evaluate the resolution of the complaint may be made if requested by the complainant or the resident.
    a. The long-term care ombudsman or ombudsman advocate is not obligated to provide any information that might jeopardize the confidentiality of any person involved in the investigation.
    b. If a complaint was referred to another agency for investigation, a follow-up contact may be made to determine what action was taken.
    c. Provisions for follow-up contacts shall be documented in the resident/client's permanent written complaint file.
5. Closure: Closure of the case shall be documented in the computerized master file as developed by the Office, if the local long-term care ombudsman program has access to a computer

system, and the resident/client's permanent written complaint file. A case may be closed under any of the following circumstances:

a. The complaint has been resolved to the satisfaction of the resident/client, the complainant, the long-term care ombudsman or ombudsman advocate.
b. The resident/client refuses further intervention or withdraws the complaint
c. The ombudsman advocate involved in the investigation and the State Long-Term Care Ombudsman agree that continued involvement has no reasonable potential for benefiting the resident/client or would not be consistent with the purpose of the Long-Term Care Ombudsman Program. In this event, the justification shall be clearly explained to the resident/client and the complainant, if appropriate.

3-007.13 Access to Facility Records: The Office and local programs must obtain the consent of the resident/client in order to have access to the medical and personal records retained by the facility of any older individual who is a patient, resident, or client of a long-term care facility.

3-007.13A If consent is given by residents of long-term facilities to allow a representative of the Office access to medical and personal records retained by a long-term care facility, such consent shall be in writing on forms provided by or approved by the Office, unless:

1. The resident is unable or unwilling to consent in writing, but is willing and able to give oral consent, in which case consent may be granted orally by the resident in the presence of a third party; or
2. The resident is under legal guardianship or conservatorship that provides the guardian or conservator with the authority to approve review of records. In such case the representative of the Office shall obtain the permission of the guardian or conservator for review of the records in the same manner as required if the resident was not under conservatorship or guardianship.
3. The consent of the legal guardian or conservator shall not be required if:
    a. The existence of the legal guardianship or conservatorship is unknown to the Office or the facility;
    b. The legal guardian or conservator cannot be reached within five working days;
    c. The subject of the complaint is the guardian or the conservator; or
    d. In case of an emergency.

3-007.13B If the resident is unable to express written or oral consent and there is no legal guardian or conservator or the notification of the legal guardian or conservator is not applicable for reasons set forth in 15 NAC 3-007.13A, item 3, or the resident is deceased, the Office shall have access to the medical and personal records of the resident without prior consent.

3-007.13C If authorized in writing by the resident, legal guardian or conservator of the resident, or any other person having legal authority to inspect records, such authorization shall be made a part of the permanent written file of the resident.

3-008 CERTIFICATION OF OMBUDSMAN ADVOCATES: Ombudsman advocates of local long-term care ombudsman programs shall meet the following requirements in order to be certified.

3-008.01 Successful completion of 20 hours of classroom training covering the following subjects:

1. Federal, state, and local laws, regulations, and policies governing long-term care facilities in the state;
2. Investigative techniques;
3. Understanding the management of long-term care facilities; and
4. Other subject areas determined to be important by the Office.

3-008.02 Successful completion of a three-month probationary period determined through an evaluation of the ombudsman advocate's performance of duties and responsibilities in accordance with these rules and regulations and an on-site evaluation at the ombudsman advocate's assigned facility.

3-008.03 Demonstration of the ability to perform duties and display competence in advocating for residents of long-term care facilities as determined by the State Long-Term Care Ombudsman.

3-009 RECERTIFICATION OF OMBUDSMAN ADVOCATES: Ombudsman advocates shall be recertified biennially, after having met the following requirements.

1. Completion of 12 hours of additional classroom training provided by the Office; and
2. Evaluation of performance of duties and responsibilities in accordance with these rules and regulations and the policies and procedures of the local program.

3-010 DECERTIFICATION OF OMBUDSMAN ADVOCATES

3-010.01 Cause for decertification of an ombudsman advocate may include the following:

1. Any conduct which adversely affects the performance of his or her duties as ombudsman advocate, or which adversely affects the sponsoring agency's ability to provide services under the Act or these regulations.
2. Disclosure of information relating to any complaints or investigations made pursuant to the Act that identifies complainants, patients, residents, or clients to any individual or agency unless such disclosure is:
    a. Authorized in writing by the complainant, patient, resident or client or the legal guardian or legal representative of such individual; or
    b. Necessary for the provision of services to the patient, resident or client and the patient, resident or client is unable to express written or oral consent; or
    c. Made pursuant to court order.
3. Failure to comply with the policies and procedures of the local long-term care program or these rules and regulations;
4. Having a conflict of interest as described in 15 NAC 3-007.10A, item 4, that has not been resolved or has not been disclosed by the ombudsman advocate to the state long-term care ombudsman.

3-010.02 The process of decertification shall be:

1. The local Ombudsman Advocate Coordinator will investigate and document the reasons for pursuing the decertification process.
2. Upon determination that valid reason exists to decertify an ombudsman advocate, the local long-term care ombudsman program will recommend to the Office that the ombudsman advocate be decertified.
3. The Office will review the recommendations and take decertification action, as appropriate.
4. The Office will send a letter to the ombudsman advocate stating that decertification has been requested by the local long-term care ombudsman program, has been approved by the Office, and the reasons for such action.
5. Within 30 days of the receipt of the letter stating that decertification has been requested, the ombudsman advocate may appeal the decision to the Department as described in 15 NAC 3-004.01.
6. The Office, in consultation with the local long-term care ombudsman program, may temporarily suspend an ombudsman advocate pending completion of the investigation and appeal of the decision.

TITLE 15 AGING SERVICES

CHAPTER 4 NEBRASKA AGING NUTRITION SERVICES

001. SCOPE AND AUTHORITY. These rules and regulations implement Nebraska Revised Statute (Neb. Rev. Stat.) Sec. 81-2201 to 81-2227 (the Act) and the Older Americans Act of 1965 (OAA), Title III-A and Title III-C.

002. DEFINITIONS. Nutrition definitions are located in this Title, Chapter 1.

003. GENERAL AREA AGENCY ON AGING REQUIREMENTS.

003.01 REQUIREMENTS. An Area Agency on Aging nutrition program must:

(A) Provide meal services at locations and according to the frequency as prescribed by the State Unit on Aging and the Older Americans Act of 1965, Title III-C;

(B) Comply with all applicable law, including the United States Department of Labor - Occupational Safety and Health Administration rules;

(C) Provide Nutritional Education approved by a Registered Dietitian or by a publicly recognized nutrition organization as prescribed by the Department. Nutrition education must be delivered to individuals at both congregate sites and through home delivered meal programs at least one time per year;

(D) Self-monitor all meal sites within each service area at least annually and as otherwise appropriate; and

(E) Have appropriate arrangements in place for emergency and disaster relief.

(F) Nutrition counseling can only be provided by a Registered Dietitian in good standing. A Medical Nutrition Therapy License is required if a client's nutritional status is medically assessed, treated, and monitored. If permitted and available, compliant distance programs may be used for Nutrition Counseling for individuals who cannot attend face-to-face sessions. Procedures must be compliant with Code of Federal Regulations (CFR) 45 Sec.160, Sec.162, Sec.164, and all applicable law.

003.02 OTHER ENTITIES. With the written permission of the State Unit on Aging, an Area Agency on Aging may delegate the provision of meals to another entity, and the provisions of this chapter and all applicable law would apply to that entity; though, that Area Agency on Aging would remain responsible for compliance with its agreements with the State Unit on Aging and with applicable law, including this chapter.

004. REIMBUREMENT REQUIREMENTS FOR MEALS.

004.01 REQUIREMENTS. An Area Agency on Aging is eligible for reimbursement at the cost of one meal served per present eligible individual per meal time. Meal costs are determined by each Area Agency on Aging. Costs must be allowable, reasonable, and allocable and must be compliant with CFR 200 Subpart E, the Nebraska Community Services Act, as prescribed by the Department, and all applicable law.

005. NON-DUPLICATION OF SERVICES.

005.01 REQUIREMENTS. An Area Agency on Aging must not duplicate services between or among the Nutrition Services Incentive Program and Title III-C with Medicaid Waiver, Title VI, Title XX, or other governmental sources. An Area Agency on Aging must properly record all eligible and non-eligible individual meals in its reimbursement report to the State Unit on Aging.

006. NUTRITION SERVICES INCENTIVE PROGRAM.

006.01 REIMBURSEMENT. Nutrition Services Incentive Program funds can only reimburse an Area Agency on Aging for meals that:

(A) Are served to eligible individuals;

(B) Are served to the spouses of participating eligible individuals and volunteers of any age who are involved directly with the meal service; and

(C) Are derived from domestically produced foods.

006.02 PROCUREMENT. Nutrition Services Incentive Program funds can only be used to reimburse an Area Agency on Aging for the purchase of food.

007. MEAL SITE OPERATIONS.

007.01 OPERATIONS. An Area Agency on Aging operating a meal site must:

(A) Ensure the meal site building and location are:

(i) Compliant with local building and safety codes, the Americans with Disabilities Act and all applicable law;

(ii) Equipped with cleaning solutions and equipment for general cleaning and sanitation;

(iii) Accessible and have connections to proper waste disposal, potable drinking water, electricity and the means to access services for equipment repair and building maintenance; and

(iv) Maintaining meal preparation, cooking, storage, dining and restroom areas to be clean and free from pests and debris;

(B) Ensure meal preparation equipment is safe, in proper working condition, holds temperatures, is sanitary for use, and staff records and monitors temperature and chemical levels; and

(C) Post signage at meal sites showing:

(i) Where exits are located;

(ii) Posted dining menus;

(iii) Cost sharing information for full price and suggested contributions; and

(iv) Signage encouraging individuals to not take home potentially hazardous foods.

008. FOOD SAFTY AND REGULATIONS.

008.01 FOOD SAFETY TRAINING. An Area Agency on Aging operating a meal site must utilize the food safety training program as specified by the Nebraska State Unit on Aging, the Nebraska Food Code, the Food and Drug Administration's Food Code, local food codes, and all applicable law.

008.02 FOODBORNE ILLNESS. An Area Agencies on Aging operating a meal site must report any outbreak of suspected foodborne illness to local health departments and the State Unit on Aging.

009. CONGREGATE MEAL SITES.

009.01 PROCEDURES. Each Area Agency on Aging operating a meal site must:

(A) Institute and maintain appropriate procedures for collecting feedback from individuals about the services received; and

(B) Ensure the provision of a meal to an eligible individual who has failed to make a reservation, when sufficient food is available.

009.02 OPERATIONS. Each congregate meal site operated by an Area Agency on Aging must:

(A) Have an appropriate person designated to be responsible for the day-to-day activities at each site, and physically be on-site during meal time;

(B) Have operational restrooms with toiletries, lighting, and ventilation that meet the requirements of local building codes and all applicable law; and

(C) Have equipment, including tables and chairs, which are sturdy and appropriate for older individuals who may be frail, disabled, or have limited mobility. Tables must be arranged to ensure ease of access and encourage socialization.

010. CONGREGATE MEAL ELIGIBLE INDIVIDUALS AND OPERATIONS.

010.01 REQUIREMENTS. Each Area Agency on Aging operating a congregate meal site must:

(A) Give each eligible individual who receives a meal the opportunity to contribute to the cost of the meal;

(B) Develop a suggested contribution and consider the income ranges of the older individuals in the community and the Area Agency on Aging's other sources of income;

(C) Post a conspicuous sign near the contribution box at each congregate meal site that indicates the suggested contribution for participating eligible individuals and that this amount is a required contribution from participating non-eligible individuals;

(D) The spouse of an eligible older adult congregate meal individual can also participate in the congregate meal program;

(E) An eligible individual cannot be denied participation because of failure or inability to contribute;

(F) Ensure that the amount of an eligible individual's contribution, if any, is kept confidential; and

(G) Establish written procedures that include at least weekly deposits and dual control of financial transactions to protect contributions and fees from loss, mishandling, and

theft. Procedures must be kept on file on-site when feasible and at the providers office when not feasible; and

(H) Use all income received in contributions to increase the number of meals served.

011. POTENTIALLY HAZARDOUS FOODS.

011.01 ALLOWENCE AND PROCEDURES. Each Area Agency on Aging operating a meal site must allow individuals to take away foods that are not potentially hazardous. Centers should have a visible sign that discourages the removal of potentially hazardous foods located at the meal site. Potentially hazardous foods are defined by the Nebraska Food Code.

012. SUGGESTED CONTRIBUTION BOX SPECIFICATIONS.

012.01 MEAL SITES. Each Area Agency on Aging operating a meal site must protect each suggested contribution box with a barrier that shields an individual's declaration or non-declaration from other individuals.

013. TAKE HOME MEALS AND FULL PRICE.

013.01 PROVISIONS. An individual who wishes to take a meal from the meal site is able to do so by paying full price. Meals that are paid for at full price are exempt from sales tax per the Nebraska Sales and Use Tax Regulations. The Area Agency on Aging must provide written instructions, when feasible, in the language of the majority of the individuals, for proper handling and re-heating of the meals sold.

014. HOME DELIVERED MEAL PROGRAM.

014.01 OPERATIONS. Each Area Agency on Aging operating a home-delivered meal program must:

(A) Complete an initial determination of eligibility in person or by telephone;

(B) Complete a written assessment, including nutrition-related supportive services, within two weeks of the individual's first meal service and referrals made as necessary;

(C) Provide reassessment of need, determined by the Area Agency on Aging, annually or with a change in individual status;

(D) Establish a waiting list for home-delivered meals when the provider(s) are unable to provide meals to all eligible individuals;

(E) Provide contribution statements to individuals that clearly state that the amount is a suggested contribution. The statements must not include the words bill, requested, required, or other language implying that it is not voluntary;

(F) Provide home-delivered meals only to persons 60 years of age or older, except a spouse of a homebound eligible individual, regardless of age, is eligible to receive a home-delivered meal if the provision of the collateral meal supports maintaining the person at home; and except an individual with a disability, regardless of age, who resides at home with an eligible individual and is dependent on the eligible individual for care is eligible to receive a home-delivered meal; and

(G) Prioritize the provision of home-delivered meals to eligible individuals with the greatest economic and social need, persons who are homebound due to illness,

incapacitating disability or who are otherwise isolated. Preference must also be given to low-income older adults, including low-income minority older adults, older adults with limited English proficiency and older adults residing in rural areas;

(H) Provide home-delivered meals to eligible individuals at nutritional risk who have physical, emotional, or behavioral conditions that would make their service at a congregate nutrition site inappropriate;

(I) Provide home-delivered meals directly to the individual recipient of the meal;

(J) While delivering home-delivered meals, inform individuals at the residence about any apparent health, fire or safety hazards noticed in the home;

(K) Provide home-delivered meals at the appropriate temperatures in accordance with the Nebraska Food Code and any other applicable law. More than one meal may be delivered for consumption each day for different meal times, if proper storage and heating facilities are available in the home and the individual is able to consume the second meal either alone or with available assistance;

(L) Utilize equipment that maintains the safe and sanitary handling of food items during packaging and transport

(M) Provide home-delivered meals in packages or containers that are easily opened by eligible individuals; and

(N) Provide written instructions, and when feasible, in the language of the majority of the individuals at the residence, for proper handling and reheating of the meals.

015. NUTRITION RISK SCREENING AND ASSESSMENT TOOLS.

015.01 REQUIREMENTS. Area Agencies on Aging must utilize a tool, questions, or both to conduct nutrition risk screenings and assessments, as prescribed by the State Unit on Aging.

016. REQUIRED FORMS.

016.01 REQUIREMENTS. Area Agency on Aging must utilize any required forms from the State Unit on Aging that are identified in program instructions, information memorandums, and applicable communications.

TITLE 15 AGING SERVICES

CHAPTER 4 SENIOR COMPANION VOLUNTEER PROGRAM

4-001 SCOPE AND AUTHORITY: These regulations govern the Senior Companion Volunteer Program. The regulations are authorized by and implement the Nebraska Senior Companion Volunteer Program Act, Neb. Rev. Stat. Sections 81-2273 to 81-2283, and Section 81-2210.

4-002 DEFINITIONS

Department means the Department of Health and Human Services.

Direct service contractor means any public or private nonprofit organization that::

1. Is not currently receiving federal funding for the federal senior companion program; and
2. Demonstrates the ability to provide the services specified in these regulations.

Frail elderly means a person who:

1. Is 60 years of age or older;
2. Has a physical, mental, or emotional health limitation; and
3. Needs assistance to achieve and maintain independent living.

In-home supportive services means those long-term care services provided by a person residing at the same location as the client.

Non-stipended volunteer means an individual who is 60 years of age and provides companion services at least four hours a week without receiving payments for service hours provided.

Senior companion volunteer means an individual who is:

1. Sixty years of age or older; and
2. Provides companion services for frail elderly individuals.

Stipend means a payment per hour of service to a senior companion volunteer that enables him or her to serve without cost to his/herself.

4-003 SENIOR COMPANION VOLUNTEERS

4-003.01 Eligibility Criteria: An individual must meet the following requirement to serve as a senior companion volunteer.

4-003.01A An individual must be age 60 or older, no longer in the regular work force, determined by a physical examination to be capable of serving adults with exceptional or special needs without detriment to either themselves or the adult served, and willing to accept supervision as required.

4-003.01B Eligibility may not be restricted on the basis of education, experience, citizenship, race, color, creed, belief, sex, national origin, handicap, or political affiliation.

4-003.01C Volunteers include both stipended (payment per hour of service) and non-stipended senior companions. Stipended volunteers cannot have an annual income, from all sources, exceeding 125% of the federal poverty level,

4-003.01D Recruitment and selection of a volunteer may not be based on any requirement of employment experience or formal education.

4-003.02 Terms of Service: Volunteers who receive stipends serve a total of sixteen hours a week, usually four hours per day. Travel time between the volunteer's home and place of assignment may not be considered part of the service schedule and is not stipended. Travel time between individual assignments is a part of the service schedule. Meal time may be part of the service schedule only if meals are taken with the individual served, and the taking of meals together is deemed by the sponsor and the volunteer station to be beneficial to the person served.

4-003.03 Direct Benefits for Volunteers: The direct benefits for stipended volunteers include payment per hour of service, insurance, transportation, meals, physical examinations, recognition and uniforms (if necessary). Direct benefits may not be subject to any tax or charge or be treated as wages or compensation for the purposes of unemployment insurance, temporary disability, retirement, public assistance, or similar benefit payments or minimum wage laws. Direct benefits, provided by the direct service contractor, include:

1. Insurance:
    a. Accident insurance;
    b. Personal liability insurance; and
    c. Excess automobile insurance;
2. Meals: Within the limits of available resources and project policy, senior companions must be provided or must receive assistance with the cost of meals taken during their service schedule;
3. Physical examinations: Senior Companions must have a physical examination prior to assignment and annually thereafter;
4. Appropriate recognition will be provided for senior companions;
5. Stipends: Eligible and authorized senior companions will receive a stipend of $2.55 per hour of service. When more than one member of a household serves as a senior companion, only one member is entitled to a stipend; and
6. Transportation: Senior companions must be provided transportation or receive assistance with the cost of transportation to and from volunteer assignments and official project activities, including orientation, training and recognition events.

4-003.04 Senior Companion Assignments

4-003.04A Assignments and activities must involve person-to-person relationships with the individuals served and may not include service to the volunteer station. Appropriate activities may include but are not limited to: personal care, nutrition duties, social/recreational activities, home management, information and advocacy, and respite care.

4-003.04B Individuals served by senior companions must be adults, primarily older adults, who have one or more physical, emotional, or mental health limitations and are not receiving in-home supportive services although in need of assistance to achieve and maintain their highest level of independent living. Program priority will be given to the frail elderly who:

1. Are bedfast or too frail or too ill to be transported to special programs;
2. Have withdrawn from all social interaction or are confined due to psychological problems; or
3. Desire but are unable to participate in adult day services programs because openings are unavailable.

4-004 DIRECT SERVICE CONTRACTORS

4-004.01 Direct Service Contractor Eligibility: The Department must award grants only to public agencies and private non-profit organizations that have the capacity to accept and the capability to administer these grants. Only grantee organizations which do not have senior companion programs as of July 13, 2000 are eligible for these state grants.

4-004.02 Direct Service Contractor Responsibility: The direct service contractor is responsible for all programmatic and fiscal aspects of the project. The direct service contractor must:

1. Designate a project director who is directly responsible to the sponsor for the management of the project;
2. Provide for the recruitment, assignment, supervision, and support of senior companions. Special efforts must be made to recruit and assign persons from minority groups, handicapped, and hard-to-reach individuals;
3. Provide financial and in-kind support to fulfill the project's local share commitment;
4. Provide the senior companions with not less than the minimum accident, personal liability, and excess auto liability insurance;
5. Provide for appropriate recognition of the senior companions and their activities;
6. Establish personnel practices and service policies for senior companions, including grievance and appeal procedures for both volunteers and project staff;
7. Maintain project records in accordance with generally accepted accounting principles and provide for accurate and timely preparation and submission of reports required by the Department;
8. Provide necessary training prior to the start of service and quarterly thereafter;
9. Provide or arrange for direct benefits (insurance, meals, physical examinations, recognition, stipends, and transportation);
10. Ensure that appropriate liability insurance is maintained for owned, non-owned, or hired vehicles used in the project;
11. Develop a realistic transportation plan for the project based on lowest cost transportation modes; and
12. Conduct an annual appraisal of the volunteers' performance and an annual review of volunteers' income eligibility.

4-005 PROJECT DEVELOPMENT

4-005.01 Solicitation of Proposals: The Department must seek applications from direct service contractors on the form attached to the regulations and incorporated by this reference. Any eligible organization may file an application for a grant. Solicited applications are not assured of approval and may have to compete with other solicited or unsolicited applications.

4-005.02 Grant Review and Award Process

4-005.02A The Department must review grant applications to ensure the program requirements are complied with and that required documentation has been attached.

4-005.02B The Department must award available funds to those applicants who proposals provide the best potential for serving the purpose of this program.

4-005.02C Individual project grants of up to a maximum of $50,000 will be awarded for a two-year period.

4-005.02D Receipt of a grant award does not preclude a direct service contractor from applying for a grant that begins in the second year of the two-year period covered by the original grant.

4-005.02E Local match may be in the form of cash or in-kind resources. Local match must be equal to or greater than 10% of the amount of the grant.

4-005.03 Program Monitoring & Reporting: The Department must monitor program activity funded through these grants. Grantees must submit quarterly program reports to the Department describing the number of volunteers, hours of service, persons served, and expenditures.

NEBRASKA SENIOR COMPANION PROGRAM APPLICATION FOR FUNDING

Applicant			
Address			
City		Zip Code	
Contact Person			

Budget

	Grant	Local Cash	Local In-Kind
Administration	$0.00	$0.00	$0.00
Personnel			
Travel			
Insurance			
Office Costs			
Other			
Volunteer Costs	$0.00	$0.00	$0.00
Stipends			
Travel			
Meals			
Physical Exams			
Other			
Total Cost	$0.00	$0.00	$0.00

Please attach a Budget Justification describing the costs in each category.

Service Area

	Stipend	Non-Stipend
Number of Volunteers by End of Year 1		
Number of Volunteers by End of Year 2		

Individuals Served by End of Year 1	
Individuals Served by End of Year 2	

Special Emphasis (optional)

TITLE 15 AGING SERVICES

CHAPTER 5 SENIOR VOLUNTEER PROGRAM

001. SCOPE AND AUTHORITY. These regulations govern the Senior Volunteer Program. The regulations are authorized by and implement the Nebraska Senior Volunteer Program Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 81-2273 to 81-2283, and § 81-2210.

002. DEFINITIONS. Senior Volunteer definitions are located in this Title, Chapter 1.

003. SENIOR VOLUNTEERS.

003.01 ELIGIBILITY CRITERIA. An individual must meet the statutory requirement to serve as a senior volunteer.

003.01(A) AGE. An individual must be age 60 or older.

003.01(B) NON-DISCRIMINATION. Recruitment, selection and eligibility may not be restricted on the basis of education, experience, citizenship, race, color, creed, belief, sex, national origin, disability, sexual orientation, or political affiliation.

003.01(C) BACKGROUND CHECKS. Background checks must meet requirements as set forth by the State Unit on Aging.

003.02 SENIOR VOLUNTEER BENEFITS. Senior volunteers may receive:

(A) Transportation expenses to and from their residences and place where services are to be rendered;
(B) One free meal when reasonably available during each day that services are rendered;
(C) An annual physical examination; and
(D) Accident, personal liability, and excess auto insurance coverage while volunteering.

003.03 SENIOR VOLUNTEER ASSIGNMENTS. Assignments and activities may involve person-to-person relationships with the individuals served or include service to the volunteer station. Appropriate activities may include but are not limited to: personal care, nutrition duties, social or recreational activities, home management, information and advocacy, respite care, service senior center meals, and home delivered meals.

004. SERVICE PROVIDER.

004.01 SERVICE PROVIDER ELIGIBILITY. Public agencies and private non-profit organizations that have the capacity to accept and the capability to administer these grants are eligible.

004.02 SERVICE PROVIDER RESPONSIBILITY. The service provider is responsible for all programmatic and fiscal aspects of the project. The service provider must:

(A) Designate a project director who is directly responsible to the sponsor for the management of the project;

(B) Provide for the recruitment, assignment, supervision, and support of volunteers. Special efforts must be made to recruit and assign persons from minority groups, people with disabilities, and hard-to-reach individuals;

(C) Provide financial and in-kind support to fulfill the project's local share commitment;

(D) Provide the volunteers with accident, personal liability, and excess auto liability insurance as provided below:

(i) Provide a Certificate of Insurance to the State Unit on Aging to ensure while volunteering, senior volunteers are included under the service provider's insurance policies; and

(ii) Adhere to the State Unit on Aging's subaward requirements related to General Insurance, Commercial General Liability and Commercial Automobile Liability insurance provisions and maintenance of the required amounts of insurance;

(E) Provide for recognition of the volunteers and their activities;

(F) Establish grievance and appeal procedures for volunteers following the guidance provided by the State Unit on Aging;

(G) Maintain project records in accordance with generally accepted accounting principles and provide for accurate and timely preparation and submission of reports required by the State Unit on Aging;

(H) Provide training prior to the start of service and quarterly thereafter;

(I) Provide or arrange for direct benefits as described in 003.02 of 15 Nebraska Administrative Code (NAC) 5;

(J) Ensure that liability insurance is maintained for owned, non-owned, or hired vehicles used in the project;

(K) Develop a transportation plan for the project based on lowest cost transportation modes; and

(L) Conduct an annual appraisal of the volunteers' performance using forms prescribed by the State Unit on Aging and an annual review of volunteers' driver's record and liability insurance.

005. PROJECT DEVELOPMENT.

005.01 GRANT APPLICATION. The State Unit on Aging may solicit project proposals. Any eligible organization may file an application for a grant. Any grant application is not guaranteed to be funded.

005.02 GRANT REVIEW AND AWARD PROCESS.

005.02(A) GRANT SELECTION. Grant applicants whose proposals provide the best potential for serving the purpose of this program may be awarded available funds.

005.02(B) FUNDING LEVEL. Individual project grants of up to a maximum of $25,000 are awarded annually and are subject to appropriations and other funding available.

005.02(C) LOCAL MATCH. Local match may be in the form of cash or in-kind resources. Local match must be equal to or greater than 10% of the amount of the grant.

005.03 MONITORING AND REPORTS. Grantees are subject to monitoring of program activity funded through these grants. Grantees must submit quarterly program reports to the State Unit on Aging describing the number of volunteers, hours of service, persons served, and training provided. Reporting format and content requirements are prescribed by the State Unit on Aging.

TITLE 15 AGING SERVICES

CHAPTER 6 LONG-TERM CARE OMBUDSMAN PROGRAM

001. SCOPE AND AUTHORITY. These rules and regulations implement Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 81-2237 to 81-2264, which directs the establishment of a statewide long-term care ombudsman program and meet the requirements of (1) Older Americans Act of 1965, 42 United States Code (U.S.C.) Sections 3058f-3058h, as amended; (2) 42 Code of Federal Regulations (CFR) Sections 483.10 through 483.13; (3) 45 CFR Parts 1321 and 1324; and (4) The Nebraska Nursing Home Act, Rev. Statutes of Nebraska, Article 60, Section 71-6019.

002. DEFINITIONS.

002.01 ADULT PROTECTIVE SERVICES. The Adult Protective Services program of the Nebraska Department of Health and Human Services.

002.02 AGENCY. Any entity seeking designation or redesignation by the Department to operate and administer a local long-term care ombudsman program in accordance with Neb. Rev. Stat. §§ 81-2237 to 81-2264 and with these rules and regulations.

002.03 CONFLICT OF INTEREST. The existence of any interest which impairs an individual's ability to carry out his or her official duties in an impartial manner.

002.04 CONTINUING CARE COMMUNITY. Any facility which provides care to an individual pursuant to an agreement effective for life, at the same or another location; housing; and at a minimum, access to health-related services, that is, priority for nursing home admission or assistance in the activities of daily living, except convenience services such as meals and housekeeping, or a system of managed health care.

002.05 DEPARTMENT. The Nebraska Department of Health and Human Services.

002.06 DIRECTOR. The Director of the Nebraska State Unit on Aging.

002.07 LOCAL LONG-TERM CARE OMBUDSMAN. A representative of the Office, other than the State Long-Term Care Ombudsman, of a local program, who is trained and certified by the Office of the State Long-Term Care Ombudsman to carry out duties in accordance with these rules and regulations.

002.08 LOCAL LONG-TERM CARE OMBUDSMAN PROGRAM. The public or private and non-profit entity designated by the Office to provide long-term care ombudsman services within a designated region of the state as defined in the Older Americans Act and in accordance with these rules and regulations.

002.09 LONG-TERM CARE FACILITY. Those facilities defined in Neb. Rev. Stat. § 71-2017.01, which are licensed or otherwise regulated to provide continuous care.

002.10 OFFICE. The Office of the State Long-Term Care Ombudsman as established by the Department.

002.11 OLDER AMERICANS ACT. The Older Americans Act of 1965, as amended.

002.12 OMBUDSMAN ADVOCATE. A volunteer of the Office, who is trained and certified by the Office of the State Long-Term Care Ombudsman to carry out duties in accordance with these rules and regulations.

002.13 REPRESENTATIVE OF THE OFFICE. An employee or volunteer of the Office who is trained and certified by the Office to carry out duties in accordance with these rules and regulations.

002.14 RESIDENT REPRESENTATIVE. Any of the following:

(A) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
(B) A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees and other fiduciaries) to act on behalf of the resident on order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
(C) Legal representative; or
(D) The court-appointed guardian or conservator of a resident.

002.15 STATE LONG-TERM CARE OMBUDSMAN. The employee appointed by the Department's Chief Executive Officer to be responsible for the implementation of the Long-Term Care Ombudsman Program in accordance with the Older Americans Act of 1965, 42 U.S.C. Sections 3058f-3058h, as amended; 42 CFR Sections 483.10 through 483.13, Neb. Rev. Stat. §§ 81-2237 to 81-2264 and these rules and regulations.

003. DESIGNATION PROCEDURES. A proposed Plan of Operation must be submitted by the agency to the Office to provide the services of a local long-term care ombudsman program within a planning and service area as described in Neb. Rev. Stat. § 81-2213(6).

003.01 PLAN OF OPERATION The proposed Plan of Operation must comply with the Act and these rules and regulations.

003.02 DENIAL The Office may deny designation of a proposed Plan of Operation for any or all of the following reasons:

(A) Failure to submit a complete Plan of Operation as outlined in these rules and regulations;
(B) Failure to provide a Plan of Operation which is in conformance with the Act; or
(C) Failure to provide in the initial Plan of Operation a reasonable time frame for providing local long-term care ombudsman services.

003.03 PROVISIONAL DESIGNATION The Office may provisionally designate a local long-term care ombudsman program for no more than 90 days provided:
(A) The local long-term care ombudsman program has complied substantially with the requirements of Neb. Rev. Stat. §§ 81-2237 to 81-3364 and these rules and regulations;
(B) There is a strong likelihood that the sponsoring agency will be able to correct any areas of non-compliance within 60 days; and
(C) No person has been or is likely to be placed in a position where his or her life, livelihood, health, or property is placed in jeopardy by the continued operation of the local long-term care ombudsman program during the period the local long-term care ombudsman program is provisionally certified.

004. APPROVAL AND DESIGNATION. Approval of a Plan of Operation and designation of a local long-term care ombudsman program is valid for two years from October 1 and ending on September 30, unless revoked by the Office at an earlier date or the Office specifies a different date.

005. REVOCATION OF DESIGNATION. The Office may revoke designation at any time for one or more of the following reasons:
(A) There is a change in status or ownership of the agency operating a local long-term care ombudsman program without prior approval of the Office;
(B) The resources allocated to the local long-term care ombudsman program by the Office or any other state or federal source are being used in violation of the Act, the Older Americans Act of 1965, as amended and its rules and regulations;
(C) The local long-term care ombudsman program fails to perform according to the approved Plan of Operation;
(D) The local long-term care ombudsman program fails to obtain approval from the Office for a change in its Plan of Operation in accordance with this chapter;
(E) Failure to disclose or resolve any individual or organizational conflict of interest; or
(F) The local long-term care ombudsman program is in violation of any of the Older Americans Act of 1965, as amended, and its rules and regulations.

006. REDESIGNATION. Any application for redesignation must be submitted by the agency to the Office 60 calendar days prior to the expiration of each two-year designation period. Failure to file for redesignation will cause designation to expire at the end of the two-year designation period.

006.01 APPLICATION. Any application for redesignation must be submitted by the agency according to the designation process as outlined in this title.

006.02 NOTICE. Notice of approval or denial of redesignation will be issued by the Office prior to the expiration of the current designation period.

006.03 DESIGNATION PERIOD. The new designation period will begin on October 1, unless otherwise provided.

007. PLAN OF OPERATION. An Agency Plan of Operation for a local long-term care ombudsman program, must provide the following information:

(A) A description of the area to be served within a planning and service area. No local program will include within its service area any facility being served by another designated program;
(B) A statement of philosophy and goals and objectives of the program;
(C) A statement of the procedures to be used to recruit and support volunteer ombudsman advocates;
(D) A statement of methods to evaluate the attainment of program goals and objectives for the program;
(E) If more than one local long-term care ombudsman program is to be established in the planning and service area, a statement detailing how the programs will coordinate services and avoid duplication of effort;
(F) An annual budget of income and expenses for the program coincident with the state fiscal year;
(G) A statement of procedures that ensure the program must comply with all requirements of the Office, including training of all representatives of the Office, confidentiality of records and reporting;
(H) A statement of procedures that ensure that no person will investigate any complaint filed with the Office unless such person is certified by the Office; and
(I) A statement of procedures that ensure the program has the ability to pursue appropriate remedies to resolve complaints, including but not limited to:
    (i) Representing residents in administrative hearings and appeals before state and federal agencies, including the Nebraska Department of Health and Human Services and the United States Department of Health and Human Services;
    (ii) Making referrals and recommending specific courses of action, referring situations to public and private agencies, such as the Nebraska Department of Health and Human Services Adult Protective Services Program, Legal Services Corporations, county attorneys' offices, the Nebraska Attorney General's office, state and federal courts and other agencies; and
(J) Serving as an agent for residents in negotiations with long-term care facilities, public and private agencies, family members, and other individuals and agencies to the extent permitted by state and federal law.

007.01 MINIMUM STANDARDS. Written policies and procedures for the administrative and programmatic operation of the program must be based upon the following minimum standards:

(A) The program must have a job description for each position, as well as written personnel policies and procedures for hiring and selection, compensation, evaluation, disciplinary action and grievance and supervision and training of employees, contractors, volunteers, students and interns. The personnel policies and procedures must include:
    (i) The following minimum requirements qualifications for individuals serving in the capacity of local long-term care ombudsman or ombudsman advocates for the State or local long-term care ombudsman programs:

(1) An understanding of long-term care issues;
(2) Experience in the fields of aging and health care;
(3) Worked with and been involved in volunteer programs;
(4) Good verbal, listening and writing skills;
(5) Commitment to serve a minimum of three hours per week in the performance of their duties facility;
(6) No known conflict of interest which would interfere with their objective performance as an ombudsman advocate;
(7) Not been employed by or affiliated with a long-term care facility within the previous 12 months;
(8) Understanding of, and agreement to follow, the ombudsman rules of confidentiality;
(9) Agreement to follow the policies and procedures of the State and local long term care ombudsman program and accept the direction of the Ombudsman Advocate Coordinator;
(10) Compliance with the Office's reporting needs to collect and analyze data relating to complaints and conditions in long-term care facilities; and
(11) Certification by the Office of the Long-Term Care Ombudsman;

(B) An Equal Opportunity Policy that includes nondiscrimination on the basis of race, disability, color, sex, affiliation, or age and an Affirmative Action statement;
(C) An organizational chart which identifies the responsibility of each position in the program;
(D) Means to ensure that no individual or organizational conflict of interest exists in accordance with 45 CFR 1324.21; and
(E) A local long-term care ombudsman program staff must include at least one individual available to conduct ombudsman advocate activities, manage the program on a day-to-day basis and coordinate and supervise ombudsman advocates and adequate support staff.

007.02 FISCAL ACCOUNTABILITY. An agency must maintain accounting records as necessary for preparation of financial statements in accordance with generally accepted accounting principles.

007.03 COMPLAINT INVESTIGATION AND RESOLUTION. A local program will investigate and resolve to the best of its ability all complaints received by or on behalf of individuals who reside in long-term care facilities.

007.03(A) INDIVIDUAL INTEREST. The Office and designated local programs will represent the interests and wishes of individuals who are residents of long-term care facilities, even if they are contrary to the interests and wishes of any person who files a complaint with the Office or local program on behalf of such individuals.

007.04 ACCESS TO RESIDENT MEDICAL RECORDS. The Office and local programs must obtain the consent of the resident in order to have access to the medical and personal records retained by the facility of any individual who is a resident, or client of a long-term care facility. The Health Insurance Portability and Accountability Act of 1996 does not preclude release by covered entities of resident private health information or other resident identifying information to the Office and local programs, including but not limited to residents' medical social or other

records, a list of resident names and room numbers, or information collected in the course of a State or Federal survey or inspection process.

007.04(A) CONSENT. If consent is given by a resident of a long-term facility to allow a representative of the Office access to medical and personal records retained by a long term care facility, such consent must be in writing, including through the use of auxiliary aids and services, unless:

(i) The resident is unable or unwilling to consent in writing, but is willing and able to give oral consent, in which case consent may be granted orally by the resident;

(ii) The resident is under legal guardianship or conservatorship that provides the guardian or conservator with the authority to approve review of records. In such case the representative of the Office must obtain the permission of the guardian or conservator for review of the records in the same manner as required if the resident was not under conservatorship or guardianship; or

(iii) The consent of the legal guardian or conservator will not be required if:

(1) The existence of the legal guardianship or conservatorship is unknown to the Office or the facility;

(2) The legal guardian or conservator cannot be reached within five working days;

(3) The subject of the complaint is the guardian or the conservator; or

(4) In case of an emergency.

007.04(B) REASONABLE CAUSE. If the resident is unable to express written or oral consent and in order to investigate a complaint, the resident representative refuses to consent to the access, a representative of the Office has reasonable cause to believe that the resident representative is not acting in the best interests of the resident the Office will have access to the medical and personal records of the resident without prior consent.

007.04(C) PERMANENT FILE. If authorized in writing by the resident, legal guardian or conservator of the resident, or any other person having legal authority to inspect records, such authorization will be made a part of the permanent file of the resident.

008. CERTIFICATION OF OMBUDSMAN ADVOCATES. To receive certification, local long-term care ombudsman programs must meet the following requirements:

(A) Successful completion of 20 hours of classroom training covering topics as listed in Revised Statute § 81-2253;

(B) Successful completion of a three-month probationary period determined through an evaluation of the ombudsman advocate's performance of duties and responsibilities in accordance with these rules and regulations and an on-site evaluation at the ombudsman advocate's assigned facility; and

(C) Demonstration of the ability to perform duties and display competence in advocating for residents of long-term care facilities as determined by the State Long-Term Care Ombudsman.

009. RECERTIFICATION OF OMBUDSMAN ADVOCATES. Ombudsman advocates must be recertified biennially, after having met the following requirements:

(A) Completion of 12 hours of additional classroom training provided by the Office; and

(B) Evaluation of performance of duties and responsibilities in accordance with these rules and regulations and the policies and procedures of the local program.

010. DECERTIFICATION OF OMBUDSMAN ADVOCATES. Cause for decertification of an ombudsman advocate may include the following:

(A) Any conduct which adversely affects the performance of his or her duties as ombudsman advocate, or which adversely affects the sponsoring agency's ability to provide services under the Act or these regulations;

(B) Disclosure of information relating to any complaints or investigations made pursuant to the Act that identifies complainants, patients, residents, or clients to any individual or agency unless such disclosure is:

(i) Authorized in writing by the complainant, resident or resident representative or the legal guardian or legal representative of such individual;

(ii) Necessary for the provision of services to the patient, resident or client and the patient, resident or client is unable to express written or oral consent; or

(iii) Made pursuant to court order;

(C) Failure to comply with the policies and procedures of the local long-term care program or these rules and regulations; or

(D) Having a conflict of interest as described in this Chapter that has not been resolved or has not been disclosed by the ombudsman advocate to the state long-term care ombudsman.

010.01 DECERTIFICATION PROCESS. The process of decertification is:

(A) The local long-term care ombudsman will investigate and document the reasons for pursuing the decertification process;

(B) Upon determination that valid reason exists to decertify an ombudsman advocate, the local long-term care ombudsman program will recommend to the Office that the ombudsman advocate be decertified;

(C) The Office will review the recommendations and take decertification action, as appropriate;

(D) The Office will send a letter to the ombudsman advocate stating that decertification has been requested by the local long-term care ombudsman program, has been approved by the Office and the reasons for such action; and

(E) The Office, in consultation with the local long-term care ombudsman program, may temporarily suspend an ombudsman advocate pending completion of the investigation and appeal of the decision.