	DELAWARE HEALTH AND SOCIAL SERVICES Division of Services for Aging and Adults with Physical Disabilities	Safe H.A.V.E.N.S. Service Specifications

Revision Table

Revision Date	Sections Revised	Description
10/26/2012		Original
6/4/2013	Attachments	Added: *Attachment C*
7/5/2017	8.3	Added
5/3/2019	2.1.1	Deleted: - *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.*
5/3/2019	2.1.1, 2.1.2	Revised section to match submitted Work Plan & Budget
5/3/2019	8.3	Deleted: *For the annual Invoice Review, the provider must supply supporting documentation for the contract invoice for the selected month of the Invoice Review. All information must be provided in an email to DSAAPD through the use of Adobe or Microsoft office based software. All supporting documentation must be sent via secure email.*
4/22/2020	Attachment A	Changed reference from Pam Williams to Michelle Welch
4/30/2021	Attachment D	Deleted per M. Serfass
4/30/2021	4.10	Deleted: *The APS/RN will complete the Interim Plan of Care (Attachment D) for participants when deemed necessary.*
4/30/2021	Attachment B	Revised per M. Serfass
5/3/2022	Attachment A	Revised
5/3/2022	Attachment B	Revised
5/3/2022	Attachment C	Revised

	DELAWARE HEALTH AND SOCIAL SERVICES Division of Services for Aging and Adults with Physical Disabilities	Safe H.A.V.E.N.S. Service Specifications

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 Occupied Rental (Daily Rate) – this is a 24 hour occupied room charge.

2.1.2 Vacancy Rental (Unoccupied Rate) – this is a 24 hour unoccupied room charge.

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

2.1.4 Certified Nursing Assistant (CNA) Fee – this is an hourly unit charge for CNA service. Any units required must be pre-approved by the APS Administrator.

3.0 ELIGIBILITY

3.1 The APS/DSAAPD 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/DSAAPD 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/ DSAAPD 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/ DSAAPD 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/DSAAPD Case Manager.

4.6 The APS/DSAAPD 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. DSAAPD funds will pay for these items.

4.7 The APS/ DSAAPD 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/ DSAAPD Case Manger or Supervisor will screen potential program as noted in the Program Service Agreement Contract.

4.9 The APS/ DSAAPD 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.

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

APS Safe Havens Program Form

Department of Health and Social Services

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

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

Resident Information:

First Name:
Last Name:
Birthdate:
Age:
Gender Identity: Choose an item.

Service Authorizations:
Dates of approved Temporary Emergency Placement

Begin Date: Click here to enter a date.
End Date: Click here to enter a date.
Number of Nights:
Needs assistance with laundry: Choose an item.
If yes, daily laundry units authorized:
Provider Authorized to Provide CNA services: Choose an item.
If Other:
Daily CNA hour's authorized:
CNA hour's to be scheduled:

Meals to Room:

☐ Day One Only	☐ First Three Days Only	☐ All Meals to Room ($3 Delivery Charge)

Resident's Activity:

Activity of Daily Living Needs:	☐ Dressing ☐ Meals ☐ Bathing ☐ Toileting	☐ Hygiene ☐ Transferring ☐ Mobility
Needs device for walking: Choose an item.		

Needs device for bathing: Choose an item.
Independent, no assistance needed: ☐
Safety needs- Resident cannot be left alone or unattended: ☐
Confidentiality: Choose an item.
List of allowed visitors:

Family/Other Emergency Contact:

Name:
Email:
Cell Phone Contact:

Background check for completed by DSAAPD/APS staff:
https://backgroundcheckcenter.dhss.delaware.gov/Services/QuickCheck/Default.asopx

Office of the Inspector General	☐ Yes	☐ No
Public Sex Offender Registry	☐ Yes	☐ No
Will client seek a permanent apartment/living arrangement at Ingleside Homes?	☐ Yes	☐ No

Medical Information:

Physician Name:			Phone Number:
Allergies:	☐ None	☐ Allergies Unknown	☐ Allergies to Food/Medications (Please List Below)
Known Medical Problems/Concerns:			
Medications the Client is Currently Using:			

DSAAPD Case Manager's Contact Information:

Name:
Email:
Cell Phone Contact:

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 Michelle.Welch@delaware.gov.

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.

Printed Name – Provider	Signature	Date
Printed Name – DHSS Casework/Representative	Signature	Date
Printed Name – DHSS Program Administrator	Signature	Date

ATTACHMENT B

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization for Release of Information

Permission to Share Information

READ FIRST: If you want the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) to share information about you with another person or agency, please make sure that you fill out all of the sections below. This will tell us what information you want us to share and who to share it with. If you leave any box blank your permission will not be valid, and we will not be able to share your information with the person(s) or agencies you listed on the form.

I understand that DSAAPD has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow DSAAPD to release some of my personal information to certain individuals or agencies.

I, _____, give my permission for DSAAPD to share the
(print name)
following specific information with:

Who I want to have my information shared with:	Name: Specific Office or Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by email

☐ *I understand that electronic mail (email) is not confidential and can be obtained and read by other people.*

What information about me will be shared:	*(List as specifically as possible, for example: name, dates of service, any documents)*
Why I want my information shared: (purpose)	*(List as specifically as possible, for example: to receive benefits)*

I understand and authorize the following agencies to release and send information to DSAAPD:

Who I want to share my information:	

This release of information is for the purpose of coordinating DSAAPD services and supports.

I understand:

- ☐ That I do not have to sign a release form. I do not have to allow DSAAPD to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like DSAAPD to release information about me in the future, I will need to sign another written, time-limited release.
- ☐ That releasing information about me could give another agency or person information that I have been receiving services from DSAAPD.
- ☐ That DSAAPD and I may not be able to control what happens to my information once it has been released to the above person or agency, and that that agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____ _____ *Expiration should meet the needs of the participant.*
Date Time

I understand that this release is valid when I sign and that I may withdraw my consent to this release at any time either orally or in writing.

_____ _____
Your Signature Date

_____
Print Your Name

If someone who has the legal authority to act for you (a court appointed guardian or Power of Attorney or a health care agent) is filling out this form, please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

If additional time is necessary to meet the purpose of this release, please fill out below:
I confirm that this release is still valid, and I would like to extend this release until _____ _____
New Date New Time

Signed: _____ Date: _____

DSAAPD Staff: Please take a picture of the signed form for your records and provide participant with original copy.

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ATTACHMENT C

PROTECTIVE SERVICES CHECKLIST

APS Protective Placement Checklist

The DSAAPD Caseworker should complete the below checklist at admission.

Client Name:	DSAAPD Staff Member:	
Wallet including picture ID, copy left at front desk	☐ Yes	☐ No
Social security card, copy left at front desk	☐ Yes	☐ No
Medicare or other insurance cards, copy left at front desk	☐ Yes	☐ No
Current medication bottles with pharmacy labels, left in room and medications noted in service agreement	☐ Yes	☐ No
Sensory aids such as glasses, dentures, hearing aids, left with client in room	☐ Yes	☐ No
Important document such as living wills, powers of attorney, birth certificates, left with client in room	☐ Yes	☐ No
Personal effects such as clothing, pictures, left in room	☐ Yes	☐ No
Client was given orientation to room, dining facility with mealtimes, mailbox, key, 911 ERS call system	☐ Yes	☐ No
Client was given orientation to smoking policy/ copy of smoking policy	☐ Yes	☐ No
Completed service agreement, checklist left at front desk	☐ Yes	☐ No
Operator at front desks informed of admission after hours	☐ Yes	☐ No
Ingleside admission co Ordinator or delegee notified of admission	☐ Yes	☐ No