County Social Services- LifeLong Links Service Delivery Flow

Information & Assistance/ Referral	Family Caregiver	Service Coordination Options Counseling	Care Transitions	Dependent Abuse Intervention	Case Management/Care Coordination	
Guidelines: ✓ General Information ✓ Persons with Disabilities	Guidelines: ✓ Adults caring for someone with disabilities. ✓ Caregiver Specific	Guidelines: ✓ Persons with Disabilities ✓ SHORT TERM	Guidelines: ✓ People transitioning from an acute care setting to community ✓ Evidenced-based models used ✓ Persons with Disabilities 18+ SHORT TERM	Guidelines: ✓ Persons with Disabilities At risk for abuse, neglect, and/or exploitation	Guidelines: ✓ Eligibility specific to each care coordination program	
					Local Programs	Service Provided by Local Programs

• Information & Referral
• Screening/ triage of agency calls
• Identify caller needs
• Communicates resources on program options
• Referral & Linkages
• "Warm" transferring to other agency staff, community agencies/programs
• Educational, information to callers (packets, etc.)
• Community resource awareness
• Follow up
• Application Assistance
  • Rent Reimbursement
  • Property Taxes
• Community presentations/outreach as requested
• Uses Resource Database
• Caregiver Support
• AIRS certification
• Level I Service Requests
	• Information & Assistance
	• Identify caller needs; transferring to other agency staff, agencies, programs
	• Communicates resources on program options (program specific)
	• Referral & Linkages
	• Follow up
	• "Warm" transferring to other agency staff, community agencies/programs
	• Educational, information (packets, Powerful Tools for Caregivers)
	• Community resource awareness
	• Caregiver support
	• Grandparent raising grandchildren, etc. (55+)
	• Outreach & marketing (caregiver specific)
	• Uses Resource Database
	• AIRS certification
		• Information & Assistance
		• Assessment based on consumer's needs, values & preferences
		• Future planning for long term services and supports
		• Phone and Face to face visits (home visits, ADRC, other locations)
		• Referral & linkages
		• Benefits counseling
		• Application assistance/submit and complete (i.e. Medicaid, Waiver programs, etc)
		• Outreach & marketing
		• Uses Resource Database
		• Documentation
		• Follow-up as needed
		• Contact for MDS 3.0 Section Q
		• AIRS certification
		• Medicare Part D
		• Enrollment into appropriate MHD Service Plan and Level II Service Requests.
			• Options Counseling Assessment
			• Hospital Visit prior to discharge from the hospital
			• Information & Assistance
			• Assist acute care settings in better coordinating care and services for those at risk for readmission
			• Nurturing of community relationships with providers
			• Support discharge planners with care transitions
			• May be part of provider multi-disciplinary team meetings
			• Client followed/engaged in program for 120 days after discharge to community
			• Assessment of service and financial need
			• Aid in understanding/adhere to post discharge instructions; medication management; nutrition; self-care; follow-up apt.'s with providers
			• Home visits
			• Referral linkages
			• Skilled Nursing Facility
			• Monitoring and follow-up
				• Information and Assistance
				• Assessment/ Reassessment
				• Consultation
				• Referral & linkage
				• Monitoring & follow-up
				• Application assistance
				• Crisis intervention
				• Multi-Disciplinary Team meetings
				• Documentation
				• Home visits
				• Outreach
					• Targeted Case Management - (multiple providers)
					• HCBS Waiver Case Management (all types)
						• Ongoing coordination of services
						• Information and Assistance
						• Assessment/ Reassessment
						• Referral & linkage
						• Education & Advocacy
						• Monitoring & follow-up
						• Home visits
						• Monthly contacts
						• Face to Face visits – every 3 months
						• Multi-disciplinary Team Meetings
						• Service Plan - Care planning (initially and as needs change)
						• Application Assistance for enrolled clients- all programs and funding types
						• Authorization of waiver dollars for service
						• Documentation

Caring Care Coordination