	DELAWARE HEALTH AND SOCIAL SERVICES	Safe H.A.V.E.N.S. services

Revision Table

Revision Date	Sections Revised	Description
10/26/2012		Original
6/4/2013	Attachments	Added: *Attachment C*

	DELAWARE HEALTH AND SOCIAL SERVICES	Safe H.A.V.E.N.S. services

1.0 SERVICE DEFINITION

1.1 Safe H.A.V.E.N.S. service provides temporary emergency placement for vulnerable persons living in unsafe environments pending the development of more long-term plans.

2.0 SERVICE UNIT

2.1 The allowable billing units for the Safe H.A.V.E.N.S. service includes:

2.1.1 Furnishing Charge – Fee for initial room set-up. This unit charge may only be applied once during a 12 month contract year, unless specifically authorized by the Program Manager.

2.1.2 Occupied Rental – this is a 24 hour occupied room charge.

2.1.3 Vacancy Rental – this is a 24 hour unoccupied room charge.

2.1.4 Laundry Fee– this is a charge for laundry cleaned by the provider.

2.1.5 Certified Nursing Assistant (CNA) Fee – this is an hourly unit charge for CNA service. Individual limit for this charge is four (4) hours a day per participant. Any additional units required must be pre-approved by the Adult Protective Services (APS) Case Manager.

3.0 ELIGIBILITY

3.1 The APS Case Manager is responsible to determine and assure participant eligibility for Safe H.A.V.E.N.S. service. Participant eligibility includes, but are not limited to, the following:

3.1.1 Resident of the State of Delaware.

3.1.2 Completed DHSS/DSAAPD Service Agreement Contract (Attachment A)

3.1.3 Completed background check of prospective participant.

3.1.4 Completed orientation of the assigned Safe H.A.V.E.N.S. facility.

3.1.5 Approval paperwork signed by provider agency for admission.

4.0 DHSS RESPONSIBILTIES

4.1 Delaware Health & Social Services (DHSS) will provide background information and medical information to the Safe H.A.V.E.N.S. Provider upon a signed Release of Information form from the participant or participant's responsible party. (Attachment B)

4.2 DHSS will pay a monthly rate; per the negotiated contract to the Safe H.A.V.E.N.S. Provider DHSS will determine level of care based upon the DHSS/DSAAPD Service Agreement Contract.

4.3 The APS Case Manager will be available to the Safe H.A.V.E.N.S. Provider for assistance and/or consultation as needed between the hours of 8:00am-4:30pm. The APS Case Manager will also be available to the Safe H.A.V.E.N.S. Provider if an emergency situation arises.

4.4 DHSS will provide orientation and ongoing training as needed to the Safe H.A.V.E.N.S. Provider.

4.5 The APS Case Manager will be responsible for transporting the program participant to and from the Safe H.A.V.E.N.S. Provider facility during the contract dates; or as agreed upon by the Safe H.A.V.E.N.S. Provider and the APS Case Manager.

4.6 The APS Case Manager will be responsible to give the Safe H.A.V.E.N.S Provider the items documented in the Protective Services Checklist (Attachment C) upon initial placement into the provider's facility, if necessary. APS funds will pay for these items.

4.7 The APS Case Manager will be trained on the Safe H.A.V.E.N.S provider's daily procedures and orientate the participant to the facility.

4.8 The APS Case Manger or Supervisor will screen potential program participants through the Delaware Criminal Justice Information System (DELJIS) information system.

4.9 The APS Case Manger will not refer potential participants that are a danger to themselves, the Safe H.A.V.E.N.S. provider's residents, or staff.

4.10 The APS/RN will complete the Interim Plan of Care (Attachment D) for participants when deemed necessary.

5.0 PROVIDER RESPONSIBILITIES

5.1 The provider must meet and comply with all Federal, State and local rules, regulations and standards.

5.2 The provider must have an active business license or a 501C (non-profit) status from the State of Delaware.

5.3 The provider must be licensed to provide Certified Nursing Assistant (CNA) service for the State of Delaware (if applicable)

5.4 The provider must be able and willing to provide Safe H.A.V.E.N.S. service seven (7) days a week.

5.5 The provider must provide food and immediate shelter to the participant for the Adult Protective Services Program Emergency Placement Program per the contract work plan.

5.6 The provider must offer three (3) meals a day to the participant and assist with any personal needs per the Service Agreement Contract.

5.7 The provider must maintain a safe and nurturing environment during the contract period agreement.

5.8 The provider must have the option to negotiate with the participant any stay longer than the contract period and with approval from the APS Case Manager.

5.9 The provider must assist with activities of daily living (ADL's) per the Service Agreement Contract.

6.0 SAFE H.A.V.E.N. RENTAL UNIT REQUIREMENTS

6.1 The Safe H.A.V.E.N.S. units should offer the following amenities

- 6.1.1 Three (3) meals per day (24 hours)
- 6.1.2 Emergency call system (pendant)
- 6.1.3 Telephone
- 6.1.4 TV service

7.0 WAITING LISTS

7.1 When the demand for a service exceeds the ability to provide the service, the APS Case Manager will manage a waiting list to assure that the most vulnerable population is handled accordingly.

8.0 INVOICING REQUIREMENTS

8.1 The provider must invoice to the APS Case Manager, pursuant to the DSAAPD Policy Manual for Contracts, Policy Number X-Q, Invoicing.

8.2 The following information will also be included on the invoice:

- 8.2.1 Name of program participant.
- 8.2.2 Service Units provided to program participant for time period of invoice.

ATTACHMENT A

SAFE H.A.V.E.N.S. PROGRAM SERVICE AGREEMENT CONTRACT

Department of Health and Social Services

☐ **Adult Protective Services Program** ☐ **Division of Aging/Physical Disabilities Program**

Safe H.A.V.E.N.S. Program Service Agreement Contract

Resident Information

NAME:_____ DOB: _____ AGE: _____ GENDER: M ☐ F ☐

Service Authorizations

Dates of approved Temporary Emergency Placement: Begin Date: ☐ End Date: ☐

Number of Nights: ☐ Needs assistance with laundry: ☐ Yes ☐ No If yes; Daily Laundry Units Authorized: ☐

Provider Authorized to Provide CNA services: ☐ Ingleside Homes, Inc. ☐ Other: _____

Daily CNA hours authorized: ☐

CNA hours to be scheduled: ☐

Resident's Activity

***Activity of Daily Living Care needs*:** ☐ Independent, No Assistance Needed

Needs assistance with dressing: ☐ Yes ☐ No Needs assistance with meals: ☐ Yes ☐ No

Needs assistance with bathing: ☐ Yes ☐ No Needs assistance with using the toilet: ☐ Yes ☐ No

Needs assistance with hygiene: ☐ Yes ☐ No Needs assistance with transferring: ☐ Yes ☐ No

Needs assistance with mobility: ☐ Yes ☐ No Needs device for walking: ☐ Wheelchair ☐ Cane ☐ Walker

****

***Safety Needs*:** ☐ Resident **cannot** be left alone or unattended.

Confidentiality: ☐ No concerns ☐ **No** Visitors ☐ **Do not** disclose that client is a resident

☐ Allow only the following visitors:_____

****

***Medical Information*:** Physician: _____ Phone number: (___)_____

Allergies: ☐ None ☐ Allergies Unknown ☐ Allergies to Food/Medications. (Please List Below)

Known Medical Problems/Concerns: _____

_____

_____

_____

_____

Ingleside Homes, Inc. agrees to provide care for the individual named above during the defined time-period. Ingleside Homes, Inc is responsible for sending the invoice for the approved services within 60 days of the contract's "End Date" (specified above). Invoices received after this time period or after the Division's annual "close out date" for the fiscal year may not be honored. All invoices should be sent via e-mail attachment to (pamela.williams@state.de.us) or fax (302) 255- 4429.

The Department of Health and Social Services agrees to reimburse the Provider for approved days of service at the approved rate as noted in this contract. DHSS will not be responsible for the payment of non-approved dates of service. Should DHSS staff need to begin earlier or extend beyond the dates noted in this contract, the provider must notify the Program's Administrator in order to receive written authorization to amend the dates of the contract. A new contract will be issued and signed PRIOR to the provision of these services. The provider must sign and return the contract to DHSS and will receive a copy of the fully executed agreement.

_____ _____

Provider Signature Date

_____ _____

DHSS Caseworker/ Representative Signature Date

_____ _____

DHSS Program Administrator Review Signature Date

	DELAWARE HEALTH AND SOCIAL SERVICES	Safe H.A.V.E.N.S services

ATTACHMENT B

AUTHORIZATION FOR RELEASE OF INFORMATION

Department of Health and Social Services

ADULT PROTECTIVE SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby give my consent to and authorize _____
to release unto _____
professional information in regard to _____
and are hereby released from all legal liability that may arise from the release of the information requested.
I understand that this information is to be disclosed for the following purpose and that purpose only:

_____

_____

_____

_____

I understand that this consent is subject to revocation by me at any time. Unless an earlier date is specified, this authorization automatically expired 90 days after the date affixed below.

DATE: _____ **SIGNED:** _____

_____

Client or Other Authorized Party

_____

Relation If Signed By Other Than Client

WITNESS: _____

ATTACHMENT C

PROTECTIVE SERVICES CHECKLIST

Protective Services Checklist

To Protective Services workers:

The following is a list of items to look for in a client's home when they are being placed in safe shelter through the Center of Elder Abuse Prevention affiliated with the Jewish Home. We have found from experience that these things are very helpful for us to have, if possible, so that we can best assist our clients with their affairs. The list is in order of priority so that if all items cannot be retrieved the ones at the top are the most important. This is certainly not an all inclusive list so that anything you can obtain would be helpful. We understand that these situations can be volatile and that in most cases time is of the essence. We appreciate anything you can do to make things a little more comfortable for our clients during this difficult time in their lives. Thank you for your attention to this matter and as always thanks for all that you do to protect seniors.

Sincerely,
The Center for Elder Abuse Prevention staff.

- **Wallet including picture ID, social security card, Medicare or other insurance cards.** This helps us to assist clients with their financial affairs or obtain covered services for them from our vendors.
- **Current medication bottles** with pharmacy labels that include medication name, dosage and dosing schedules. This helps us to develop a medication schedule consistent with what that have been prescribed to take home. Unfortunately our policy is not to accept any unlabeled medications so if they are in bottles without labels you do not need to bring them.
- Any **sensory aids** such as glasses, dentures, hearing aids, etc. This helps client's to be able to handle this change of environment better especially if there are cognitive defects
- Any **important document such as living wills, powers of attorney, birth certificates etc.** This helps us to know what our clients' wishes are and to know who they have placed in charge of their affairs. It also helps us to advocate for them with banks, insurance companies, etc.
- Any **personal effects** such as clothing, pictures, etc. These things make the client more comfortable and make the shelter environment feel most like home to them. Of course they are not essential if they cannot be obtained. We have a large amount of donated clothing that we can provide to the clients. As in Maslow's Hierarchy of Needs, safety is the most important thing at this time and supersedes creature comforts.

Note: This is a brief list of things to look for. As stated earlier anything you can get would be helpful.

ATTACHMENT D

INTERIM PLAN OF CARE

Department of Health and Social Services
Interim Plan of Care

Background

ADDRESS:_____ CITY: _____ ZIP: _____

PHONE: _____SOCIAL SECURITY #: _____

MEDICAID #: _____MEDICARE: #:_____

OTHER INSURANCE:_____

REASON FOR PROTECTIVE PLACEMENT: _____

_____

Recommended Interim Recommended Health Aide Care Plan

PSYCHOSOCIAL	ASSISTIVE DEVICES	NUTRITION
☐ Alert	☐ Hearing Aids L / R	☐ Prepare Meals
☐ Oriented	☐ Glasses / Reading Only	☐ Assist to Dining Room
☐ Confused	☐ Dentures	☐ Assist with Meals
☐ Forgetful	☐ Walker	**SPECIAL INSTRUCTIONS**
☐ Needs Redirection	☐ Wheelchair	☐ Vital Signs – PRN
☐ Hard of Hearing	☐ Crutches	☐ Other:
☐ Bowel/Bladder Incontinent	☐ Hospital Bed	
☐ Amputee	☐ Bath Bench	
☐ Paralyzed	☐ Commode	
☐ Non-Verbal Communication	☐ Ostomy Equipment	
☐ Blind	☐ Prosthetic Devices	
☐ Other:	☐ Braces TEDS	

PERSONAL CARE	TOILET / ELEMINATION	MOBILITY
☐ Total Bed Bath	☐ Urinal	☐ Bed Rest / Turn Every _____ hrs.
☐ Assist Bed Bath	☐ Bed Pan	☐ Assist with Transfer
☐ Assist Shower	☐ Commode	☐ Assist with Ambulatory
☐ Assist Tub Bath	☐ Toilet	☐ Wheelchair
☐ Sponge Bath	☐ Incontinence Brief	☐ Walker
☐ Shampoo	☐ Incontinence Care	☐ Cane
☐ Hair Care	☐ Empty Urinary Drainage Bag	☐ Crutches
☐ Mouth Care	☐ Empty Ostomy Pouch	☐ Escort
☐ Shave	☐ Other:	☐ Other:
☐ Skin Care	**PRECAUTIONS**	**SUPPORT SERVICES**
☐ Nail Care (Clean / File)	☐ Infection Control: Hand Hygiene	☐ Housekeeping / Client Services
☐ Assist with Clothing	☐ Choking	☐ Change Linens
☐ Support Self Administered Meds	☐ Bleeding	☐ Bed Making
☐ Comfort Measures:	☐ Oxygen	☐ Laundry
☐ Apply / Remove:	☐ Other:	☐ Shopping / Errands

SIGNATURE:_____ **DATE:**_____
(DHSS Case Manger)

SIGNATURE:_____ **DATE:**_____
(DHSS RN Completing Interim HHA Care Plan)