DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

MEDICAID PROGRAM: REAL CHOICE SYSTEMS CHANGE & AGING AND DISABILITY RESOURCE CENTER/AREA AGENCY ON AGING GRANTS

Invitation to Apply for FY2008

Combined Real Choice Systems Change and Aging and Disability Resource Center/Area Agency on Aging Grants

Grant Category:

Development and Implementation of a Person-centered Hospital Discharge Planning Model

Additional Options
Grant Option #1: Enhancing or Expanding Aging and Disability Resource Centers/ Single Entry Point Programs (ADRC/SEP)

Grant Option #2: Development of a New Aging and Disability Resource Center/ Single Entry Point Program (ADRC/SEP)

<u>CFDA 93.779</u>

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PART ONE OVERVIEW INFORMATION

Department of Health and Human Services
Centers for Medicare & Medicaid Services

MEDICAID PROGRAM: REAL CHOICE SYSTEMS CHANGE & AGING AND DISABILITY RESOURCE CENTER/AREA AGENCY ON AGING GRANTS

Initial Announcement

Invitation to Apply for FY2008:

Combined Real Choice Systems Change (RCSC) and Aging and Disability Resource Center/Area Agency on Aging Grants (ADRC)

Grant Category:
Development and Implementation of a Person-centered Hospital Discharge Planning Model

Agency Funding Opportunity Numbers

HHS-2008-CMS- RCS-0009

CFDA 93.779

April 17, 2008

Applicable Dates:

Voluntary Notice of Intent to Apply:	May 9, 2008
Grant Application Due Date:	July 17, 2008
Issuance of Notice of Grant Awards:	Prior to September 30, 2008
Grant Period Start Date:	September 30, 2008
Grant Period of Performance/Budget Period:	September 30, 2008- September 29, 2011 (36 months)

For more details and news about events relevant to this and other related grant opportunities, please periodically consult our Web site at www.grants.gov and http://www.cms.hhs.gov/Realchoice. Please note: there is no applicant teleconference.

This information collection requirement is subject to the Paperwork Reduction Act (PRA). The burden for this collection requirement is currently approved under OMB control number 0938-0836 entitled "Real Choice Systems Change Grants" with a current expiration date of January 31, 2009.

PART TWO: FULL TEXT OF THE ANNOUNCEMENT

I. FUNDING OPPORTUNITY DESCRIPTION

A. Background

In 1990, Congress enacted the Americans with Disabilities Act (ADA) (Pub. L. 101-336). The ADA recognized that "society has tended to isolate and segregate individuals with disabilities, and, despite improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem" (42 U.S.C. §12101(a)(2)). The ADA gave legal expression to the desires and rights of Americans to lead lives as valued members of their own communities despite the presence of disability.
Fulfillment of the ADA has been the subject of significant State and Federal leadership through the President's *New Freedom Initiative*. In February 2001, President George W. Bush announced this broad new initiative to "tear down the barriers to equality" and grant a "new freedom" to children and adults of all ages who have a disability or long-term illness so that they may live and prosper in their communities. For more information on the Centers for Medicare & Medicaid Services (CMS) activities related to the President's *New Freedom Initiative,* visit http://www.cms.hhs.gov/NewFreedomInitiative.

Congress has recognized that States continue to face formidable challenges in their efforts to fulfill their legal responsibilities under the ADA. Since fiscal year 2001, Congress has appropriated funds for Real Choice Systems Change (RCSC) grants, specifically to improve community-integrated services. The RCSC grants are designed to assist States and others in building infrastructure that will result in effective and enduring improvements in long-term support systems. These system changes are designed to enable children and adults of any age, with any payer source, who have a disability or long-term illness to:

- Live in the most integrated community setting appropriate to their individual support requirements and preferences;
- Exercise meaningful choices about their living environment, the providers of services they receive, the types of supports they use, and the manner by which services are provided; and,
- Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

Through fiscal years 2001- 2007, CMS has awarded grants totaling approximately $270 million to all 50 States, the District of Columbia, and two territories. With this support, States are continuing to address issues such as personal assistance services, direct service worker shortages, transitions from institutions to the community, respite service for caregivers and family members, better transportation options, access to HCBS, and quality improvement and quality assurance initiatives.

Beginning in 2003, CMS and the Administration on Aging (AoA) offered grants to States to develop Aging and Disability Resource Centers (ADRCs). These ADRCs serve as integrated Single Point of Entry (SEP) into the long-term support system, commonly referred to as "one stop shops" and are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services and supports. ADRC/SEP

programs must work with their Area Agency on Aging (AAA), Centers for Independent Living (CIL) and other entities representing specific target populations to be served. Currently 150 ADRC pilots are operating in 43 States. ADRCs now cover 957 counties serving 30% of the U.S. population and are an integral part of the nation's long-term care system.
Single Point of Entry (SEP) programs should serve as a resource for both public and private-pay individuals and serve older adults, younger individuals with disabilities, family caregivers, and persons planning for future long-term support needs.

To further support States' effort, CMS has also implemented an ambitious national technical assistance strategy to enhance States' efforts to improve community-based service systems and enhance employment supports, providing support to States by posting a repository of "Promising Practices" on its Web site at http://www.cms.hhs.gov/PromisingPractices and by supporting the dissemination of technical assistance materials at http://www.hcbs.org.

Additional support was garnered with the passage of the Deficit Reduction Act of 2005 (DRA). The DRA of 2005 bolstered States' efforts to continue to improve and expand community-based services systems. By offering State plan options for self-directed care, expanded home- and community-based services, and an expansion of Title XIX (coverage for families of children with disabilities), the DRA of 2005 expanded on the groundwork of the RCSC grant program. The DRA also offered almost $2 billion, over a five year period, for the Money Follows the Person Rebalancing Demonstration Grants, Family-to-Family Health Information Centers, and Community-based Alternatives to Psychiatric Residential Treatment Facilities grants. This significant investment parallels and expands the goals of the RCSC Grant Program and will provide a more stable funding source for the initiative.

In fiscal year 2007, Congress appropriated over $15 million in funding another round of RCSC grants. These funds were used to offer 10 State Profile Tool Grants (SPT): Assessing a State's Long-Term System grants and 18 Person-centered Planning and Implementation Grants.

In addition, CMS developed a plan for long-term care reform to improve care for Medicare and Medicaid beneficiaries now and throughout the 21st century (http://www.cms.hhs.gov/MedicaidGenInfo/07_LTCReform.asp#TopOfPage). The plan, initiated in FY06, establishes overarching principles for long-term care and offers a vision to guide current and future reform activities to make long-term care sustainable in the coming decades. The central concept of CMS's vision for long-term care is that the system will be Person-centered; that is, the system will be organized around the needs of the individual, rather than around the settings where care is delivered. The Person-centered system of the future will:

- optimize choice and independence;
- be served by an adequate workforce;
- be transparent, encouraging personal responsibility;
- provide coordinated, high quality care;
- be financially sustainable; and,
- utilize health information technology.

Optimizing choice and independence will enable beneficiaries to have greater flexibility to choose from a broad spectrum of long-term care services, including greater access to home and community-based services as well as institutional services.

Despite progress made by States, institutional bias still exists today. Between 1995 and 2005, spending on long-term care nearly doubled. Although institutional care increased about 50% over the 10-year period, in 2005 it still represented 63% of all long-term care spending (compared to 81% in 1995.) One major issue still confronting consumers is not being given the choice to access home and community-based services verses institutional services. Hospitals are responsible for a majority of nursing facility admissions nationwide. Medicaid beneficiaries, and others currently being discharged from hospitals, are often directed to institutional care instead of home and community-based alternatives. The issues affecting discharge decisions include:

- Institutional providers do not have strong relationships with the community-based resources such as the ADRCs, Area Agency on Aging (AAAs), Centers for Independent living (CILs), and HCBS providers;
- It is easier and may require less time to refer to familiar nursing home providers instead of providing caregivers the needed supports to provide care in the home with appropriate healthcare supports;
- Often discharge planning does not take place until the day of discharge which may be too late to effectively involve the caregiver and arrange for HCBS services; and
- Discharge planners are currently relying on whatever information is readily accessible and available and are often not afforded the opportunity to research and access community information that would benefit beneficiaries on a case-by-case basis.

Optimal, effective discharge planning is further compromised by a lack of understanding of the presence and role of informal caregivers. Although caregivers offer invaluable, uncompensated support, they are not recognized as individuals with needs separate from those of the patient. Many argue for a routine assessment of the caregiver's needs for support, including training. Informal caregivers are often not seen as integral members of the health care team and incorporated into the hospital discharge planning process. Informal caregivers are often not given training essential to ensuring patient safety and preventing unnecessary emergency room visits and re-hospitalization. In addition, in recent years the tasks caregivers are asked to do have become increasingly complex as a result of shortened hospital lengths of stay and increased reliance on complex treatments.

B. Overview of Funding

For FY 2008, Congress demonstrated continued support for the RCSC program by appropriating approximately $9.8 million in funding to continue to support States' efforts to address complex issues in long-term care reformation. In addition, CMS was also awarded $5 million for Aging and Disability Resource Center /Area Agency on Aging grants. This grant solicitation will build upon the successes and direction of earlier RCSC and ADRC grant opportunities by providing targeted assistance to States' in their efforts to improve hospital discharge planning through collaboration with ADRCs, AAAs and CILs. Specifically, this grant opportunity is designed to:

1. Promote the development and implementation of: enhanced hospital discharge planning models that meaningfully engage Medicaid-eligible individuals with disabilities (and their informal caregivers);

2. Increase the capacity of existing -- and develop new-- single entry points (including ADRCs) to provide critical linkages to available long-term care services in the community and much needed supports for informal caregivers themselves;
3. Inform CMS, other Federal agencies and Congress on national policy related to hospital discharge planning, Person-centered planning, and caregiver assessment.

Eligible applicants, for the FY 2008 grant opportunity, apply for one grant. In addition to the requirement for Developing and implementing a Person-centered Hospital Discharge Planning Model there are two optional funding opportunities for ADRCs/SEPs outlined in this solicitation.

C. Requirements for the RCSC/ADRC Grant

Development and Implementation of a Person-centered Hospital Discharge Planning Model

Overview

The overall goal of the grant program is to maximize opportunities for people to live in the community post hospitalization by developing and executing a “model” discharge planning process. This grant opportunity provides funding for States to develop “Person-centered Hospital Discharge Planning Models” in partnership with hospitals, patients and their caregivers, community-based and providers and single entry points to long-term supports. States will develop and execute a “person-centered” discharge planning process that systematically solicits input regarding the needs, preferences, strengths, capacities and desired health outcomes of the individual being discharged from the hospital. In the process, the patient should be given the tools they need to make informed decisions about where and how they will receive services and supports after discharge. Grantees have the option of enhancing or creating new Aging and Disability Resource Centers that serve as the conduit of information on community based options to the patient and his or her caregivers.

Grantees will develop and execute a discharge planning model that is focused on:

- Sustainable and collaborative partnerships between States, hospitals, institutional and community-based providers. These partnerships must include collaboration and coordination with hospital discharge planners, the ADRC/SEP and their AAA and CIL partners currently operating in the State, or to be developed under this grant opportunity, and any other partners deemed necessary by the State.
- Meaningful involvement of the individual and his/her informal caregiver(s) in the discharge planning process.
- Creation and/or enhancement of systems for exchange of accurate, useful and timely information on available home and community-based long-term supports (through ADRCs/SEPs or other means) between community-based providers, discharge planners and individuals and their caregivers, (i.e. development of a web-based tool that provides information on available resources, eligibility information, and contact information) that will assist hospital discharge planners in locating community-based care options.
- Coordination of hospital discharge planning activities with existing Medicaid case management functions, if appropriate.

At a minimum, the Person-centered Hospital Discharge Planning Model must address the following issues:

1. What kinds of sustainable collaborative partnerships a State can form that will enhance the effectiveness of the discharge planning process?
2. Specifically, how is the process of effective discharge planning part of an overall person-centered planning approach?
3. What are some means by which individuals and their caregivers can be meaningfully involved in the discharge planning approach?
4. How can States build or enhance existing systems for exchange of accurate, useful and timely information on available home and community-based long-term supports?
5. How can community-based providers form better relationships with hospital providers so that information on available community-based options is accessible?
6. What supports can States provide to hospitals to encourage participation in this grant program, i.e. training in person-centered planning principles?
7. What can hospital providers do to enhance the discharge planning function, i.e.:
   - If the patient expresses a preference to live in the community, provide effective linkages to the appropriate organization(s) that can provide the spectrum of quality supports and services needed by the patient to live in the community such as assistive technology and coordination with a Medicaid case manager, if appropriate.
   - Means for the hospital to inform the patient and his/her family caregiver(s) of the patient's expected care needs, identification and information on the spectrum of potential service options for post-hospital care, and inclusion of the patient and his/her family caregiver(s) in the development of the discharge plan.
   - If the hospital is considering implementing a discharge plan that relies upon one or more family caregivers to provide some or all of the patient's continuing care, (1) a process to assess and document whether or not the family caregiver(s) are both *willing and able* to provide that care
   - A system to supply of a list of conditions that indicate that the patient may require prompt medical attention and instructions on how to access reliable help to the caregivers.

In their applications, States are encouraged to describe additional issues that they suspect their model could address.

There are several CMS endeavors presently underway in the area of discharge planning and related processes. Grantees and their partners (hospitals, community providers, single entry points, consumers and caregivers) have a unique opportunity to serve as critical partners in developing and executing important initiatives in the areas outlined below. Grantees may be asked to collaborate directly with CMS and its contractors to consult, and possibly test, new innovative models.

The assigned CMS Project Officer (PO) for the Hospital Discharge Planning Model Grants will work closely with grantees to coordinate their efforts with these endeavors.

Dependent on the timing and progress of these projects, there will be a need to integrate specific activities that will enhance the Grantee's proposed person-centered hospital discharge models. CMS will include these activities in grant-specific terms and conditions. CMS will request a revised budget at the time of the award to accommodate any additional activities.

The CMS discharge planning-related projects include:

- Development of a Consumer Discharge Planning checklist (for use by consumers and their caregivers) and outreach campaign in spring 2008, followed by development of a best practice discharge planning model. CMS Office of the Administrator (OA).
- Quality Improvement Organizations (QIO) Program 9th Statement of Work: QIOs will work with providers in geographically defined areas to improve after hospital care by improving the reliability of high quality care, improve efficiency and value of care, and develop insights and infrastructure. CMS Office of Clinical Standards and Quality's (OCSQ).
- Development and testing of a consumer assessment instrument; "Internet-based CARE (Continuity Assessment Record & Evaluation) Patient Assessment Instrument" being tested for use by multiple providers including hospitals. CMS Office of Clinical Standards and Quality's (OCSQ).

Amount of Funding Offered

CMS is offering a total of approximately $13 million to qualifying States based on a competitive award process. This total represents combined funding from two separate Congressional appropriations. For FY 2008, CMS will have available $8 million in Real Choice Systems Change funding for grants (authorized under Public Law 110-161 of the Consolidated Appropriations Act of 2008). CMS has an additional $5 million in ADRC/AAA Grants (authorized under Section 118 of the Medicare, Medicaid and SCHIP Reauthorization Act) which is being made available under Options 1 and 2 of this solicitation.

Successful awardees will receive one grant award based on this solicitation. Base funding will be awarded for Development and Implementation of a Person-centered Hospital Discharge Planning Model; and additional funding may be requested under Options #1 or #2. CMS will determine the allocation of funding to award from the two appropriations.

- Three-year grants to States for Developing and Implementing a Person-centered Hospital Discharge Planning Model are to be awarded in an amount not to exceed $800,000.
- Applicants may request additional funding for:
  - Options #1 Enhancing or Expanding Aging and Disability Resource Centers/ Single Entry Point Programs (ADRC/SEP) $300,000 to $500,000
  - Option #2, Developing a new ADRC or SEP $800,000

NOTE: Applicants may not apply for both Options.

Target Population for the Development and Implementation of a Person-centered Discharge Panning Model

Applicants can select one or more of the following groups of Medicaid eligible individuals (i.e., individuals of any age with long-term disabilities or chronic illnesses) in the development and implementation of this grant opportunity. These groups include:

- Individuals, of any age, with Physical Disabilities or Chronic Illnesses

- Individuals, of any age, with Mental Retardation/Developmental Disabilities
- Individuals, of any age, with Mental Illness
- Individuals with any combination of illnesses and disabilities listed above.(e.g. Dually or Multiply Diagnosed)
- See Option #1 and #2 for specific requirements for target populations

Who May Apply

This grant opportunity is open to any single State Medicaid Agency, State mental health agency, State mental retardation and developmental disabilities agency, State Units on Aging or an instrumentality of the State. Only one application per State will receive an award, but a State may submit more than one application. Specific requirements pertaining to eligible applicants in a State and the required supporting documentation can be found in, Section III., *Eligibility Information*. Failure to comply with all requirements of this solicitation will result in withdrawal of the application from competitive status.
See Option #1 and #2 for specific requirements for who may apply for Options.

Phases of the Grant:

The grant is divided into two 18-month periods over 36 months.
If an applicant chooses to apply for only a Person-centered Hospital Discharge Planning Model Grant or the Person-centered Hospital Discharge Planning Model and Option 1 to enhance an ADRC/SEP the phases of the grant will be:

Phase I (Initial 18 months)**:**

During Phase I, the grantee is required to develop a Person-centered Hospital Discharge Planning Model. During this phase the model is selected, refined, and expanded to include all needed partnerships, plans for assessments, etc. The Product to be submitted as the Eighteen Month Report: PCP Hospital Discharge Planning Model Document

Phase II (Last 18 months):

The Grantee will implement their distinct PCP discharge model and analyze the results of the grants efforts to improve and expand the discharge planning process
Product: Evaluation Outcomes and Final Report

If a grantee chooses to also apply for the Person-centered Hospital Discharge Planning Model and Option #2, Developing a new ADRC or SEP, the phases of the grant will be:

- Phase #1

  24 month Development Period that includes bringing on-line a new ADRC/SEP and developing a Person-centered Hospital Discharge Planning Model is selected, refined, and expanded to include all needed partnerships, plans for assessments, etc.
  Product: Person-centered Hospital Discharge Planning Model Document
- Phase #2:

  12 month Implementation Period the grantee will implement their distinct PCP discharge model and analyze the results of the grants efforts to improve and expand the discharge planning process
  Product: Evaluation Outcomes

For both phases, the grantee is expected to complete two progress reports, for CMS, which will be due 30-days after the conclusion of phase #1, and 90 days after phase #2 at the end of the project period.

Minimum Requirements of the Application:
Narrative: (maximum eight single-spaced pages). The narrative should address the following issues:

1. A description of the development of the Person-centered Hospital Discharge Planning Process to include the following issues:
   - Which consumers are the target population(s);
   - Geographic reach (statewide or regional); and
   - Describe the collaborative partnerships that the State will form that will enhance the effectiveness of the discharge planning process and collaborate in the development and implementation of the Model. These partnerships include institutional and community-based providers, the ADRC/SEPs including AAA and CIL partners and any existing single entry points for information and referral currently operating in the State,
2. What are your Strategies for Achieving your Vision to include the following issues? :
   How do you anticipate :
   - How will Person-centered Planning be achieved? Specifically, how do you see consumers' preferences being elicited and customized choices promoted?
   - Who will receive the training on the model and how will this be accomplished;
   - If your model relies upon family caregivers to provide some or all of the patient's continuing care, how will you assess and document whether or not the family caregiver(s) are both *willing and able* to provide that care.
   - What should be the role of discharge planners as they relate to Medicaid case managers?

   3. Outcomes Measures of the Person-centered Hospital Discharge Planning Model to include the following issues:
   - What specific outcome measures do you propose to evaluate the effectiveness of your model? (Include at least three {3} outcome measures)

Budget for the 3-year Project Period:
- A maximum of a two (2) page budget with appropriate budget line items and a narrative that identifies the funding needed to accomplish the grant's goals. Do not include any costs associated with the execution of Option #1 or Option #2.
- Note: A separate budget as described in the Requirements for Option #1 or Option #2 must be submitted if the applicant chooses either Option in addition to the Budget requirement for Developing and Implementation of a Person-centered Discharge Planning Model.

Memorandum of Agreement
- All participating entities that will take part in the development and implementation of the Person-centered Hospital Discharge Planning Model must sign a memorandum of agreement to collaborate on the Project with the State.
- Entities include State Agencies and Administrations, Hospitals, ADRCs, AAAs, CILs, SEPs, provider agencies and any other entity that will participate.
- The memorandum of agreement must State the goals and objectives of the project and a timeline which identifies which entity will be responsible for what tasks.

Technical Assistance
In order to accomplish the goals and objectives proposed by the applicant, grant funds can be used to purchase technical assistance. For purposes of this solicitation, technical assistance is defined as the provision of consulting services from individuals who are not part of the grant staff to complete grant goals. Thus, technical assistance contractors are not grant staff (either State employees and/or contracted staff). They are contracted consultants. The technical assistance purchased can be used for the development and/or implementation of this RCSC grant. It is not to be used for the following two functions: *to hire a project manager or to hire a project director*. Only State/State Personnel Contract grant staff may be permitted to carry out these roles.

Definitions
For this solicitation:
A **consumer** is defined as a person of any age or disability who seeks to reside in the community with the support of public funding. Persons included are patients being discharged from hospitals to rehabilitation facilities, nursing homes ICF-MR and other types of institutional settings. Informal Supports are defined as family members, neighbors or friends whose regular assistance helps the consumer reside in the community. The consumer chooses support from the family caregiver(s) as part of the PCP process for community living.

Person-centered Planning is defined as a plan that empowers people with disabilities by focusing on the desires and abilities of the individual. Person-centered Planning involves a team of family members, friends, professionals and most importantly, the individual. The individual chooses their team members. This team then identifies the skills and abilities of the individual that can help them achieve their goals of competitive employment, independent living, continuing education, and full inclusion in the community. They also identify areas in which the individual may need assistance and support and decide how the team can meet those needs. While it is recognized that not all of the elements of a complete person-centered plan can be achieved prior to discharge from the hospital, many elements can be addressed. Elements, such as working with the patient to develop the most independent living arrangement and providing assistance and supports that are desired by the patient are included. The patient with involvement of family members, professionals and others work toward the ultimate discharge plan goal of living as independently as possible with home and community-based services.

Informal Community Network is defined as the consumer's current and potential friends and other social connections that do not provide continual care to the person but provide social support and may help intermittently with tasks and chores.

Helpful information may be accessed at the following websites:

Caregiver Assessment: Principles, Guidelines & Strategies for Change. *Vol. 1.* April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf

Caregiver Assessment: Voices and Views from the Field. Vol. II. April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v2_consensus.pdf

Caregivers Count Too. An Online Toolkit to Help Practitioners Assess the Needs of Family Caregivers. June 2006. http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1695

Feinberg, Lynn Friss. *The State of the Art: Caregiver Assessment in Practice Settings.* September 2002. http://www.caregiver.org/caregiver/jsp/content/pdfs/op_2002_state_of_the_art.pdf

Grant Option #1: Enhancing or Expanding Aging and Disability Resource Centers/ Single Entry Point Programs (ADRC/SEP)

Overview
In addition to developing and implementing the Person-centered Hospital Discharge Planning Model, funding may be sought through this grant opportunity for assistance in enhancing or expanding existing Aging and Disability Resource Center (ADRC) programs or other single entry point (SEP) programs. An award under this option will better position ADRCs/SEPs to play an active role in implementing the State's proposed Person-centered Hospital Discharge Planning Model.

Applicants seeking funding under this option must be expanding or enhancing their ADRC/SEP projects within the framework established under the AoA and CMS ADRC Program Announcements published in 2003 and 2005. The key ADRC elements that must be supported are described in detail in Appendix "A", The CMS and AoA ADRC Model, as well as in Appendix "B", Criteria for a Fully Functioning Single Entry Point System/ADRC. In addition, ADRC/SEP programs funded under this option must work in partnership with Area Agency on Aging, Centers for Independent Living and other entities representing specific target populations to be served.

CMS recognizes that additional funding opportunities are available to assist States in their efforts to streamline access to long-term care for older Americans and individuals with disabilities. Applying for and securing funding from multiple sources is encouraged. Applicants applying for funding under this program announcement must outline in their proposal all current funding resources directly supporting their ADRC/SEP and all grant applications pending/planned for FY 2008 that include activities to support their ADRC/single entry point program.

Program Expansion to Additional Communities
The AoA and CMS vision is to have Aging and Disability Resource Centers in every community across the country serving as highly visible and trusted places where people with disabilities of all ages can turn for information on the full range of long-term support options and to access single point of entry to public long-term support programs and benefits. To assist States in their efforts to achieve this vision in coordination with the Person-centered Hospital Discharge Planning Model, applicants may apply to make ADRC services available to consumers in additional communities.

State ADRC expansion may be achieved in several ways. For example, an existing ADRC pilot site service area may be expanded to cover a larger geographic region or to provide statewide coverage. An ADRC pilot model tested in one part of the State may be replicated in other areas of the State. Resource Centers may be established based on a model that is being demonstrated in another State. A State may also choose to demonstrate a new ADRC model that will provide additional infrastructure to meet the specific needs of a Person-centered Hospital Discharge Planning Model. However, if a State chooses to expand the availability of ADRC services for the

purposes of this initiative, CMS strongly encourages all applicants to continue their efforts towards eventual statewide availability of the ADRC.

Program Enhancement

Under this option, applicants have the opportunity to advance their ADRC as a fully operational single point of entry to long-term care capable of supporting a Person-centered Hospital Discharge Planning Model. A number of activities may be undertaken to better position the ADRC:

- Project activities designed to foster coordination between ADRCs and hospitals around diverting individuals from institutional care may be proposed.
- Enhance the ability of management information systems to be used across agencies to avoid duplication of information and permit ADRCs to gather information and pass it onto other entities involved in approving applications for publicly funded programs. Such systems may also be used to allow other entities to gather information and share it electronically with the ADRC.
- Activities designed to enhance the effectiveness of the ADRC through information technology. Fundable activities include activities to enhance or integrate management information systems, the development/expansion of ADRC websites including web-based resource databases, applications, assessment tools and client tracking capabilities.
- Applicants may propose to use grant funding to expand the target populations of people with disabilities served by the ADRC, working towards the goal of one day serving people with disabilities of all types and ages.
- Supplement evaluation activities to document the specific benefits of using the ADRC as the single point of entry for diversion programs such as the Person-centered Hospital Discharge Planning Model. Documented savings to Medicaid or other public funding may serve to encourage additional support from State, Federal, and other resources.
- In partnership with the Single State Medicaid Agency, fund activities that explore the feasibility of, or prepare for the implementation of the ADRC as the only point of entry to publicly funded long-term care.

Target Populations: ADRCs under this Option must, at a minimum, serve the older adult population and at least one of the following major target groups: (a) individuals with physical disabilities, (b) individuals with serious mental illness, and/or (c) individuals with mental retardation/developmental disabilities. Individuals with traumatic brain injury may be classified by the State in the target group that best conforms to the State's service delivery system and historical practice. The same principle applies to any other condition that often spans target group boundaries such as those individuals with multiple diagnosis. For the definition of "older adult" in this solicitation, we use age 60 and above as specified in the Older Americans Act.

Eligible to Apply (This Option)

Eligible applicants under this option include States that received a CMS and AoA ADRC grant in 2003, 2004 or 2005 or a State that has an existing Single Entry Point (SEP) program that conforms with the definition of a Fully Functional SEP as detailed in Appendix B.

Minimum Requirements for the Application Option #1

A maximum of six (6) pages: Narrative of the expansion or enhancement intervention being proposed. The summary must include:

- For States applying under this option that have not received a CMS and AoA ADRC grant in the past, the application should also include a maximum of two (2) additional pages describing their SEP program and how it meets the definition of a fully operational SEP/ ADRC as described in Appendix "B". **This Program Description must be noted in the Application Table of Contents and noted at the top of the first page of the submission of the Problem Statement/Narrative for this Option.**

  Problem Statement/Application Narrative:
  - A description of the ADRC/SEP project's planned enhancement or expansion.
  - How will this project advance the development and implementation of the Person-centered Hospital Discharge Planning Model
  - The summary should also include a clear delineation of the roles and responsibilities of project staff, consultants, and partner organizations, and how they will contribute to achieving the project's objectives and outcomes
  - Applications including "Program Expansion" activities should include the following elements in their application:
    - Identify the geographic area to be served by the ADRC/SEP expansion as well as the ADRC model to be used
  - Identify any additional funding secured or pending that will contribute to the enhancement or expansion of your ADRC/SEP.
- A maximum of a one (1) page - Work Plan/Timeline
  - A Work Plan/Timeline for the proposed goals objectives and activities related to the expansion and/or enhancement of the ADRC/SEP.
- A maximum of one (1) page- Description of the Grant Implementation and Outcomes
  - A description of any measurable performance goals and indicators to be used to measure the success of the interventions related to the ADRC/SEP program's visibility trust, ease of access, responsiveness, efficiency, and cost effectiveness.
- A maximum of two (2) pages -Budget Presentation for Option #1:
  - Line item budget with narrative notes for the three-year project period that does not exceed $500,000.

Grant Option #2: Development of a New Aging and Disability Resource Center/ Single Entry Point Program (ADRC/SEP)

Overview

In addition to developing and implementing the Person-centered Hospital Discharge Planning Model, funding may be sought through this grant opportunity for assistance in developing a new Aging and Disability Resource Center (ADRC) program or other single entry point (SEP) program. An award under this option will better position an ADRC/SEP to play an active role in implementing the State's proposed Person-centered Hospital Discharge Planning Model.

The goal of the CMS and AoA Aging and Disability Resource Center (ADRC) Program is to empower individuals to make informed choices and to streamline their access to long-term supports and services. The vision is to have Single Entry Point (SEP) programs serving as highly visible and trusted places where people can turn for information on the full range of long-

term support options and a single point of entry to public long-term support programs and benefits.

SEP programs should serve as a resource for both public and private-pay individuals and serve older adults, younger individuals with disabilities, family caregivers, and persons planning for future long-term support needs. ADRC/SEP programs must partner with Area Agency on Aging, Centers for Independent Living and other entities representing specific target populations served by an ADRC.

For the purposes of this grant option, the availability of information and counseling for private-pay individuals is a central element of the SEP program. Reaching people before they are institutionalized and before they become Medicaid-eligible is a key function. SEP programs can assist consumers of all ages and disabilities in their efforts to remain at home and in the community and can assist them in making better use of their own resources and prevent or delay spend-down to Medicaid.

Target Populations
ADRCs/SEPs under this Option must, at a minimum, serve the older adult population and at least one of the following major target groups: (a) individuals with physical disabilities, (b) individuals with serious mental illness, and/or (c) individuals with mental retardation/developmental disabilities. Individuals with traumatic brain injury may be classified by the State in the target group that best conforms to the State's service delivery system and historical practice. The same principle applies to any other condition that often spans target group boundaries such as those individuals with multiple diagnoses. For the definition of "older adult" in this solicitation, we use age 60 and above as specified in the Older Americans Act.

<u>The CMS/AoA vision is for ADRC/SEP Programs to</u>:

- Provide **Awareness and Information** - public education; information on long-term support options.
- Provide **Assistance** – long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.
- Provide **Access** - eligibility screening; assistance in gaining access to private-pay long-term support service; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.
- Include a **plan for streamlining access to long-term care signed** by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities.
- Serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). Projects should move towards the goal of serving persons with disabilities of all ages and types.
- **Target private-pay individuals** in addition to those eligible for publicly funded services.
- Create formal linkages between and among the **critical pathways to long-term support.**

- **Meaningfully involve stakeholders, including consumers**, in planning, implementation and evaluation activities.
- Have a **management information system** that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.
- Establish **measurable performance objectives** including objectives related to visibility of Resource Centers, consumer trust in Resource Centers, ease of access to services, responsiveness to consumer needs, efficiency of operations and effectiveness of the Resource Center program.

A detailed description of the CMS and AoA ADRC model is included with this Program Announcement as Appendix "A". Applicants seeking funding under this option should develop an application narrative that describes in ten (10) pages or less their plan for developing a SEP program in one or more regions of the State that meets the vision laid out by CMS and AoA in Appendix "A" and that strives to meet the definition of a fully functional SEP, as described in Appendix "B" within 18 to 24 months.

Eligible to Apply (This Option)
Any State or territory that has not previously received a CMS and AoA ADRC grant and that does not currently have a SEP program that is fully operational as defined in Appendix "B".

Minimum Requirements for the Application Option #2
Applicants seeking to develop an ADRC/SEP program as described under this should submit proposal of up to a maximum of ten (10) pages in length that includes the following:

Narrative: Developing a New ADRC/SEP -maximum eight (8) pages which must include:

- A Problem Statement/Target Population – The applicant must provide a general description of its long-term support system, including a description of how the current system limits or facilitates individual choice and access for both public and private pay individuals in the applicant's target population. The applicant should describe current efforts to address information and access issues and problems.
  Target Populations – a statement of the target population to be served initially and a commitment to work towards serving individuals of all ages and disabilities.

- Proposed Intervention a description of the planned approach to advance the vision and goals outlined in Appendix "A" of this announcement that includes:
  - The provision of information, referral, and options counseling.
  - The plans to streamline, coordinate, and/or integrate existing intake, screening, assessment, eligibility determination, and counseling services.
  - How the project will ensure that targeted populations will utilize the SEP system to access the long-term support system.

- Describe how the proposed SEP/ADRC will facilitate the Person-centered Hospital Discharge Planning Model.
- Describe how you will address the identified problems related to consumer access to long-term supports and services to create a SEP program as defined in Attachment "A" and how your approach is likely to be effective streamlining access to long-term supports and services for the proposed target populations.

- Describe how your proposed SEP would coordinate significant programs – including Medicaid, programs for individuals with disabilities, the Older Americans Act, and State-only programs – supporting efforts by individuals to access long-term support options including individuals being discharged from acute care settings.
- Include a description of the commitment from partners and include any letters of support in an appendix to your application.
  Describe how consumers and other stakeholders will have meaningful involvement and planning and implementation of the proposed project.
- Describe the applicant's capacity to accomplish the proposed project and identify the principle investigator/project coordinator with lead responsibility for planning and implementation.

Evaluation, Formative Learning and Management Information System - maximum of one (1) page:

- Performance outcome measurement – description of the initial measurable performance goals and indicators that you plan to use to measure the success of your program over the long run, including those related to the program's visibility**,** trust, ease of access, responsiveness, efficiency, and cost-effectiveness .States should indicate at least three (3) outcome measures.
- Describe your proposed data collection and management strategies, consistent with the Resource Center vision for tracking progress on the program goals and objectives and incorporating feedback into the project's ongoing operations.

ADRC/SEP Work Plan- maximum of one (1) page: A timeline is required with the project goals and objectives consistent with those outlined in the basic narrative. The work plan should document reasonable benchmarks, milestones, timeframes, and identifies the responsible parties to accomplish the goals of the project.

Budget Presentation for Option #2 - maximum of two (2) pages:

- A line item budget with narrative notes for the three (3) year project period that does not exceed $800,000.
- Funds for two representatives to attend two ADRC meetings/events during each year.
- Include the required 5% State Match.

II. AWARD INFORMATION

A. TABLE OF RCSC/ADRC GRANTS FY2008

This solicitation discusses the available funding from CMS for RCSC/ADRC Grants for FY 2008. The appropriation for this Grant Program may be found in the Consolidated Appropriations Act, Public Law P.L.110-161. The ADRC/AAA appropriation is found in Section 118 of the Medicare Medicaid SCHIP Extender Bill of 2007. These grants are authorized by the President's Executive Order 13217 "Community-Based Alternatives for Individuals with Disabilities" and pursuant to §1110 of the Social Security Act (the Act). This solicitation for the RCSC/ADRC Grants is also available at http://www.cms.hhs.gov/RealChoice/

Note: The "maximum award" spans the project period of thirty-six (36) months.

CFDA 93.779 Grant Opportunity	Total Funding	Who May Apply?	Max. No. of Grant Awards per State per Type of Grant	Maximum Award*	Project Period	Percent Allowable for Direct Services **	Estimated Number of Awards
Development and Implementation of the Person-centered Hospital Discharge Planning Model	Approx. $8 Million	Single State Medicaid Agency, State Mental Health Agency, State MRDD, State Dept. of Aging or Instrumentality of the State	1	$800,000	36 months	0	10
Option#1: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Enhancing Aging and Disability Resource Centers	Approx. $2.6 to $3.4 Million	Single State Medicaid Agency, State Mental Health Agency, State MRDD, State Dept. of Aging or Instrumentality of the State	1	$300,000-$500,000	36 months	0	4-7
Option#2: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Development of a new Aging and Disability Resource Center	Approx. $1.6 to $2.4 Million	Single State Medicaid Agency, State Mental Health Agency, State MRDD, State Dept. of Aging or Instrumentality of the State	1	$800,000	36 months	0	2-3

B. Anticipated Award Date

Awards will be announced by September 30, 2007.

C. The Period of Performance

The period of performance for both grant categories will be September 30, 2008 to September 29, 2011 (36 months).

D. Renewal or Supplements of Existing Projects are eligible to compete for these new awards.

All Entities that meet the eligibility requirements as stated in **Section III, Eligibility Information** are eligible to apply if they also have existing projects.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

This grant opportunity is open to any single State Medicaid Agency, State Mental Health Agency, State Mental Retardation or Developmental Disability Agency, State Unit on Aging or instrumentality of a State (as defined under State law) may apply for the RCSC/ADRC Grants. By "State" we refer to the definition provided under 45 CFR 74.2 as "any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments." "Territory or possession" is defined as Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands. Please see additional eligibility requirements under Option #1 and Option #2.

2. Cost Sharing or Matching

Grantees are required to make a non-financial contribution of **5 percent** of the total approved cost of the project (including all direct and indirect costs). Non-financial contributions may include the value of goods and/or services contributed by the grantee (e.g., salary and fringe benefits of staff devoting a percentage of their time to the grant not otherwise included in the budget or derived from Federal funds). The non-financial contribution requirement may also be satisfied if a third party participating in the grant makes an "in-kind contribution," provided that the grantee's contribution and/or the third-party in-kind contribution total 5 percent of the total grant award (including all direct and indirect costs). Third-party in-kind contributions may include the value of the time spent by consumer task force members (using appropriate cost allocation methods to the extent that non-Federal funds are involved) who specifically contribute to the design, development, and implementation of the grant. Non-financial contributions must be included in the applicant's budget in Item 15 (Estimated Funding) on Standard Form 424A and described in the Budget Requirements subsection of the application (see Section V.3).

3. Other

Not applicable**.**

4. Foreign and International Organizations

Foreign and International Organizations are not eligible to apply.

5. Faith-Based Organizations

Faith-Based Organizations are not eligible to apply.

IV. APPLICATION AND SUBMISSION INFORMATION

Applications not received by the application deadline will not be reviewed.
Even though an application may be reviewed and scored, it will not be funded if the application fails to meet any of the requirements as outlined in, Section III, *Eligibility Information* and, Section IV*, Application and Submission Information.*

Applicants are **strongly encouraged** to use the review criteria information provided in Section V., *Application Review Criteria and Information*, to help ensure that you adequately address all the criteria that will be used in evaluating the proposals.

1. Address to Request Application Package

Applicants must submit their applications electronically through http://www.grants.gov. ***Please note*** *when submitting your application electronically, you are required, additionally, to mail a signed SF-424 only to Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Acquisition and Grants Management, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850.* The mailed SF-424 form must be received at the Centers for Medicare & Medicaid Services within two (2) business days of the application closing date.
Up-to-date information about the RCSC/ADRC grants may be accessed at:
http://www.cms.hhs.gov/RealChoice/.
A complete electronic application package, including all required forms, for the RCSC grants is available at http://www.grants.gov.
Standard application forms and related instructions are available online at
http://www.grants.gov/agencies/approved_standard_forms.jsp#1 and
http://apply.grants.gov/forms/sample/SSA_AdditionalAssurances-V1.0.pdf
Standard application forms and related instructions are also available from Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Acquisition and Grants Management, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850 or by e-mail at Nicole.Nicholson@cms.hhs.gov.

2. Content and Form of Application Submission

In the event that the electronic submission of the application has failed through http://www.grants.gov , please mail the complete paper application and CD to Nicole Nicholson. You **must** include a copy of the failed submission notice from http://www.grants.gov with the paper application as evidence of attempted submission. If you have successfully submitted an electronic application through grants.gov, please do **not** mail in a paper application as well. Only the signed SF-424 form should be mailed.

A. Form of Application Submission for Failed Electronic Application Submission

- The Office of Acquisitions and Grant Management (OGAM) will provide instructions to applicants.

B. Required Contents

For a RCSC/ADRC grant, a complete application consists of the following materials organized in the following sequence:

Notice of Intent to Apply

Applicants are encouraged to submit a non-binding Notice of Intent to Apply. Notices of Intent to Apply are not required and their submission or failure to submit a notice has no bearing on the scoring of proposals received. But receipt of such notices enables CMS to better plan for the application review process. These may be submitted in any format; however, a sample is included in Attachment 1. ***Notices of Intent to Apply are due May 2, 2008 and should be faxed to Sona Stepp at 410-786-9004.***

Application Check Off Cover Sheet

Complete the check-off cover sheet as indicated; refer to Attachment "3".

Standard Forms (SF)

Standard forms are available as detailed in, Section IV.A*, Address to Request Application Package.* The following standard forms must be completed with an original signature and enclosed as part of the proposal:
SF 424: Official Application for Federal Assistance (see **Note** below)
SF 424A: Budget Information Non-Construction
SF 424B: Assurances—Non-Construction Programs
SF LLL: Disclosure of Lobbying Activities
Additional Assurances Certifications :
http://apply.grants.gov/forms/sample/SSA_AdditionalAssurances-V1.0.pdf

Note: On SF 424 "Application for Federal Assistance":

- Item 15 "Descriptive Title of Applicant's Project." Please indicate in this section the name of this grant: **Developing and Implementation of a Person-centered Planning Hospital Discharge Model. If you are applying for either Option please indicate Option #1, or Option #2.**
- Check box "C" to item 19, as Review by State Executive Order 12372 does not apply to these grants.
- Insure that the **total Federal grant funding requested is for all three years**.

Required Letters of Support and Memorandum of Agreement

A letter of support from the State Medicaid Director must be included. Additional letters of support from the partners that are not the single State Medicaid Agency are encouraged such as from the agency administering a relevant §1915 (c) home and community-based waiver.
A **Memorandum of Agreement must be submitted** for all the partners that will play a key role in the development and implementation of the grant. Such as the: State Mental Health agency, the Office of Mental Retardation and Developmental Disabilities and the Office on Aging, the Hospital entity/s participating in the grant, the local Area Agency on Aging, the ADRC and all other partners in the grant project.
Failure to include the required letter of support and Memorandum of Agreement will result in an incomplete application, which is not eligible for review and award.

Project Abstract

A one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, a description of how the grant will be used to develop or improve community-based services.

Applicant's Application Cover Letter

A letter from the applicant must identify the agency serving as the lead organization, indicating the title of the project, the total amount of funding requested for the three years, Option of the RCSC/ADRC grant proposal, and the names of the major partners actively participating in the project. The letter must also clearly identify the Principal Investigator/Project Director of the grant project with contact information. The letter should indicate that the submitting agency has clear authority to oversee and coordinate the proposed activities and is capable of convening a suitable working group of all relevant partners. This letter should be addressed to:
Nicole Nicholson
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Applicant's Budget

The applicant is required to provide a detailed budget for the three-year grant period. If you also are applying for Option #1 or Option #2, you must submit a separate budget for that option following the instructions below and any additional requirements found in the Option Budget Requirements in Section I of the solicitation.

The budget presentation must include the following:

- Estimated Budget Total. Provide the budget broken down by the Federal grant funding request as indicated in the requirements for the Grant and any Option. Please provide for the required 5 percent State match contribution and indicate this contribution in the line items where you will provide for this requirement.
- Total estimated budget broken down by year, and then by Federal and State funding.
- Total estimated funding requirements for each of the following line items, and a break down for each line item by grant year—provide estimated funding requirements for:
  - Personnel
  - Fringe benefits
  - Contractual costs, including consultant contracts
  - Indirect charges, by Federal regulation
  - Travel
  - Supplies
  - Equipment
  - Other costs
  - Completion of the Budget Form 424A remains a requirement for consideration of your application. This Estimated Budget Presentation is an important part of your proposal and will be reviewed carefully by CMS staff. Remember all three years of the budget must be included on this form.
  - If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.
  - Provide budget notes for major expenditures and notes on personnel costs and major contractual costs.

Appendices

- Letters of Support
- Memorandum of Agreement
- Required Attachments (do not include a copy of your Letter of Intent to Apply)

Required Attachments (Placed in Appendix)

Resumes/Job Descriptions (Key project staff) (Project Director, Assistant Director only)

3. Submission Dates and Times

Notices of Intent to Apply

Voluntary Notices of Intent to Apply for this grant are due by **May 9, 2008** and should be faxed to Sona Stepp at (410) 786-9004. It is not mandatory for an applicant to submit a Notice of Intent to Apply; however, such submissions help CMS plan its review process, including its review panels. Submission of a Notice of Intent to Apply does not bind the applicant to apply; nor will it cause a proposal to be reviewed more favorably.

Grant Applications

All grant applications are due by July 17, 2008. Applications submitted through **http://www.grants.gov** until 11:59 p.m. Eastern time on **July 17, 2008** will be considered "on time." All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

Please note when submitting your application electronically, you are required, to *mail* a signed SF- 424 only to Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Acquisition and Grants Management, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850. The mailed SF-424 form must be received at the Centers for Medicare & Medicaid Services within two (2) business days of the application closing date**.**

4. Intergovernmental Review

Applications for these grants are not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" to item 19 of the SF-424 (Application for Federal Assistance) as Review by State Executive Order 12372 does not apply to these grants.

5. Funding Restrictions

Indirect Costs

The provisions of the OMB Circular A-87 govern reimbursement of indirect costs under this solicitation. A copy of OMB Circular A-87 is available online at: http://www.whitehouse.gov/omb/circulars/a087/a087.html

Direct Services

Grant funds are **not** to be used to pay for direct services to consumers.

Reimbursement of Pre-Award Costs

No grant funds awarded under this solicitation may be used to reimburse pre-award costs.

6. Other Submission Requirements

Electronic Applications

The deadline for all applications to be submitted through http://www.grants.gov is July 17, 2008. For information on how to register with Grants.gov, please visit http://www.grants.gov/applicants/get_registered.jsp . **We strongly recommend that you do not wait until the application deadline date to begin the application process through Grants.gov.** We recommend you visit Grants.gov at least 20 days prior to filing your application to fully understand the process and requirements. We encourage applicants to submit well before the closing date and time so that if difficulties are encountered, an applicant will have time to solicit help.

Also visit the following website: http://www.grants.gov/resources/newsletter.jsp for all of the latest information about the benefits and success of this initiative. In order to submit their applications electronically, applicants will need to:

- Download and install PureEdge Viewer from the http://www.grants.gov/DownloadViewer site. This small, free program will allow applicants to access, complete, and submit applications electronically and securely.
- Find an opportunity for which you wish to apply at http://www.grants.gov/applicants/find_grant_opportunities.jsp and enter the Funding Opportunity number or CFDA. *Please note there is no competition ID associated with this grant solicitation.*

- Download the complete electronic grant application package from http://www.grants.gov.
- Register with Central Contractor Registry (CCR)—Applicants may register for the CCR by calling the CCR Assistance Center at 1-888-227-2423 or online at http://www.ccr.gov. Online registration will take about 30 minutes before attempting to register with CCR. Applicants should receive their CCR registration confirmation within 5 business days after CCR registration. Note: Registering with the CCR requires that applicants have a DUNS number from Dun & Bradstreet.[1]

The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following Website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 5 on the Form SF-424, Application for Federal Assistance), with the annotation "DUNS" followed by the DUNS number that identified the applicant. The name and address in the application should be exactly as given for the DUNS number.
Register with the Credential Provider—Applicants must register with the Credential Provider to receive a username and password to securely submit their grant application.
Register with http://www.grants.gov — registering with Grants.gov is required to submit grant applications electronically on behalf of your organization. After completing the registration process, applicants will receive e-mail notification confirming their ability to submit applications through Grants.gov. (Technical support for Grants.Gov is available Monday-Friday from 7:00 a.m. to 9:00 p.m. Eastern time.)
Upon submission of the grant application to http://www.grants.gov, applicants will receive an e-mail confirming that the application was received.
Applicants may not submit the same application in more than one format, and the choice of one application format over another will not cause an application to be reviewed more favorably. All standard application forms may be obtained as detailed in, Section IV.1, *Address to Request Application Package,* of this solicitation.

7. CCR Requirements

Central Contractor Registration (CCR) - *Further Information*
The Central Contractor Registration (CCR) is a web-enabled government wide application that collects, validates, stores, and disseminates business information about the Federal Government's trading partners in support of contract and grant awards, and the electronic payment processes.
Check to see if your organization is already registered at the https://www.bpn.gov/ccrsearch/Search.aspx . You will be able to search CCR by using either your organization's DUNS Number or legal business name. If your organization is already registered, take note of who is listed as your E-Business Point of Contact (E-Business POC). This person will be responsible for authorizing who within your organization has the responsibility to submit applications at Grants.gov.
If your organization is not already registered, you'll need to register your organization before you can submit a grant application through Grants.gov. Go to the CCR website at https://www.bpn.gov/ccr/scripts/index.html and select "New" to begin the registration process. Please allow 1-2 business days for processing of your registration including the IRS validating

[1] The requirement that applicants have a DUNS number to apply for a grant or cooperative agreement from the Federal government went into effect beginning October 1, 2003.

your Employer Identification Number (Social Security Number - also known as your Taxpayer Identification Number). If you have the information ready, online registration will take about 30 minutes, depending on the complexity of your organization.

Once you finish this process, you are able to move on to the next step of the Grants.gov registration the very next business day. When your organization registers with CCR, you will need to designate an E-Business Point of Contact (POC). This designee authorizes individuals to submit grant applications on behalf of the organization. A special Marketing Partner ID Number (MPIN) is established as a password to verify the E-Business POC. Your organization's E-Business POC will need to know the MPIN in the CCR Profile to login.

V. APPLICATION REVIEW INFORMATION

1. Criteria

This section fully describes the evaluation criteria for the funding opportunity for RCSC/ADRC Grants for FY2008, to which this solicitation applies.

In preparing applications, applicants are strongly encouraged to review the programmatic requirements detailed in, Section I, *Funding Opportunity Description*. The Project Narrative and all other submission requirements <u>must</u> adhere to the requirements as detailed in, Section IV, *Application and Submission*, of this solicitation.

<u>RCSC/ADRC Grant Review Criteria</u>

Person-centered Hospital Discharge Planning Model

A. <u>Problem Statement/Application Narrative</u> (Weight 60 points)

Does the Applicant clearly address <u>the following issues:</u>

i. Targeted populations and geographic reach of the grant.
ii. Ability to form and sustain the collaborative partnerships that will be needed to develop and implement the model. Do these partnerships include the institutional and community-based providers, the ADRCs, AAAs, and the CILs?
iii. Strategies for achieving Person-centered Planning. Specifically, does the applicant clearly describe:
    - A plan intended to identify consumers' preferences and then promote customized choices;
    - The needed training dedicated to the model, and how this training will be delivered;
    - If the model relies upon family caregivers to provide some, or all of the patient's continuing care, does the applicant describe the plan to assess and document whether or not the family caregiver(s) are both *willing and able* to provide that care.
    - The role of discharge planners as they relate to Medicaid case managers?
    - Specifically, does the applicant clearly describe at least three (3) outcome measures which can be used to evaluate the effectiveness of the proposed model?

B. <u>Work Plan and Timeline</u>: (Weight: 20 points)

Does the applicant provide a clear work plan that documents reasonable key activities and timeframes for the completion of these activities for the entire 3

year period of the grant? In addition, does the applicant identify the responsible parties needed to accomplish the key activities and goals of the project?

C. Project Budget for the 3 year Project Period: (Weight: 10 points)

Are the budget and corollary budget notes justified with respect to the objectives and activities provided in the work plan and timeline for the 3 year period of the grant?

D. Memorandum of Agreement: (Weight: 10 points)

Is the memorandum of agreement adequate and sufficient to encompass all the partnerships required to achieve effective outcomes for the grant?

OPTION #1 Review Criteria

A. Problem Statement/Application Narrative (Weight 60 Points)

1. Does the Applicant include the following:

i) If a State has not received a CMS and AoA ADRC grant in the past, did the applicant describe fully their SEP program and how it meets the definition of a fully operational SEP/ADRC as described in Appendix "B".
ii) A description of the ADRC/SEP project's planned enhancement or expansion.
iii) A description of how this project will advance the development and implementation of a Person-centered Hospital Discharge Planning Model
iv) A description of any measurable performance goals and indicators to be used to measure the success of the interventions related to the ADRC/SEP program's visibility trust, ease of access, responsiveness, efficiency, and cost effectiveness.
v) Coordination and linkages are fully described and should also include a clear delineation of the roles and responsibilities of project staff, consultants, and partner organizations, and how they will contribute to achieving the project's objectives and outcomes
vi) For applications including "Program Expansion" activities:
vii) Does the application identify the geographic area to be served by the ADRC/SEP expansion as well as the ADRC model to be used?
viii) Does the application identify any additional funding secured or pending that will contribute to the enhancement of expansion of the ADRC/SEP?
ix) Are any additional target groups to be served and are they clearly described?

B. Work Plan/Timeline (Weight 10 Points)

i) Has the applicant evidenced clear goals objectives and described activities related to the expansion and/or enhancement of their ADRC/SEP and the development and implementation of the Person-centered Hospital Discharge Planning Model?

ii) Are the goals and objectives reasonable and likely to be effective?

iii) Is the timeline reasonable based on the goals and objectives?

C. Performance Measures and Indicators (Weight 20 Points)

i) Does the applicant describe measurable performance goals and indicators that will be used to measure the success of the interventions related to the ADRC/SEP program's visibility trust, ease of access, responsiveness, efficiency, and cost effectiveness?

D. Budget Presentation (Weight 10 Points)

i) Are the applicant's budget and budget notes justified with respect to the goals, objectives and activities provided in the Work Plan/Timeline?

ii) Does the budget reflect the salary and fringe benefit cost or contractual cost of adequate staff including a project director and other key staff to assure proper direction, management and timely completion of the grant project?

OPTION #2 Review Criteria

A. Problem Statement /Approach (Weight: 60 points)

Problem Statement

- Does the applicant describe and demonstrate an understanding of the State's current long-term support system and analyze the strengths and challenges of the current system as it relates to information and access?
- Does the applicant highlight current strengths that the Resource Center will be building on and what challenges must be overcome for the SEP to succeed?

Target Population

- Are the target groups to be substantially served by the Resource Center clearly described and include older adults?

Methods of Addressing the Problem:

- Has the applicant clearly described a coherent approach that would successfully address the existing systemic problems in the areas of information assistance, and streamlined access to long-term supports and services?
- Does the applicant describe how the proposed SEP/ADRC will facilitate the Person-centered Hospital Discharge Planning Model?

Coordination and Linkages:

- Has the applicant demonstrated that the proposed project utilizes existing programs and services in a coordinated way to improve long-term support options?
- Does the applicant describe how the proposed project will coordinate significant programs – including Medicaid, programs for individuals with disabilities, the Older Americans Act, and State-only programs – to support efforts by individuals to access long-term support and reflect a commitment from partners including letters of support?
- Does the application reflect meaningful involvement on the part of consumers and other stakeholders in the planning and implementation of the project?

Organization, Management, and Qualifications:

- Has the applicant indicated that a project lead will be designated? Does the organization have the capacity to implement the proposed project?

B. <u>Formative Learning and Information Management</u> (Weight: 20 points)

- Evaluation, Formative Learning and Management Information System: Has the applicant outlined proposed data collection strategies that have identified at least three (3) outcome measures, consistent with the Resource Center vision and incorporating feedback into the project's ongoing operations, in a way that will improve program quality?

C. <u>Work Plan and Timeline:</u> (Weight: 10 points)

- Has the applicant included a work plan that documents reasonable benchmarks, milestones, timeframes, and identifies the responsible parties to accomplish the goals of the project?

D. <u>Budget and Resources:</u> (Weight: 10 points)

- Has the applicant proposed a reasonable and detailed budget with budgeted costs that are reasonable in relation to the project's objectives, design and significance and included the required non-financial or cash recipient contribution.

2. Review and Selection Process

CMS will be employing a multiphase review process to determine the applications that will be reviewed, and the merit of the applications that are reviewed. The multiphase review process includes the following:

- Applications will be screened by Federal staff to determine eligibility for further review using the criteria detailed in the "Eligibility Information" section of this solicitation. Applications that are received late or fail to meet the eligibility requirements as detailed in the "Applicant Eligibility" section of this solicitation or do not submit the required Memorandum of Agreement, letter of support from the State Medicaid Director and other required forms will not be reviewed.
- Applications will be objectively reviewed by a panel of experts, the exact number and composition of which will be determined by CMS at its discretion, but may include private sector subject matter experts, beneficiaries of Medicaid supports, and Federal policy staff. The review panels will utilize the objective criteria described in the "Application Review Criteria Information" section of this solicitation to establish an overall numeric score for each application.
- The results of the objective review of applications will be used to advise the approving CMS official. Additionally, CMS staff will make final recommendations to the approving official after ranking applications using the scores and comments from the review panel and weighing other factors as described in the "Factors Other than Merit that May be Used in Selecting Applications for Award" indicated below.
- Factors Other than Merit that May be Used in Selecting Applications for Award: CMS may assure reasonable balance among the grants to be awarded in terms of key factors such as geographic distribution and broad target group representation. CMS may redistribute grant funds (as detailed in the "Award Information" section of this

solicitation) based upon the number and quality of applications received and the submission of grant Option #1 and Option #2 (e.g., to adjust the minimum or maximum awards permitted or adjust the aggregate amount of Federal funds allotted to a particular category of grants). CMS will not fund activities that are duplicative of efforts funded through its grant programs or other Federal resources. For applicants that have been awarded previous RCSC/ADRC Grants, past programmatic performance will be considered in selecting applications for award. To assess the applicant's past programmatic performance, CMS will use program evaluation of semi-annual, annual, and financial reports submitted by the applicant under the Terms and Conditions of their previously awarded RCSC/ADRC Grant. For applicants that have never received a RCSC/ADRC Grant, past programmatic performance will not be a consideration in selecting applications for award.

3. Anticipated Announcement and Award Dates

All grant awards will be made prior to September 30, 2008, and will have a start date on or before September 30, 2008.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive a Notice of Award (NOA) signed and dated by the CMS Grants Management Officer. The NOA is the document authorizing the grant award and will be sent through the U.S. Postal Service to the applicant organization as listed on its SF-424. Any communication between CMS and applicants prior to issuance of the NOA is not an authorization to begin performance of a project. Unsuccessful applicants will be notified by letter, sent through the U.S. Postal Service to the applicant organization as listed on its SF 424, after October 1, 2008.

2. Administrative and National Policy Requirements

<u>Usual Requirements</u>

1. Specific administrative and policy requirements of grantees as outlined in 45 CFR 74 and 45 CFR 92 apply to this grant opportunity.
2. All grantees receiving awards under these grant programs must meet the requirements of:
   - Title VI of the Civil Rights Act of 1964,
   - Section 504 of the Rehabilitation Act of 1973,
   - The Age Discrimination Act of 1975,
   - Hill-Burton Community Service nondiscrimination provisions, and
   - Title II Subtitle A of the Americans with Disabilities Act of 1990.
3. All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the grantee's original grant application or agreed upon subsequently with CMS, and may not be used for any prohibited uses.
4. Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project. CMS expects all grant budgets to include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families.

Terms and Conditions
A funding opportunity award with CMS will include the *Health and Human Services (HHS) Grants Policy Statement* at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm and may also include additional specific grant "special" terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel or CMS.

3. Reporting
Grantees must agree to cooperate with any Federal evaluation of the program and provide reports at the intervals listed in the terms and conditions of the award, and a final report at the end of the grant period in a form prescribed by CMS (including the SF-269a "Financial Status Report" forms). Progress reports may be submitted electronically. These reports will outline how grant funds were used, describe program progress, and describe any barriers and measurable outcomes. CMS will provide a format for reporting and technical assistance necessary to complete required report forms. Grantees must also agree to respond to requests that are necessary for the evaluation of the national RCSC/ADRC grants' efforts and provide data on key elements of their own grant activities. An original and two copies of the interim SF-269a must be mailed to the Office of Acquisition and Grants Management (OAGM). The frequency of the SF-269a report will be identified in the terms and conditions of the grant award. The final SF-269a submitted to this office must agree with the final expenditures reported on the SF-272 to the Payment Management System. Before FSR submission all obligations must be liquidated. An original and two copies are due no later than 90 days after the project period end date. Use Standard Form 269a, which is available online at: http://www.whitehouse.gov/omb/grants/sf269a.pdf. Please note that interim SF-269a reports should not be marked as final. If awarded a grant, please be prepared to provide the contact information of the person or office that will complete the Financial Status Reports.

VII. AGENCY CONTACTS

1. Programmatic Content

Programmatic questions about the RCSC/ADRC grants may be directed to the e-mail address shown below. This e-mail address is: *RealChoiceFY08@cms.hhs.gov*.
In addition, inquiries may be directed to Cathy Cope, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, DEHPG/DASI, Mail Stop S2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850, 410-786-8287 (voice), or 410-786-9004 (fax) or to Sona Stepp, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, DEHPG/DASI, Mail Stop S2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850, 410-786-6815 (voice), or 410-786-9004 (fax).

B. Administrative Questions

Administrative questions about the RCSC/ADRC grants may be directed to Nicole Nicholson, Centers for Medicare & Medicaid Services, Office of Acquisition and Grants Management,

Acquisition and Grants Group, C2-21-15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244-1850 by e-mail at Nicole.Nicholson@cms.hhs.gov.

VIII. Other Information

There will be no applicant's teleconference scheduled.
Attachment 1 – Notice of Intent to Apply
Attachment 2 – Prohibited Uses of Grant Funds
Attachment 3 – Real Choice/ADRC Check-Off Cover Sheet
Appendix "A"- Aging and Disability Resource Center Model
Appendix "B" - Criteria for a Fully Functioning Single Point of Entry Program

ATTACHMENT 1

Notice of Intent to Apply

Submission by Facsimile preferred
Fax: 410-786-9004

Please complete and return by **May 9, 2008** to:
Sona Stepp, Health Insurance Specialist

Centers for Medicare & Medicaid Services
Mail Stop: S2-14-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: 410-786-6815, Fax: 410-786-9004

1. Name of State: ______________________________

2. Applicant Agency/Organization: ______________________________

3. Contact Name and Title: ______________________________

4. Address: ______________________________

5. Phone: ______________ Fax: ______________________

6. E-mail address: ______________________________

Grant Opportunity: Development and Implementation of the Person-centered Hospital Discharge Planning Model

If you are also applying for either Option as described in Part I Funding Opportunity Description C. Grant Option #1 or #2. The above named Agency intends to submit an application for the following (Please put an X in the Box). (Note: A State may apply for one option only)

☐ **Option#1: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Enhancing or Expanding Aging and Disability Resource Centers/Single Point of Entry Programs**

☐ **Option#2: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Development of a new Aging and Disability Resource Center/Single Point of Entry Program.**

ATTACHMENT 2

Prohibited Uses of Grant Funds
RCSC/ADRC Grants for FY 2008 funds may not be used for any of the following:

1. To provide direct services to individuals.
2. To match any other Federal funds.
3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
4. To provide infrastructure for which Federal Medicaid matching funds are available at the 90/10 matching rate, such as certain information systems projects.
5. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.
6. To be used for expenses that will not primarily benefit individuals of any age who have a disability or long-term illness.
7. To be used for data processing software or hardware in excess of the software and personal computers required for staff devoted to the grant.

ATTACHMENT 3

2008 RCSC/ADRC GRANT
APPLICATION CHECK-OFF COVER SHEET

Grant Opportunity: Development and Implementation of the Person-centered Hospital Discharge Planning Model

Identifying Information;

DUNS #: ____

State Agency: ____
Primary Contact Person, Name: ___________________________
Telephone number: __________________________________
FAX number: ____
Email address: ____
Any Options Applicant is Applying for:

☐ **Option#1: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Enhancing or Expanding Aging and Disability Resource Centers/Single Point of Entry Programs**

☐ **Option#2: Development and Implementation of the Person-centered Hospital Discharge Planning Model and Developing a new Aging and Disability Resource Centers/Single Point of Entry Programs**

For CMS Administrative Purposes Only:
Completeness Check: _______________

Panel Assignment: ________________

APPENDIX "A"

CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
ADMINISTRATION ON AGING

AGING AND DISABILITY RESOURCE CENTER MODEL

Background The AoA/CMS Resource Center initiative reflects and supports the values of individual choice, independence, self-determination and community living inherent in President Bush's *New Freedom Initiative*. Single entry point programs developed based on this model will be another tool to help States tear down barriers to community living and redirect their systems of support to be more consumer-driven and more supportive of home and community-based service options. Building a sustainable infrastructure to support streamlined access to community-based services and long-term care reform constitute over-arching goals of this initiative. The essence of the ADRC program is not about offering new services or adding staff, but re-aligning infrastructure and orienting staff.

Goal and Vision The goal of the Aging and Disability Resource Center initiative is to empower individuals to make informed choices and to streamline access to long-term support. Long-term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help individuals with disabilities.

AoA and CMS share a vision for the Resource Center program. The vision is to have Resource Centers in every community serving as highly **visible and trusted** places where people can turn for information on the full range of long-term support options and a single point of entry to public long-term support programs and benefits. The Centers will be a resource for both public and private-pay individuals. They will serve older adults, younger individuals with disabilities, family caregivers, as well as persons planning for future long-term support needs. The Centers will also be a resource for health and long-term support professionals and others who provide services to older adults and to people with disabilities.

AoA and CMS believe Resource Centers are a key component of an effectively managed, consumer-driven system of long-term support. In many communities, long-term support services are supported by numerous funding streams, administered by multiple agencies, and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult for persons who qualify for publicly-funded supports and for those who can pay privately. These barriers can lead to institutional long-term support as the default outcome. A single, coordinated system of information and access for all persons seeking long-term support will minimize confusion, enhance individual choice and support informed decision-making. It will also improve the ability of State and local governments to manage resources and to monitor program quality through centralized data collection and evaluation. Resource Centers will enable policy makers and program administrators to more effectively respond to individual needs, address system problems, and limit the unnecessary use of high-cost services, including institutional care. The strategy is not to add resources, but to ensure the needs and preferences of consumers underpin all aspects of the system. Implementation of this approach may require some realignment or reorientation of a State's long-term care system, particularly the eligibility processes and resources.

The AoA/CMS vision is for single entry point programs such as ADRCs to:

- Actively promote public awareness of both public and private long-term support options, as well as awareness of the Resource Center, especially among underserved and hard-to-reach populations.
- Provide information and counseling as needed, on all available long-term support options.
- Help people assess their potential eligibility for public long-term support programs and benefits.
- Determine programmatic eligibility for public long-term support programs and benefits, including level of care determinations for Medicaid nursing home and HCBS waiver programs.
- Assist people with the Medicaid eligibility determination process (in collaboration or coordination with Medicaid eligibility determination staff).
- Provide short-term assistance or case management to stabilize long-term support individuals and their families in times of immediate need and before they have been connected to ongoing support (e.g., enrolled in a home and community-based waiver). Resource Centers may also provide on-going case management to public- and/or private-pay individuals.
- Provide information and referral to other programs and benefits that can help people remain in the community, such as disease prevention and health promotion programs, transportation services, and income support programs.
- Help people plan for their future long-term support needs.
- Organize, simplify, and ensure "one-stop shopping" for access to all public long-term support programs.

The operational configuration of Resource Centers will vary from State to State. In most States, Resource Centers will involve a State/local partnership, where the State will provide oversight and guidance, but may arrange for responsibility for the operation of Resource Center functions to be vested in local entities. In some communities, all Resource Center functions may be performed in a single location. However, in some localities, Resource Centers may be decentralized and have multiple sites and organizations involved in performing the information and access functions. Some communities may even have different access points for different populations, provided they perform all functions of a Resource Center. Regardless of the configuration, **the functions of the Resource Center will be coordinated and standardized to ensure that all individuals are provided with uniform information and access to long-term support**, with the system appearing seamless.

Resource Centers will create **formal linkages between and among the major pathways to long-term support**, including preadmission screening programs for nursing home services, hospital discharge planning, physician services, and the various community agencies and organizations that serve the Resource Center's target populations. These linkages will ensure people have the information they need to make informed decisions about their support options as they pass through critical transition points in the health and long-term support system.

Aging and Disability Resource Center programs will **coordinate closely with other long-term care systems change initiatives** at the state and local level to ensure a single and efficient State approach to long-term care reform. This will include close coordination with CMS Real Choice Systems Change grant programs, Department of Health and Human Services Administration on Developmental Disabilities Family Support 360 grants and other initiatives.

In addition, Resource Center programs will **establish collaborative working relationships** with programs that provide services important to consumers who are either seeking home and community-based services or planning for future long-term support needs. Collaborative relationships must be established with State Health Insurance Assistance Programs (SHIP), National Family Caregiver Support Programs, Alzheimer's Disease service and support programs, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. A strong collaborative relationship with local CMS SHIP programs is particularly important to ensure streamlined access for consumers interested in planning for future long-term care needs.

Resource Centers will gather and manage information from individuals in a way that ensures their confidentiality, but limits repeated collection of the same information throughout their long-term support careers. The individual-level data will be used, in part, as the foundation of a **management information system that will track client intake, needs assessment, service plans, utilization, and costs**. The management information system will support on-going program analysis, planning, budgeting, quality assurance, program evaluation, and continuous improvement, as well as State and local policy development.

AoA and CMS recognize that all States can not immediately implement the ideal Resource Center described above. However, the vision indicates the latitude of design possibilities for Resource Centers and our long-range expectations. We believe implementation of the full vision can achieve success in meeting individual needs and preferences and in effectively managing public resources, while implementation of too few of the elements will limit the success of a Resource Center program.

Overview of the Program

Building on previous State efforts, Resource Centers will move beyond information and assistance and assume the role of primary entry point into the long-term support system. People, who are eligible for Medicaid long-term support, including HCBS waiver services or Medicaid funded institutional services, will access those programs through the Aging and Disability Resource Center.

Forty-three States have received ADRC awards since the grant's inception in 2003. The ADRC Technical Assistance Exchange website (www.adrc-tae.org) is a repository of valuable information associated with the program and acquired knowledge to date. Information on key topics such as management information systems (MIS), partnership development, program governance, stakeholder involvement, program administration, program evaluation, outreach and a number of other topics are available on this website.

Target Groups Resource Centers should, at a minimum, serve the older adult population and at least one of the following major target groups by the first quarter of the second year: (a) individuals with physical disabilities, (b) individuals with serious mental illness, and/or (c) individuals with mental retardation/developmental disabilities. States may elect to develop distinct entry points for different target groups as long as they are a coordinated part of the single State Resource Center program. Individuals with traumatic brain injury may be classified by the State in the target group that best conforms with the State's service delivery system and historical practice. The same principle applies to any other condition that often spans target group boundaries. For the definition of "older adult" in this solicitation we use age 60 and above as specified in the Older Americans Act.

Involvement of Stakeholders and Public-Private Partnerships. States should meaningfully involve stakeholders in the planning, implementation, and evaluation of their Resource Center program. In addition, we encourage the development of public-private partnerships that make the most effective use of each partner's expertise. Specific letters of support should be included with the application. Coordination and collaboration efforts must include intersection with other programs as well as including functional areas such as employment, transportation and affordable housing. Innovative approaches that drive coordination, joint planning, single access points and streamlined eligibility for programs associated with long-term care community resources are encouraged. As an example, available transportation, employment and housing are critical components of aging in place but are often not included in a discrete definition of home and community-based services. In summary, detailed letters of support showing partnerships across a broad stakeholder constituency should be included in responses to this solicitation.

States should also establish or designate an Advisory Board to assist in the development and implementation of their Resource Center program. The Advisory Board will advise the lead State agency on: (a) the design and operations of Resource Centers, (b) stakeholder input, (c) the State's progress toward achieving the goal and vision described in this announcement, and (d) other program and policy development issues related to the State's Resource Center program.

The Advisory Board should be composed of (a) individuals representing all populations served by the State's Resource Center program including individuals who have a disability or a chronic condition requiring long-term support, (b) representatives from organizations that provide services to the individuals served by the program, and (c) representatives of the government and non-governmental agencies that are impacted by the program.

Resource Center Design Issues

A State's Resource Center program must provide information and assistance to both public- and private-pay individuals and must include both public and private programs in its information and assistance functions. A State's Resource Center program must also serve as the entry point to publicly administered long-term supports for individuals who are eligible for, or appear to be eligible for, those publicly supported programs. An

ADRC/SEP should perform the following functions of "Awareness, Assistance, and Access":

Awareness and Information
- Public Education.
- Information on Long-term support Options.

Assistance
- Long-term Support Options Counseling.
- Benefits Counseling
- Employment options counseling for people who are interested in, or may be interested in, such counseling. Grantees would be expected to coordinate with other sources funding employment counseling in their State, such as the Social Security Administration and/or the Department of Labor, to ensure access and prevent duplication.
- Referrals to other programs and benefits that can help people remain in the community, including programs that can assist a person in obtaining and sustaining paid employment.
- Crisis Intervention.
- Helping people to plan for their future long-term support needs.

Access
- Eligibility Screening.
- Assistance in gaining access to long-term support service that may be paid with private funds.
- Comprehensive assessment of long-term support needs and care planning.
- Programmatic Eligibility Determination for long-term support services (see Section II for a definition of Long-term Support Services).
- Medicaid Financial Eligibility Determination that is either integrated or so closely coordinated with the Resource Center that each individual applicant experiences a seamless interaction.
- One-Stop Access to all public programs for community and institutional long-term support services administered by the State under Medicaid, and those portions of Older Americans Act programs that the State has determined will be devoted to long-term support services (see definition), and any other publicly funded services which the State determines should be accessed through the Resource Center.

Resource Centers should have a **management information system that supports the functions of an ADRC**. The system should allow for the tracking of client intake, needs assessment, care plans, utilization, and costs. It is recognized that Resource Centers will build upon existing State and local information systems.

Measurable Performance Goals
Resource Centers should establish measurable performance goals for their programs, along with indicators that can be used to track progress on the performance goals. The

measurable performance goals and indicators should be used to measure the success of the Resource Center program over the long run.

Performance goals and indicators related to Resource Center programs should measure: (a**) Visibility** - extent to which the public is aware of the existence and functions of the Resource Center, (b) **Trust** on the part of the public in the objectivity, reliability, and comprehensiveness of the information and assistance available at the Resource Center, (c) **Ease of Access** (e.g., reduction in the amount of time and level of frustration and confusion individuals and their families experience in trying to access long-term support), and (d) **Responsiveness** to the needs, preferences, unique circumstances, and feedback of individuals as it relates to the functions performed by the Resource Center. Grantees must also establish performance goals and indicators related to the program's **Efficiency** and **Effectiveness** (e.g., reduction in the number of intake, screening, and eligibility determination processes, diversion of people to more appropriate, less costly forms of support, improved ability to match each person's preferences with appropriate services and settings, ability to rebalance the State's long-term support system, ability to implement methods that enable money to follow the person. etc.)

DEFINITIONS

Aged (or Older adult Person): As defined in the Older Americans Act, "an individual who is 60 years of age or older."

Benefits Counseling: The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), Supplemental Security Income (SSI), Food Stamps, Medicare, Medicaid and private pension benefits. For purposes of this program, Benefits Counseling funded under the Older Americans Act that is provided to individuals who need help in order to remain in the community, is included in this definition.

Coordination With Medicaid Financial Eligibility Determination: The determination of financial eligibility for Medicaid may take place either at the Resource Center or off-site. Regardless of where it takes place, the Resource Center must assure that the process is coordinated or integrated with the functions of the Center so that it takes place in an expeditious manner that avoids duplication of effort for individuals, their families and agency workers. The result of this coordination should be a seamless system of long-term support as experienced by the individual.

Counseling and Referral to Help People Remain in the Community: The provision of comprehensive and accurate information on services and programs that can help people to remain at home and in the community. These include (a) direct services (such as home and community-based waiver programs, home health, personal care, case management), (b) generic community sources of help (such as nutrition programs, prescription drug programs, health promotion and disease prevention programs, transportation services, home repair programs, real property tax relief), and public or private insurance (such as

long-term care insurance, Medicare, Social Security Disability Insurance (SSDI), and SSI). For purposes of this program, counseling and referral activities designed to help individuals to remain in the community that are funded under the Older Americans Act are included in this definition.

Eligibility Screening: Is a non-binding inquiry into an individual's income and assets, as necessary, and other circumstances in order to determine probable eligibility for programs, services, and benefits, including Medicaid. This screening should be provided to all individuals who may be eligible for publicly funded programs.

Crisis Intervention: Resource Center programs must be able to respond to situations where short-term assistance is needed to support an individual until a plan for long-term support services can be put in place. For example, an individual whose existing support system has fallen apart may need immediate support to assist them while a more comprehensive plan is developed and implemented. If an individual is in danger to self or others, Resource Centers will refer to, and coordinate with, existing supports such as Adult Protective Services, in accordance with State laws and agency procedures.

Information on Long-term Support Options: The information available must be comprehensive, objective, up-to-date, citizen-friendly, and cover the full range of available options, including in-home, community-based, and institutional services (including nursing home services). The information must cover options that people will use immediately (such as Medicaid services) to long-range options (such as private long-term care insurance). The information must also cover programs and services that support family caregivers, as well as any special options in the State to maintain independence or direct one's own long-term support services.

Long-term Support Services: Long-term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help individuals with disabilities or chronic conditions with activities of daily living or instrumental activities of daily living. Public long-term support services are those administered by a governmental entity. For purposes of this program, long-term support services under Medicaid include home health, personal care, targeted case management, home and community-based waivers under section 1915(c) of the Social Security Act, nursing facility services, and Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Long-term support services under the Older Americans Act include personal care and other in-home services similar to those provided under section 1915(c) of the Social Security Act. Long-term support services under State-only programs include home health and personal care. Finally, for purposes of this program, the State may include in the definition of long-term support services any other publicly-funded service which the State determines should be accessed through the assessment process of the Resource Center.

Long-term Support Options Counseling : Resource Centers will help people make informed decisions by assisting individuals and their families in understanding how their strengths, needs, preferences, and unique situations translate into possible support strategies, plans, and tactics, based on the options available in the community. The

counseling includes helping individuals assess their needs and resources, the assessment of the needs of family caregivers, developing a plan, and assisting the individual/family in implementing their long-term support choices. Counseling links individuals to other counseling programs and services, including Web-based information and counseling programs. For purposes of this program, Long-term Support Options Counseling activities funded under the Older Americans Act are included in this definition.

One-Stop Access to Public Programs: The organizational ability and authority to provide intake, full access, and comprehensive point of entry to publicly supported long-term support services for individuals who are eligible for, or appear to be eligible for, publicly supported long-term support services, as those services are defined under Section II. A single program performs these functions, along with information and assistance, through a simple, convenient, single contact point. The program may involve more than one entry point (or "site) at the community level (e.g., different access points for different populations) so long as (a) each access point is authorized and performs all functions of a single point of entry, (b) the process of access experienced by individuals is uniform across all entry points, and (c) individuals do not access long-term support services through admission points that do not perform all functions of a single point of entry. One-stop access to public programs also ensures that individuals have the information they need to make informed decisions and that individuals reliant on public support are not admitted to service by alternate means or by direct admission through an individual provider of services.

Programmatic Eligibility Determination: A determination of the publicly supported benefits or services to which a person is eligible, based on non-financial criteria. This may require a formal assessment to determine the full scope of the individual's needs. It may include a functional assessment of the individual's current health conditions and provide a situational assessment of the client's environment, available resources, and current support. For Medicaid services, this function includes the "Level of Care" determination process.

Public Education and Outreach: Activities related to ensuring that all potential users of long-term support (and their families) are aware of both public and private long-term support options, as well as awareness of the Resource Center, especially among underserved and hard-to-reach populations.

APPENDIX “B”

Criteria for a fully functioning Single Point of Entry Program

Program Component	Criteria/ Description	Recommended Metrics
Awareness and Information	*Public education; information on long-term support options.* • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.	• The SEP/ADRC has a proven **outreach and marketing plan** in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The SEP/ADRC has a **comprehensive resource database** which includes information about the range of long term support options in the SEP/ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database. - Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The SEP/ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide **consistent and uniform information.** • The SEP/ADRC actively markets to and serves **private pay** consumers in addition to those that require public assistance.

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Assistance	*Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.* • The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. • ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. • ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer's Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. • ADRC consistently conducts follow-up when needed to determine outcome of options counseling. • ADRC enables people to make informed, cost-effective decisions about long term care. • ADRC has process to ensure that people are connected to the appropriate crisis intervention services. • ADRC assists individuals to plan for future long-term care needs.	Options Counseling • SEP/ADRC has the capability, either in-house or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. • All SEP/ADRC entry point agencies use standard intake and screening instruments. • Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumer that have gone through a comprehensive assessment process. • Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. • SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. • SEP/ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: - Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, State revenue programs and others) - Employment - Health promotion/disease prevention - Transportation - Crisis/Emergency services - Services for family caregivers - Residential care including assisted living Referrals and Follow Up • SEP/ADRC has the ability to track referrals made. • SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. Crisis Intervention • SEP/ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. • Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. Future Long Term Support Needs Planning • Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Own Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.
Access	*Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated*	• SEP/ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. • For SEP/ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. • Financial and functional eligibility determination

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	with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services. • ADRC serves as the entry point to publicly funded long term care. • The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. • ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services.	processes are highly coordinated. • SEP/ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk. • SEP/ADRC staff conducts level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. • ADRC/SEP staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). • Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed application to the agency authorized to determine financial eligibility directly on behalf of consumers. • SEP/ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and re-determination. • In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the wait list and the SEP/ADRC conducts follow-up with those individuals. • There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. • SEP/ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. • There is a reduction in the rate of institutional placement in the SEP/ADRC service area. • SEP/ADRC tracks diversions and transitions (i.e., # nursing home diversions attempted and # of successful diversions; # nursing home relocations to community completed). • SEP/ADRC can report the proportion of consumers requesting services that actually receive them. • SEP/ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).
Target Populations	*ADRCs must serve the elderly and at least one **target population** of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.*	• Actual served against resident population estimate, by target population. • SEP/ADRC demonstrates competencies relating to serving all of its target populations. • SEP/ADRC is accessible to all of the populations it serves. • There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities.
Critical Pathways to Long Term Support	*ADRCs will create formal linkages between and among the **critical pathways to long-term support.***	• SEP/ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: (1) providing training and education about the

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		SEP/ADRC to critical pathway providers (CPPs); (2) involving CPPs in advisory board representation; and (3) establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnerships & Stakeholder Involvement	*ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.* *ADRCs must establish strong partnerships with the* ***State Health Insurance Assistance Program (SHIP****) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agency on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.* *ADRCs must* ***meaningfully involve stakeholders, including consumers****, in planning, implementation and evaluation activities.*	Medicaid • SEP/ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. Aging or Disability Partners • There is evidence of collaboration, including formal agreements, at the State and pilot level between aging and disability partners. • SEP/ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. Stakeholders • If the SEP/ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. • There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. Consumers • Formal mechanisms for consumer involvement have been established, including consumer representation on the State/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.
IT/MIS	*The ADRC program must have a* ***management information system*** *that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.*	• SEP/ADRC uses a management information system that can support the program functions. • SEP/ADRC can submit evidence of reports on the following: - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. o Types of assistance provided o Timing of eligibility determinations o Information regarding level of impairment and preferred support need o Disposition/placements (e.g., waiver, institution) • SEP/ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Evaluation Activities	*At a minimum, ADRCs must have* ***performance goals and indicators*** *related to visibility, trust, ease of access,*	• Evidence that the SEP/ADRC is measuring performance related to the established indicators. • SEP/ADRC can demonstrate ability to develop reports summarizing issues and making

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	responsiveness, efficiency and effectiveness.	recommendations for corrective action or quality improvement based on performance indicators. • SEP/ADRC has used information obtained from consumer satisfaction evaluations to improve performance. • SEP/ADRC can demonstrate ability to document the impact on nursing home use • SEP/ADRC can demonstrate the ability to document the impact on the use of home and community-based services. • SEP/ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • SEP/ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • SEP/ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.
Staffing and Resources	• Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs	• SEP/ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • SEP/ADRC has an individual assigned to be the overall director/manager/coordinator of all SEP/ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when SEP/ADRC functions occur in more than one location or agency. • SEP/ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.