South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 1, Intake Services

Revision Number: 17-01 **Effective Date: 7/12/2017**

Review Date: 12/8/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 1, Intake Services

Revision Number: 17-01 **Effective Date: 7/12/2017**

Review Date: 12/8/2017

100 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. The Adult Protective Services (APS) Program is part of the Adult Advocacy Division of the South Carolina Department of Social Services (DSS). The APS Program has the responsibility to investigate and provide Protective Services to a person eighteen (18) years of age or older who resides within the community setting who has a physical or mental condition which prevents the person from providing for his or her own care or protection. This includes adults who are impaired because of brain damage, advanced age, and physical, mental or emotional dysfunction.

AUTHORITY. The Omnibus Adult Protection Act provides the APS Program the authority to investigate or cause to be investigated **noncriminal** reports of alleged abuse, neglect, and exploitation of Vulnerable Adults occurring in settings other than those facilities for which the Long Term Care Ombudsman Program is responsible for the investigation pursuant to SECTION 43-35-15(C) of the South Carolina Code of Laws.

INTENT. The intent of the APS Program is to provide intervention and protection for Vulnerable Adults who cannot provide care or protection for themselves in a manner that ensures attention will be given to the Vulnerable Adult's right to self-determination, the client's lifestyle and culture, and the requirement that services be provided in the least restrictive environment appropriate for the Vulnerable Adult as determined by the Vulnerable Adult's level of care and safety.

SCOPE OF INTAKE SERVICES. The Department of Social Services will receive and determine the most appropriate response to a report of alleged or suspected abuse, neglect, self-neglect or exploitation of a Vulnerable Adult. The scope of APS Intake Services includes the utilization of the APS Intake Tool by Information Gathering and Decision Making, Assigning Response Time, and Creating, Documenting and Processing APS Reports.

110 INTRODUCTION

DSS will provide a twenty-four (24) hour reporting system for receiving reports of alleged or suspected maltreatment of a Vulnerable Adult.

Each report is assessed to determine whether the alleged maltreatment occurred in a setting that DSS is responsible for investigating. Refer to Chapter 1, SECTION 100, Intake Services Policy, 135, **JURISDICTION TO INVESTIGATE BASED ON LOCATION**.

Each report is assessed to determine whether the subject of the report is a Vulnerable Adult.

Each report is assessed to determine whether the alleged maltreatment was committed or is likely to be committed by the Vulnerable Adult's caregiver or is a result of the Vulnerable Adult's self-care.

Each report is assessed to determine a typology of the allegations and assign the most appropriate response time for Vulnerable Adults who may have been maltreated or are at risk of being maltreated.

A decision to accept or not accept a report for investigation will be made upon completion of the APS Intake Tool and/or within 0 – 2 hours upon receiving the Intake Report. The Intake Practitioner in the HUB will notify the county APS office no later than two (2) hours after the Intake Decision has been made that their county has an accepted Intake Report in need of investigation.

Adult Protective Services reports must meet the following legal criteria to be accepted for investigation:

a. The alleged victim must be eighteen (18) years of age or older.
b. There must be an allegation of abuse, neglect, self-neglect or exploitation or a potential that a maltreatment may occur.
c. The alleged abuse/neglect/self-neglect/exploitation or the potential thereof must have occurred in a community setting.
d. The alleged victim must be a Vulnerable Adult as determined by having a physical or mental condition which substantially impairs the person from providing for his or her own care or protection. This include adults who are impaired because of brain damage, advanced age, and physical, mental, or emotional dysfunction. A person should not be considered a Vulnerable Adult just because the person has a physical or mental disability or advanced age. A person who appears to have a significant disability is not necessarily a Vulnerable Adult in need of protection.

The Alleged Perpetrator must be or have been in caregiver status to the Vulnerable Adult for an Intake Report to be accepted for investigation for Neglect by Caregiver, Abuse or Financial Exploitation. If the alleged perpetrator does not meet caregiver status, a referral must be made to Law Enforcement by the Intake Practitioner and the Intake allegation(s) must be assessed for self-neglect.

120 DEFINITIONS

The following terms and definitions are commonly used in the Adult Protective Services Program:

120.01 Adult Protective Services

Adult Protective Services is one of the programs under the Adult Advocacy Division. The mission of APS is to protect Vulnerable Adults from abuse, neglect, self-neglect and exploitation by investigating and providing temporary assistance until risk is minimized and services are secured.

120.02 Caregiver

A caregiver is a person who provides care to a Vulnerable Adult, with or without compensation, on a temporary, permanent, full or part-time basis. This individual may include but is not limited to: a relative, household member, day care personnel, adult foster home sponsor, and personnel of a public or private institution or facility.

120.03 Community Setting

A community setting is a private residence or any non-institutional setting not investigated by the Long Term Ombudsman Office.

120.04 Facility

A facility is a nursing care facility, community residential care facility, a psychiatric hospital, or any residential program operated or contracted for operation by the Department of Mental Health or the Department of Disabilities and Special Needs.

120.05 Level of Care

Skilled Nursing Care and Intermediate Care are the two levels of nursing home care. Skilled care is for individuals with more severe functional deficits who require more hands-on assistance than individuals at the intermediate level of care.

Skilled Nursing Care is health care given when a person needs skilled nursing staff, a registered nurse (RN) or a licensed practical nurse (LPN) to manage, observe, and evaluate care. Skilled nursing care requires the involvement of skilled nursing staff in order to be given safely and effectively.

Intermediate Care is provided by skilled professionals such as registered or licensed practical nurses, and therapists, under the supervision of a physician. Medicare Part A does not cover intermediate care in nursing homes.

The appropriate **Level of Care (LOC)** is determined by the Vulnerable Adult's primary care physician, medical provider or Community Long Term Care (CLTC). CLTC will complete a thorough assessment on the Vulnerable Adult to determine the LOC.

120.06 Occupational Licensing Board

This is a health professional licensing board which is a state agency that license and regulates health care providers and includes, but is not limited to, the Board of Long Term Health Care Administrators, State Board of Nursing for South Carolina, State Board of Medical Examiners, State Board of Social Work Examiners, and the State Board of Dentistry.

120.07 Vulnerable Adult

A Vulnerable Adult is a person eighteen (18) years or older who has a physical or mental condition which substantially impairs the person from adequately providing for his/her own care or protection. This includes impairments due to infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction. A person's legal competency status does not determine whether the person is a Vulnerable Adult. A person may be legally competent but still be a Vulnerable Adult. Any resident of a facility is a Vulnerable Adult.

120.08 Other Definitions - See Chapter 1, SECTION 100, Intake Services Policy, 133, **DETERMINING IF THE REPORT MEETS THE CRITERIA OF ABUSE, NEGLECT, SELF-NEGLECT OR EXPLOITATION** for definitions of abuse, neglect and exploitation.

130 POLICIES

131 RECEIVING AN ADULT PROTECTIVE SERVICES REPORT

South Carolina's APS Intake process begins with a report of alleged or suspected abuse, neglect, self-neglect or exploitation of a Vulnerable Adult. This report can be made on an anonymous basis. At this time, the Intake Practitioner will begin a process of gathering information. The Intake Practitioner must gather as much information as possible by completing the South Carolina Department of Social Services **Adult Services Intake Worksheet** (DSS Form 1559).

All DSS forms mentioned throughout APS policy can be found in the Master Forms Index with instructions located on the DSS Unite page.

The Intake Practitioner must try to obtain the following information at the minimum:

a. The Date and Time the report was received.
b. Vulnerable Adult's name.
c. Vulnerable Adult's DOB.
d. Vulnerable Adult's usual address.
e. Vulnerable Adult's current location.
f. Directions to where Vulnerable Adult is located.
g. Telephone Number where Vulnerable Adult can be reached.
h. Typology of allegations.
i. Why the Reporter believes that the individual is a Vulnerable Adult.
j. Ask the Reporter to describe surrounding circumstances accompanying the allegations.
k. Ask the Reporter to describe how the individual behaves, the current status, condition and vulnerability of the Vulnerable Adult.
l. Ask the Reporter to describe the location of the Perpetrator/Caregiver and his/her relationship to the Vulnerable Adult, caregiving practices, behavior, and how he/she relates to others. If the Perpetrator is not the Caregiver, make a note of that.
m. Ask the Reporter to describe the condition of the house. Describe dangers e.g., dogs, weapons, etc. which the Investigator should anticipate on initial visit.
n. Marital Status of Vulnerable Adult.

o. If Vulnerable Adult owns or rents their residence.
p. Vulnerable Adult's Social Security Number
q. Vulnerable Adult's Medicaid Number.
r. Vulnerable Adult's Medicare Number.
s. Household Information: name, age/DOB, sex, race, relationship to Vulnerable Adult, place of employment or source of income of other persons that live in the home with the alleged victim.
t. Names and contact information for other known relatives.
u. Names and contact information for other people or agencies assisting the Vulnerable Adult including the name of the Vulnerable Adult's medical doctor.
v. Ask the Reporter about any known danger influences of the Vulnerable Adult which includes but is not limited to medical care needed, wandering, lack of income/resources, poor mental/emotional health, social isolation, alcohol/drug abuse, lack of utilities, lack of food, bizarre behavior, poor physical/functional abilities, recent change in behavior, previous incidents, inadequate/unsafe housing and other (describe).
w. Ask the Reporter about any known danger influences of the Caregiver/Perpetrator which includes but is not limited to in hospital, substance abuse, ignorance of caregiving, intoxicated now, may move client, poor mental/emotional health, lack of income/resources, bizarre behavior, displaying a weapon now and other (describe).
x. The Intake Practitioner must attempt to collect the Reporter's information including Name, Address, Phone Number, Relationship to/Knowledge of Vulnerable Adult and How Reporter came to know the Vulnerable Adult.
y. Ask Reporter if follow up information is requested on the status of the Intake Decision. **Other information in the case file is confidential.**

132 THE APS INTAKE TOOL

The Intake Practitioner must complete the **APS Intake Tool** (DSS Form 1566) in its entirety on each report or referral that is received to determine if the alleged victim is a Vulnerable Adult and if there is a viable allegation of abuse, neglect, self-neglect or exploitation or a potential thereof. Each intake report whether it is accepted or not accepted for investigation must be entered into CAPSS by the Intake Practitioner.

133 DETERMINING IF THE REPORT MEETS THE CRITERIA OF ABUSE, NEGLECT, SELF-NEGLECT OR EXPLOITATION

To meet the criteria for an accepted report, there must be reason to believe abuse, neglect or exploitation by the Caregiver or self-neglect of the Vulnerable Adult has occurred or is likely to occur in a community setting.

The Intake Practitioner must complete *Part I: Information Gathering Guide*, of the APS Intake Tool. The Practitioner will select if there is an actual allegation of a maltreatment or if the maltreatment is likely to happen and if there are other concerns.

Under *Allegation/Reason for Call*, the Intake Practitioner must select a typology for the maltreatment of the alleged victim. If there is no clear allegation, the Intake Practitioner will use the *Risk Factors* ratings to assist in deciding if maltreatment is likely to happen. The following definitions are used to clarify the typologies:

133.01 Abuse

Abuse means physical or psychological abuse.

133.02 Physical Abuse

Physical abuse means intentionally inflicting or allowing to be inflicted physical injury on a Vulnerable Adult by an act or failure to act. Physical abuse includes, but it not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery as defined in S.C. Code of Laws, SECTION 43-35-10(8), use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment. A therapeutic procedure prescribed by a licensed physician or other qualified professional or that is part of a written plan of care by a licensed physician or other qualified professional is not considered physical abuse. Physical abuse does not include altercations or acts of assault between Vulnerable Adults.

133.03 Psychological Abuse

Psychological abuse means deliberately subjecting a Vulnerable Adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

133.04 Sexual Battery

Sexual Battery is defined in S.C. Code of Laws, SECTION 16-3-651(h) as sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, except when such intrusion is accomplished for medically recognized treatment or diagnostic purposes.

133.05 Neglect by a Caregiver

The failure or omission of a caregiver or fiduciary to provide the care, goods, or services that are necessary to maintain the health or safety of a Vulnerable Adult including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services.

133.06 Self Neglect

An adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (A) obtaining essential food, clothing, shelter, and medical care;

(B) obtaining goods and services necessary to maintain physical health, or general safety; or (C) managing one's own financial affairs.

133.07 Exploitation

(a) causing or requiring a Vulnerable Adult to engage in activity or labor which is improper, unlawful, or against the reasonable and rational wishes of the Vulnerable Adult. Exploitation does not include requiring a Vulnerable Adult to participate in an activity or labor which is a part of a written plan of care or which is prescribed or authorized by a licensed physician attending the patient;

(b) an improper, unlawful, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a Vulnerable Adult by a person for the profit or advantage of that person or another person; or

(c) causing a Vulnerable Adult to purchase goods or services for the profit or advantage of the seller or another person through: (i) undue influence, (ii) harassment, (iii) duress, (iv) force, (v) coercion, or (vi) swindling by overreaching, cheating, or defrauding the Vulnerable Adult through cunning arts or devices that delude the vulnerable adult and cause him to lose money or other property.

134 DETERMINING IF THE ALLEGED VICTIM IS A VULNERABLE ADULT

A Vulnerable Adult is a person eighteen years or older who has a physical or mental condition which **substantially impairs** the person from adequately providing for his/her own care or protection. This includes impairments due to infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction. For a report to be accepted for investigation, the alleged victim must meet the criteria of a Vulnerable Adult. The Intake Practitioner must complete the APS Intake Tool to determine if the alleged victim is a Vulnerable Adult.

An answer of yes/no must be selected on the Intake Tool to assess if there is an allegation of Impairment. The following definitions are used as a guideline to determine if there is an actual or potential claim that the alleged victim is impaired:

A Physical Disability is when the Vulnerable Adult has an illness, disorder, physical injury, or infirmity of aging that impacts his/her mobility and/or gross motor skills.

A Cognitive Disability is when the Vulnerable Adult suffers from either a traumatic brain injury or disorder that limits his/her basic reasoning and problem-solving skills.

Memory Loss is when the Vulnerable Adult suffers from forgetfulness that routinely impacts performance of daily activities.

Mental Illness is when the Vulnerable Adult suffers from emotional disturbances caused by illnesses including but not limited to anxiety, depression, and bi-polar disorder.

A yes/no/unknown response must be selected by the Intake Practitioner to determine if the subject of the report is able to perform their *Basic Activities of Daily Living (ADLs)*. This determination must be made in the following categories: **Bathing, Dressing, Toileting, Transferring, Continence and Feeding.**
A selection of yes/no/unknown must also be made to determine if the alleged victim can complete his/her *Instrumental ADLs* as outlined:

Financial Management - To answer **Yes**, the person must have the ability to manage financial matters independently (budget, write checks, pay rent and bills, conduct banking), collect and keep track of income.

Medication Management - To answer **Yes**, the person must have the ability to be responsible for taking medication in correct dosages at correct times. (A person does not have the ability to manage medication independently if the medication is prepared in advance in separate dosages by another person).

Telephone Usage - To answer **Yes**, the person must have the ability to operate the telephone on own initiative, communicate using the phone, and look up and dial numbers.

Shopping - To answer **Yes**, the person must have the ability to take care of all shopping needs independently.

Food Preparation - To answer **Yes**, the person must have the ability to plan, prepare, and serve adequate meals independently.

Housekeeping - To answer **Yes**, the person must have the ability to maintain their house alone, performing light daily tasks such as dishwashing and bed-making, with occasional assistance for heavy work.

Laundry - To answer **Yes**, the person must have the ability to do personal laundry completely.

Transportation - To answer **Yes**, the person must have the ability to travel independently on public transportation; arrange own transportation via taxis, friends, family; or drive own car.

135 JURISDICTION TO INVESTIGATE BASED ON LOCATION

The location of the incident must be documented on the APS Intake Tool to clarify if it happened in a community setting giving APS the authority to investigate. If the incident happened in a facility, the Ombudsman, SLED, local Law Enforcement or S.C. Attorney General's Office investigates.

If the hospital makes a report regarding an incident of maltreatment, the Intake Practitioner must gather more information to determine if the incident occurred before admission to the hospital or if there are some allegations of maltreatment that will occur at the time of discharge like the person is unable to provide care for herself/himself and there is no one else available to provide care for the Vulnerable Adult. If the answer is yes to either question, DSS may need to investigate. If the

alleged victim is currently in the hospital but is a resident from a nursing home and plans to return to the nursing home upon discharge from the hospital, the Intake Practitioner must advise the reporter to contact the Ombudsman's Office and the Intake Practitioner will make a report to the Ombudsman's Office within twenty-four (24) hours as well.
Accepted Intake Reports will be initially assigned to the county where the victim is currently located. See the Adult Protective Services Policy and Procedure Manual, Chapter 2, SECTION 200, Investigations Policy, 237, **TRANSFER STAFFING TO ANOTHER COUNTY**, for further guidance.

When the location of an alleged victim is not immediately available, the Intake Practitioner must make an attempt to verify the Vulnerable Adult's address. The verification process should include but is not limited to the following sources: contacting the reporter, researching CAPSS, Whitepages.com, CHIPS, County Public Access System, http://www.judicial.state.sc/caseSearch, local Law Enforcement, collateral contacts in the report.

136 SYSTEMS CHECK

To complete the information gathering process, the Intake Practitioner must conduct a systems check and update the following SECTIONs of *Part I: Information Gathering* of the APS Intake Tool with any new information: Impairments, Basic and Instrumental ADLs, and Risk Factors.
The systems check should include but is not limited to the following sources: CAPSS, CHIPS, County Public Access System, (http://www.judicial.state.sc./caseSearch), and local Law Enforcement.

137 ACCEPTING REPORTS

The APS Intake Tool guides the Intake Practitioner in a structured decision-making process to make an independent recommendation in regards to accepting or not accepting a report or referral for investigation. This recommendation is forwarded to the Intake Supervisor to complete the final approval process. When the Intake Supervisor has confirmed that the alleged victim in the report meets the legal definition of a Vulnerable Adult and there is an actual or potential allegation of abuse, neglect, self-neglect or exploitation as evidenced by the results of the APS Intake Tool, the report may be accepted for investigation.

138 ASSIGNING RESPONSE TIME TO AN ACCEPTED REPORT

The Intake Supervisor must ensure that a typology has been assigned to the report. The typology determines when "initial face to face" contact must be made with the alleged victim. **Emergency Situations** are determined based on the risk and safety for the alleged victim and requires immediate action ***(0-2 hr. response).***

Below are criteria that would qualify a response time of 0-2 hours. These are examples but not an all-inclusive list. Critical thinking should still be used to determine response time.

- The reporter states that the alleged victim is dehydrated, bedbound, has not eaten in several days, may have stage three or four bedsores.

- There is reported serious injury to a Vulnerable Adult.
- An alleged victim is left alone/abandoned and requires immediate care (consider functioning and mental status of adult).
- There is an allegation of sexual abuse and the perpetrator lives with or has access to the alleged victim.
- The Vulnerable Adult resides where there is an active meth lab.
- Law Enforcement requests immediate assistance.

Abuse must be investigated no later than 24 hours after Intake Time.

Neglect by another must be investigated no later than 48 hours after Intake Time.

Exploitation must be investigated no later than 48 hours after Intake Time.

Self-Neglect must be investigated no later than 72 hours after Intake Time.

139 AFTER HOURS RESPONSE

In order to ensure that Vulnerable Adults are protected as soon as possible, county staff are required to maintain on-call systems so reports may be responded to after office hours, on weekends and holidays. The APS Intake Tool must be completed on all Intake Reports including Intakes and Referrals received during afterhours when the county office is closed for regular business. On-call APS Case Managers are responsible for responding to reports ensuring that response times are met in a timely manner during afterhours.

140 MANDATORY REPORTING

Certain individuals are listed in S.C. Code of Law, SECTION 43-35-25(A) as being required to report when they have reason to believe abuse, neglect, self-neglect or exploitation of a Vulnerable Adult has occurred or is likely to occur. A physician, nurse, dentist, optometrist, medical examiner, coroner, other medical, mental health or allied health professional, Christian Science practitioner, religious healer, school teacher, counselor, psychologist, mental health or intellectual disability specialist, social or public assistance worker, caregiver, staff or volunteer of an adult day care center or of a facility, or law enforcement officer having reason to believe that a Vulnerable Adult has been or is likely to be abused, neglected, or exploited shall report the incident in accordance with this section. Any other person who has actual knowledge that a Vulnerable Adult has been abused, neglected, or exploited shall report the incident in accordance with this section.

Any other person who has reason to believe that a Vulnerable Adult has been or may be abused, neglected, or exploited may report the incident.

A person required to report is personally responsible for making the report; however, a state agency may make a report on behalf of an agency employee if the reporting procedure is approved by SLED or the investigative entity in writing.

140.01 Reporting Procedures

(1) A person required to report under S.C. Code of Laws, SECTION 43-35-25(A) must report the incident within twenty-four (24) hours or the next business day.
(2) A report must be made in writing or orally by telephone or otherwise to the Vulnerable Adults Investigations Unit of SLED for incidents occurring in facilities operated by DMH or DDSN, Long Term Care Ombudsman Program for incidents occurring in facilities and to the Adult Protective Services Program for incidents occurring in all other settings.
(3) In the event an investigative entity receives a report which is not within its investigative jurisdiction, it shall forward the report to the appropriate entity no later than the next business day.
(4) No facility may develop policies or procedures that interfere with the reporting requirements of this section.
(5) Provided the mandatory reporting requirements of this section are met, nothing in this section precludes a person from also reporting directly to law enforcement, and in cases of an emergency, law enforcement must also be contacted.
(6) Any other person who has actual knowledge that a Vulnerable Adult has been abused, neglected, or exploited shall report the incident in accordance with S.C. Code of Laws, SECTION 43-35-25(A).

141 PENALTY FOR FAILING TO REPORT

A person required to report according to the S.C. Code of Laws, SECTION 43-35-25(A) who has actual knowledge that abuse, neglect, or exploitation has occurred and who knowingly and willfully fails to report the abuse, neglect, or exploitation is guilty of a misdemeanor and, upon conviction, must be fined not more than twenty-five hundred dollars or imprisoned not more than one year. A person required to report under this chapter who has reason to believe that abuse, neglect, or exploitation has occurred or is likely to occur and who knowingly and willfully fails to report the abuse, neglect, or exploitation is subject to disciplinary action as may be determined necessary by the appropriate licensing board.

142 IMMUNITY

A person acting in good faith who reports pursuant to S.C. Code of Laws, SECTION 43-35-75(A) or who participates in an investigation or judicial proceeding resulting from a report is immune from civil and criminal liability which may otherwise result by reason of this action. In a civil or criminal proceeding, good faith is a rebuttable presumption.

143 NOTIFICATION TO THE REPORTER

All professional and mandated reporters will receive a call back from the Intake Practitioner informing the reporter of the Intake decision. All other reporters will be asked at the time that the report is taken if they would like to be informed of the Intake decision. All reporters who request to be notified of the Intake decision will be called back immediately after the Intake decision is made.

144 REPORTING OR REFERRING TO OTHER AGENCIES

Intake Practitioners must document all referrals in CAPSS that are made to other agencies. Reporters may be informed to make referrals to other agencies; however, it is the responsibility of the Intake Practitioner to also make referrals to other agencies within twenty-four (24) hours of the time that the Intake Report was received.

144.01 Health Care Professional

An allegation that a health care professional abused, neglected, or exploited a Vulnerable Adult must be reported to the occupational licensing board by whom that person is licensed.

144.02 Intakes reported to Law Enforcement or SLED

As required by SECTION 43-35-40 of the South Carolina Code of Laws, The Adult Protective Services Program must refer reports of abuse, neglect, and exploitation to local Law Enforcement or to the Vulnerable Adult Investigations Unit of the South Carolina Law Enforcement Division (SLED) immediately but no later than twenty-four (24) hours if there is reasonable suspicion of **criminal conduct** regardless of how the report is otherwise processed. **Notification to Law Enforcement** (DSS Form 1506) will be used for this purpose. It is the responsibility of the Intake Practitioner to make the referral and document in CAPSS that DSS Form 1506 has been completed and forwarded to Law Enforcement.

144.03 Intakes referred to LTCOP

The Long Term Care Ombudsman Program (LTCOP) shall investigate or cause to be investigated noncriminal reports of alleged abuse, neglect, and exploitation of Vulnerable Adults occurring in facilities. Intake reports involving residents of facilities must be immediately referred by the Intake Practitioner to the LTCOP. This referral must be documented in CAPSS by the Intake Practitioner.

144.04 Intakes reported to DMH Client Advocacy Program

Intake Practitioners must refer reports of abuse, neglect, and exploitation involving residents committed to the Department of Mental Health (DMH) in which there is no reasonable suspicion of criminal conduct to the Department of Mental Health Client Advocacy Program for investigation.

144.05 Notification to Attorney General's Office Medicaid Fraud Unit

The Medicaid Fraud Control Unit of the Attorney General's Office investigates incidents of Medicaid Fraud. Medicaid Fraud, when alleged, should be investigated by the Long Term Care Ombudsman's Office whose jurisdiction it is to investigate such complaints/issues as found in licensed Nursing Homes (NH) and Residential Care Facilities (RCF).

If an Intake Practitioner receives an Intake report alleging Medicaid Fraud in a licensed NH or RCF, the Intake Practitioner must take the reporter's contact information as well as the name, type, phone number and address of the facility and a brief accounting of the allegation and forward the

information to the Regional Long Term Care Ombudsman's Office as well as the Attorney General's Office Medicaid Fraud Unit.

145 REPORTS ON A DSS EMPLOYEE OR IMMEDIATE FAMILY MEMBER OF AN EMPLOYEE

When an APS report is received on a DSS employee or immediate family member of a DSS employee, the Intake Practitioner will complete the normal Intake process using the APS Intake Tool. The Regional Director in that area will be notified immediately. The Intake staff will complete the administrative security process to ensure that the DSS employee does not have access to the case record in CAPSS.

146 REPORTS INVOLVING THE DEATH OF A VULNERABLE ADULT

When the Intake Practitioner receives a report that alleges probable cause that the Vulnerable Adult died as a result of abuse/neglect, the Intake Practitioner must report the death of the alleged victim to the Coroner or Medical Examiner and the appropriate Law Enforcement agency.

147 REPORTS INVOLVING A VICTIM OF SEX TRAFFICKING

When the agency receives a report involving a victim of sex trafficking, the Intake Practitioner must process the report in the usual manner using the Adult Protective Services Intake Tool and arrive at an Intake decision. A referral must be made to Law Enforcement immediately.

148 ACCOMMODATING SENSORY-IMPAIRED CLIENTS AND CLIENTS WITH LIMITED ENGLISH PROFICIENCY

The Intake Practitioner gathers information from the reporter to determine if the alleged victim has any concerns that require special accommodations which includes but is not limited to speech or hearing impairment and/or limited English Proficiency. If the report is accepted for investigation, the Intake Practitioner must ensure that these concerns are transferred to the county APS office. Special accommodations must be made for alleged victims with special needs.

149 RECURRENT REPORTS

When more than one report is received on the same alleged victim, each report will be processed according to the normal Intake procedures using the APS Intake Tool. If there is a current open investigation that is addressing the same allegations, then the information received in the report may be forwarded to the county APS office as additional information.

150 QUALIFICATIONS OF APS INTAKE PRACTITIONERS

All APS Intake Practitioners must have successfully completed the training module for the administration of the APS Intake Tool, completed the APS Basic Training course or completed the specialized APS HUB training course and received a test grade of (eighty-five) 85 or higher.

151 FINAL RESOLUTION OF APS INTAKE DISPUTES

The Director of the Adult Advocacy Division or his/her designee reserves the right to make the final resolution of all APS Intake disputes. However, the dispute resolution process will not delay the county APS Investigator from responding timely to the Vulnerable Adult. Once the Intake Hub has accepted an Intake Report for investigation, the county is expected to initiate the investigation.

Referenced Documents

S.C. Code of Laws, Title 43, Chapter 35: Omnibus Adult Protection Act
S.C. Code of Laws, Title 16, Chapter 3
APS Intake Tool (USC)

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 2, Investigations

Revision Number: 17-02 **Effective Date: 12/8/2017**

Review Date: 12/8/2017

Table of Contents

242 Emergency Protective Custody (EPC)
243 Emergency Protective Custody Procedure
244 Ex-Parte Removal Order
245 The Probable Cause Hearing
246 The Merits Hearing
247 The Full Hearing
248 Unable To Locate Vulnerable Adult
249 Securing Access To The Vulnerable Adult
250 Securing Access To Information
251 Cases Involving Two Vulnerable Adults
252 Investigations Involving Multiple Counties
253 Assessing A Vulnerable Adult Aging Out Of Foster Care By Court Order Into Adult Protective Services
254 Adult Day Care Programs
255 Investigations Of Reports Involving DDSN Programs And Services
256 Health Care Consent Act
257 Penalties
258 APS Case Manager Responsibilities
259 APS Supervisor Responsibilities
260 APS County Director Responsibilities
261 Confidentiality Of Adult Protective Services Records
262 Case File Management
263 Contents Of The Case Record
264 Adult Face Sheet
265 Organization Of Adult Protective Services Records
266 Contents Of The Case Narrative
267 Reporting Critical Incidences And Fatalities Involving Vulnerable Adults
268 Case Closure
Referenced Documents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 2, Investigations

Revision Number: 17-02 **Effective Date: 12/8/2017**

Review Date: 12/8/2017

200 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. The Adult Protective Services (APS) Program has the responsibility to ensure that all Intake Reports alleging abuse, neglect and/or exploitation that meet the definition of the law are thoroughly investigated for the protection of each Vulnerable Adult.

AUTHORITY. The Omnibus Adult Protection Act gives the Adult Protective Services Program the authority to investigate or cause to be investigated noncriminal reports of alleged abuse, neglect, and exploitation of Vulnerable Adults occurring in all settings other than those facilities for which the Long Term Care Ombudsman Program is responsible for the investigation pursuant to SECTION 43-35-15(C) of the South Carolina Code of Laws.

PURPOSE. The purpose of the investigation is to determine if 1) the alleged victim is a Vulnerable Adult 2) the Vulnerable Adult is at substantial risk of being or has been abused, neglected or exploited, 3) whether the Vulnerable Adult is unable to protect herself of himself and 4) Protective Services are necessary to protect the Vulnerable Adult from substantial risk of or from abuse, neglect or exploitation.

INTENT. It is the intent of the Adult Protective Services Program to conduct a thorough Investigation that promotes the protection of the Vulnerable Adult. While performing assigned duties as an investigative entity, the APS Program seeks to reduce risk and promote the safety of the Vulnerable Adult while restoring each individual's highest level of independence and integrity.

SCOPE OF INVESTIGATIVE SERVICES. The scope of APS Investigative Services includes Timely Initiation of an Accepted Intake Report, Conducting the Investigation, Completing the Risk Assessment, Completing the Case Decision Process, Documenting the Investigation in CAPSS and Participating in Court Proceedings.

210 INTRODUCTION

The Adult Protective Services Program seeks to complete a thorough investigation of all accepted Intake Reports in a timely manner while safeguarding the safety of Vulnerable Adults. This Chapter sets forth the Department's policy and procedures for investigating reports of abuse, neglect, self-neglect and exploitation of Vulnerable Adults.

220 POLICIES

221 CREDENTIALS OF AN APS INVESTIGATOR/CASE MANAGER

An APS Investigator/Case Manager will have at least one of the following: A bachelor's degree in social work; A bachelor's degree in a behavioral science or human services field; A bachelor's degree in another field with at least one year of relevant experience. All incoming APS Case Managers are required to undergo background checks including pre-hire fingerprint checks. All APS Case Managers must have completed the APS Basic Training course and received a test grade of eighty-five (85) or higher. Thereafter, twenty (20) hours of training is required annually including ten (10) mandatory hours in Adult Protective Services subject matter.

222 INITIATING THE INVESTIGATION

All accepted APS Intake Reports will be investigated in a timely manner. In all cases, to initiate the investigation, a visit must be made to the location of the Vulnerable Adult and he/she must be directly observed (face to face) and assessed within the specified time frame of the typology. If the client cannot be located or observed in the specified time frame of the typology, the investigator must complete an activity note in the Child and Adult Protective Services System (CAPSS) to show the continued efforts to make contact in the required time frame and the reason(s) why face to face contact with the client was not made. Failed attempts to make face to face contact with the alleged victim must be staffed immediately with the APS Supervisor to obtain further instruction and direction. Refer to Chapter 2, SECTION 200, Investigations Policy, 248, **UNABLE TO LOCATE VULNERABLE ADULT** for further guidance.

Emergency situations are determined based on the risk and safety for the alleged victim and requires immediate action ***(0-2 hr. response).*** Refer to Chapter One, SECTION 100, Intake Services Policy, 138**, ASSIGNING RESPONSE TIME TO AN ACCEPTED REPORT** for further guidance.

Accepted reports of **Physical, Psychological and Sexual Abuse** must be initiated no later than 24 hours after Intake Time. **Neglect by a Caregiver** must be initiated no later than 48 hours after Intake Time. **Exploitation** must be initiated no later than 48 hours after Intake Time. **Self-Neglect** must be initiated no later than 72 hours after Intake Time. Once the investigation is initiated, the Investigator must conduct a thorough investigation of all typologies.

223 RIGHTS AND RESPONSIBILITIES

At the on-set of the Investigation, the APS Investigator must review and have the alleged victim or representative of the alleged victim sign important documents. Vulnerable Adults must be told what their Rights and Responsibilities are during the DSS investigation. The Investigator must explain the **Social Services Block Grant Services Rights and Responsibilities** (DSS Form 3795) to the alleged victim. The Investigator must note in CAPSS that the form has been explained and signed by the alleged victim or a representative. A signed copy of the form must be placed in the hard file and uploaded into the electronic file. The date that the client's Rights and Responsibilities were explained to them must also be entered in the Interpretation Tab of the Risk Assessment. **All**

DSS forms mentioned throughout APS policy can be found in the Master Forms Index with instructions located on the DSS Unite page.

224 COMPLIANCE WITH CIVIL RIGHTS LAWS

The South Carolina Department of Social Services and its providers must serve the people of South Carolina without discrimination. At the on-set of the investigation, DSS Brochure 2416 - **Know Your Rights** must be given to the alleged victim explaining that DSS is in compliance with the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Food and Nutrition Act of 2008, the Americans with Disabilities Act of 1990, the Multi-Ethnic Placement Act of 1994 and all federal and state civil rights laws. The APS Investigator must note in CAPSS that this brochure has been explained and given to the alleged victim.

225 NOTICE OF HIPPA PRIVACY PRACTICES ACKNOWLEDGEMENT

At the on-set of the investigation, a copy of DSS Booklet 4017- **Notice of HIPPA Privacy Practices** must be explained and given to the alleged victim. The APS Investigator must complete and have the alleged victim or the representative of the alleged victim to sign **Notice of HIPPA Privacy Practices Acknowledgement** (DSS Form 4000). CAPSS must be noted and a signed copy must be placed in the hard file and uploaded into the electronic file.

226 ADULT PROTECTIVE SERVICES MEDICAL STATUS REPORT

The **Adult Protective Services Medical Status Report** (DSS Form 1568) must be sent to all Medical Providers including mental health professionals so that an accurate status of the alleged victim's mental and physical well-being can be assessed. This form must be sent out at the on-set of the investigation to assist the Investigator in determining if the alleged victim is a Vulnerable Adult and if any abuse or neglect has occurred or the potential thereof. The form must be placed in the hard file and uploaded into the electronic file. Medical information must be secured once a year and updated as needed in each Vulnerable Adult's file.

227 ACCOMMODATING SPECIAL NEEDS

During the course of an investigation, information is gathered from the reporter and from the client to determine if the client has a communication limitation (limited English proficiency, speech or hearing impairment). The Case Manager must assess the client's language needs and provide an interpreter, translated materials, or other appropriate language accommodations for the client. For detailed instructions, please refer to the Civil Rights ToolKit found on the DSS SharePoint Unite page under manuals for guidance and directions on accommodating special needs. This policy was revised on 11/21/2016 to provide instructions on how to effectively communicate with all clients and to ensure that both staff and clients have information about and access to the resources that they need. Instructions on how to service persons with limited **English Proficiency** or **Sensory Impairment** is addressed in this policy.

228 NOTIFICATION TO LAW ENFORCEMENT

When an accepted Intake Report reaches the county APS office, the county staff must determine if Law Enforcement notification is necessary because of a reasonable suspicion of criminal activity. Criminal activity involves the intentional abuse, neglect, or exploitation of a Vulnerable Adult by another person or the potential thereof. Immediate involvement of Law Enforcement is always important if evidence needs to be preserved. Reports involving financial exploitation, sexual battery, and physical abuse with visible injuries are appropriate for immediate notification. The APS Supervisor will review the Intake Report to make the determination regarding notification to Law Enforcement. If he/she decides that Law Enforcement should be notified before the Case Manager begins the assessment, the APS Supervisor will complete **Notification to Law Enforcement** (DSS Form 1506). However, the APS Supervisor may also determine that law Enforcement has already been appropriately notified by the Intake Practitioner. In this case, the APS Supervisor will ensure that the Law Enforcement case is properly monitored by the APS Case Manager. The APS Case Manager will immediately notify Law Enforcement if at any time during the Investigation he/she suspects that the allegation of abuse, neglect or exploitation may involve a criminal element. Should the Case Manager call Law Enforcement to the location of the client and the client is taken into Emergency Protective Custody (EPC), Law Enforcement will complete **Emergency Protective Custody of a Vulnerable Adult** (DSS Form 15109) and the Law Enforcement Incident Report. The Case Manager will note Law Enforcement's involvement in CAPSS and the completed forms will be filed in the hard file and uploaded into the electronic file.

229 ASSESSING RISK AND SAFETY

During the investigation, the APS Investigator must assess the vulnerability of the client and the risk and safety factors in the situation. The purpose of assessing the risk is to identify the client's vulnerability, medical condition, culture, resources, verbal ability, stability and ability for accepting or refusing services. All areas that pose a risk or identifies a need of the client must be documented during the assessment and properly entered into the Risk Assessment Tool.

During the investigative process, the Case Manager will gather information and records from the client's physician, the Department of Disabilities and Special Needs (DDSN), the Department of Mental Health (DMH), family members, etc. These areas may include but are not limited to the Client's Vulnerability, Health Functions, Adult's Financial Functioning and Household Management, Living Arrangements, Social Skills, Legal Protection, and post Institutional Care needs:

The Client's Vulnerability: (a) What is the age of the client? (b) What is his/her diagnosis? (c) When was the diagnosis made? (d) How does the diagnosis affect his/her ability to provide for self-care?

Health Functions: (a) What is the physical and mental condition of the client? Example: we need to consider the client's physical and mental state to determine that he/she is a Vulnerable Adult even if he/she can perform some Activities of Daily Living (ADLs). (b) What are your observations about his/her actual abilities and inabilities? (c) How does it affect their appearance, behavior and ability to care for self? (d) Is the client's judgment impaired (unsafe or irrational decisions, unable to accept advice)? (e) What are the recommendations of the client's medical and mental health providers?

Adult's Financial Functioning and Household Management: (a) What is the client's financial circumstances? (b) Does the client have income? (c) Does the client have prior employment history? (d) Who manages the client's income? (e) How does he/she pay their bills, i.e. rent, mortgage, insurance, food, utilities, medical bills, electricity? (f) What has been the consistent pattern with paying their living expenses and managing their money?

Living Arrangements: (a) Who shares the home with the client and what is their role in the household? (b) What are the responsibilities of the other persons who live in the home? (all individuals in the household ten (10) years and older must be interviewed) (c) Does the client need to live at home, in a nursing home or a residential care facility? An evaluation for "level of care" may be needed by Community Long Term Care (CLTC) to answer this question. (d) Who assists the client regularly (children, parents, relatives, neighbors, friends, CLTC, home health, etc.)? (e) Who can be contacted in an emergency? (f) Who is willing to be a regular support to the client? Who cooks, cleans, pay bills and does the laundry?

Social Skills: (a) How does the client function socially and culturally? (b) What is the social support system? (c) What are the client's interpersonal relationships with members of their immediate family and others? (d) How does his/her lack of social skills impact quality of life?

Legal Protection: (a) If the client cannot manage his/her own resources, who will manage the client's personal affairs to prohibit abuse, neglect and exploitation? Will they need a conservator and/or a guardian appointed through Probate Court?

Institutional Care: (a) If the client is being discharged from an institution (medical or mental health), what level of care is recommended from their physician? (b) How does the discharge affect the service plan? (c) What resources and services will have to be implemented to meet the client's needs? (d) Who will assist the client during and after the transition?

230 ASSESSING PHYSICAL INDICATORS OF ABUSE, NELECT BY A CAREGIVER, SELF-NEGLECT AND EXPLOITATION

Indicators are signs or clues that abuse or neglect has occurred. Physical Indicators include visible signs on the body such as bruises etc. Behavioral Indicators demonstrate ways in which the alleged victim behaves and how he/she interacts with the suspected abuser. The APS Investigator must be familiar with physical and behavioral indicators of Physical Abuse, Psychological Abuse, Sexual Abuse, Neglect by a Caregiver, Self-Neglect and Exploitation. The following is a list of some physical and behavioral Indicators but is not entirely inclusive of all Indicators:

Indicators of Physical Abuse
Timeframe for initial client contact—within 24 hours

Cuts, lacerations, puncture wounds;
Bruises, welts, discoloration;
Any injury incompatible with history;
Loss of weight;
Soiled clothing or bedding;

Dehydration and/or malnourished without illness-related cause;
An injury which has not been properly cared for;
Medical examination should be done;
Unexplained withdrawal from normal activities;
A sudden change in alertness;
Use of power control;
Frequent arguments between caregiver and adult.

Indicators of Sexual Abuse
Timeframe for initial client contact---within 24 hours

Bruises around the breasts or genital area may result from sexual abuse;
Genital or anal pain, irritation, or bleeding;
Bruises on external genitalia or inner thighs;
Difficulty walking or sitting;
Torn, stained, or bloody underclothing;
Sexually transmitted diseases;
Inappropriate sex-role relationship between victim and suspect;
Inappropriate, unusual, or aggressive sexual behavior.

Indicators of Psychological Abuse
Timeframe for initial client contact---within 24 hours

Deliberate threats;
Harassment or other forms of intimidating behavior causing fear, confusion or emotional stress;
Threats and unusual depression may be indicators of emotional abuse;
Vulnerable Adult may not be given the opportunity to speak or see others without the caregiver (suspected abuser);
Attitudes of indifference or anger toward the dependent person;
Family or caregiver blames the Vulnerable Adult;
Unexplained withdrawal from normal activities;
Previous history of abuse to others;
A sudden change in alertness;
Use of power control;
Inappropriate display of affection by the caregiver;
Conflicting accounts of incidents by family members;
Unwillingness to comply with service providers.

Indicators of Neglect by a Caregiver
Timeframe for initial client contact---within 48 hours

Unusual weight loss, malnutrition, dehydration;
Untreated physical problems, such as bed sores;
Unsanitary living conditions: dirt, bugs, soiled bedding and clothes;
Being left dirty or unbathed;
Unsuitable clothing or covering for the weather;

Unsafe living conditions (faulty electrical wiring, other fire hazards)
Abandonment of a Vulnerable Adult.

Indicators of Self-Neglect

Timeframe for initial client for Self-neglect---within 72 hours

Inability to manage personal finances;
Inability to manage activities of daily living;
Inadequate clothing, fecal/urine smell;
Change in intellectual functioning e.g. confusion, disorientation to time and place;
Inability to toilet independently;
Bedsores, bedridden, unattended medical needs, poor hygiene, and unusual weight loss may indicate possible neglect;
Hoarding;
Failure to take essential medications;
Not keeping medical appointments for serious illnesses;
Leaving a burning stove unattended;
Poor hygiene;
Confusion;
Inability to attend to housekeeping;
Dehydration;
Stage one, two, three or four decubitus (assessed by healthcare provider).

Indicators of Exploitation

Timeframe for initial client contact---within 48 hours

Unusual or inappropriate activity in bank accounts;
Unusual concern by caregiver;
Numerous unpaid bills;
Deliberate isolation by a caregiver;
Power of attorney given when the person is capable of making own decisions;
Missing personal belongings;
Sudden changes in financial situations may be the result of exploitation.

231 COMPLETING THE INITIAL RISK ASSESSMENT

The Initial Risk Assessment is due within forty-five (45) days from the date the Intake Report is accepted for investigation. The Initial Risk Assessment must be completed in the Assessment Service Line in CAPSS. The Risk Assessment is to address each allegation listed in the APS Intake Report. The Risk Assessment should include specific statements made by the client, caregiver, collaterals, or anyone having knowledge of the alleged problem. Observations should reflect behavioral, environmental, and physical indicators with supporting documentation. The Initial Risk Assessment is to address the allegations as they were **at the time of the APS report, NOT the situation at the end of the assessment timeframe.**

It is the APS Supervisor's responsibility to review the Risk Assessment and to annotate in CAPSS that the review of the tool was completed.

The APS Investigator must complete the entire Risk Assessment examining three tabs in CAPSS: **Client Factors, Caregiver/Perpetrator and Interpretation.** The completion of the Risk Assessment ensures that a thorough investigation has been completed. Although not limited to just this list, the Investigator must obtain and examine the answers to the following questions:

A. Client Factors

1. Physical and Functional Abilities

 Physical Health
What are the client's physical complaints? Does the client have a diagnosed medical condition? Is it chronic or progressive? Is the client receiving treatment/therapy for the condition? Did the client have surgery recently?
 Mobility
Is the client able to ambulate? What assistance is needed? Does the client require a walker or wheelchair? Is the client bed-confined? Can the client transfer from wheelchair to bed or chair with or without assistance? Does he/she lie in urine or feces?
 Clothing
Are the client's clothes clean or dirty? Are they soiled with urine/feces? Does the client select appropriate garments? Are the clothes torn or inadequate?
 Personal Care
What is the client's personal appearance? Is it unkempt? Is there a presence of urine or feces? Is the hair clean or matted? Are the client's fingernails or toenails overgrown? Does the client appear to have bathed (body/hair)? Does the client need assistance bathing? Does the client have unhealed sores or untreated injuries? Is the client obese or undernourished? Does the client have decubitus ulcers?
 Communication
Is the client able to communicate? Can the client make clear statements, understand verbal communication, read, and/or use the phone? Can the client write?
 Hearing
Is the client hard of hearing? Does the client have and use a hearing aid? Does it help?
 Vision
Does the client have vision problems? Is the client receiving treatment for a vision problem? Does the client have and wear glasses? Do they help?
Instrumental Activities of Daily Living
Can the client self-medicate, use the telephone, prepare his/her own meals, shop/run errands, manage finances, and arrange transportation? If not, who assists and to what extent?
 Activities of Daily Living
Can the client bathe, dress, toilet, feed self? If not, who assists and to what extent?

2. Mental/Emotional Health

 Is there documented proof that client is a person with intellectual disabilities? If so, what is the client's level of functioning? Does the client attend and participate in Disabilities and Special Needs programs?

 Has the client been diagnosed with a mental illness? If so, what was the diagnosis? Does the client receive treatment or take medication for the mental illness? Does the client have a private psychiatrist or attend a Mental Health clinic? Has the client ever been hospitalized for their mental illness?
 Does the client exhibit destructive behaviors? Does the client display intentional physical self-abuse, threaten violence toward others, threaten suicide, etc.? Is the client verbally abusive? Does he/she use foul language? Is the client physically assaultive? Does he/she strike out?
 Does the client show signs of confusion (bewildered, forgetful, disoriented)? Does the client hallucinate (perceives what is not present)? Does the client show signs of depression (persistent feelings of hopelessness, withdrawn, loss of appetite)? Is the client easily agitated (hyperactive, anxious, fluctuates emotionally)?
 Does the client have disrupted sleep patterns? Does he/she stay awake at night and/or sleep during the day?
 Has the client had any recent, significant losses or changes in "life situations": death of family or friend; serious illness of self, family, or friend; marriage, divorce, separation; victim of a crime; change of financial status; retirement of self or spouse?
 Is the client's judgment impaired (unsafe self-direction, unable to accept advice)? Is the client oriented to self, place, and time? Does the client show memory loss? If so, is it short-term (recent events) or long-term (long past events)?
 Is the client alert and responsive? Comatose? Passive? Afraid? Resistive to help?

3. Income and Financial Resources

 What are the client's income sources, dollar amount of income, and payment due dates? Is the client aware of the amount of income and when it is received?
 What is the amount of monthly bills and expenses? Is budget management a problem?
 Is the client getting adequate food, clothing, medicines, etc.?
 Are there benefits the client may be eligible for but is not currently receiving?
 What debts exist? If income does not meet expenses, why not?
 Does client have credit cards? Does he/she use them? Does anyone else have access to them?
 Does client hoard money? What is the client's spending style (frugal, impulsive, reckless)?
 Does the client receive his/her own income? If not, why not, and who does receive the checks? To what address does the income go? Is the income directly deposited into a bank account? Whose name is on the account? Does the client sign his/her own checks? If not, who does? Does the client have a representative payee?
 If money is managed by someone else, is it spent on the client?
 What kind of bank accounts does the client have? Whose name is on the accounts? Have there been any changes in the accounts? Large or frequent withdrawals? Signatures that appear to be forged?
 Does the client have any other assets? CD's, stocks, bonds, property? Who has control of them?
 Has the client given anyone their Power of Attorney (POA)? If so, who? Is there a copy of the POA filed with the Clerk of Courts? Does anyone have a copy of the POA? Was the client capable of understanding a POA at the time it was given?
 Has the client recently signed any papers? Does the client have any insurance policies (life, health, auto, etc.)? Who is the insured, who is the beneficiary, and who pays the premium?

 Does the client have Conservator or Guardian appointed by the Probate Court? If so, who is it and when were they appointed?
 Does the client own a home, jewelry, safety deposit boxes? Does anyone else have access to them? Is anyone using the client's residence or utilities without permission?
 Has there been a change in the mortgage status? Has the client recently transferred property to someone else? If so, is this a problem? What were the circumstances?
 Has the client signed any papers recently?
 Has the client been accompanied to the bank by a family member or stranger and seemed to be coerced into making a withdrawal? Did the client appear nervous or afraid of the person accompanying him/her?

4. Food and Nutrition

 Is there food in the house?
 Who prepares the food?
 How many times per day does the client eat?
 Is the client on a special diet for a medical condition? Diabetic? Low salt? Does the client follow this diet?
 What kind of diet does the client have? Is it an improper diet?
 Is the food stored properly? Is the stored food rotted or bug-infested?
 Who does the grocery shopping?
 Does the client receive a Home Delivered meal? From whom? How often?
 Does the client refuse or forget to eat?
 Does the client complain about the taste of food? Does the client eat all of the meal? Does he/she display signs of malnutrition or wasting away?
 Is the client receiving sufficient liquids? Is the client dehydrated?
 Does the client have a feeding tube? Is the client receiving the proper amount of nourishment via the feeding tube? Is the feeding tube properly cared for?

5. Compliance with Medical Treatment Regime

 What are the client's medications? (Can be listed under **Other Relevant Information** in the risk analysis SECTION.)
 Does the client understand illness and the need for medical treatment? Does the client understand the purpose of each prescription? Can the client follow the instructions on the prescription bottle?
 Does the client possess all the medications he/she was prescribed? Is the client taking the medications as prescribed?
 What difficulties does the client experience in taking the medications? Does anyone assist the client with securing or taking medications?
 Is there excessive medication or under-medication?
 What side effects does the client have?
 Is the client able to go to the doctor? Can the client make his/her own appointments? Does someone else take the client to the doctor?
 Who is the client's doctor? When was the last doctor's visit? Does the client like the doctor? Does he/she follow the doctor's orders?

 Does the client have Home Health Care (RN, PCA, Therapist)? How often do the medical persons see the client and for what reason? Does the client have CLTC services?
 Does the client follow the medical regime of ancillary medical providers (Home Health, Therapists)?
 Are there any unmet medical needs (decayed teeth, dentures, glasses, hearing aids, overgrown fingernails)?
 Are medications stored properly? Does disorganization of medical supplies suggest need for attention to compliance?
 Does the client require, have, or use any special medical equipment?

6. Client Viewpoint

 Does the client refuse to let the worker in the house or yard?
 What is the client's perception of the APS report?
 Does the client accept/refuse services?
 Does the client seem evasive?
 Is the client trusting of others? Is there anyone the client trusts?
 Is the client hostile? Motivated? Does the client procrastinate? Does the client want nothing to do with "welfare"?
 Is the client aware of his/her situation?
 Can the client seek and/or apply for resources to solve his/her own problems?
 Is the client involved in pastimes, personal activities, church, family activities, etc.?
 What is client doing or not doing, saying, etc.?
 Does the client's level of reasoning or social history have an impact on the thought process?

7. Substance Misuse and Abuse

 Describe specific or documented use of alcohol or illegal substances and give examples.
 Does the client deny the use of alcohol and/or illegal substances? How often does the client use alcohol and illegal substances? How much?
 Does the client have a past history of alcohol or drug abuse?
 Is there a presence of alcohol containers? Where? (In the refrigerator, in plain view, in the cabinet, in the trash, scattered about the yard)
 Are illegal substances or paraphernalia present in plain view?
 Does the client exhibit signs of alcohol or illegal drug use (dilated pupils, unsteady gait, strong odor of alcohol, glazed eyes, red eyes, and/or slurred speech)?
 Are there prescription medications bottles scattered about? Are there unidentified pills not in bottles?
 Does the client need prescriptions for sleeping or pain? Why?
 Does the client frequent different doctors or the emergency room for medication? Does the client run out of medication frequently?
 Does the client take over-the-counter medication? What and how often?
 Does the client mix prescription or over-the-counter medications with alcohol?
 Assess the client's ability to explain medications and how to take them.
 Does the client's improper or unsafe storage of medications suggest non-compliance?

 Have other referral agencies documented a potential substance abuse problem? Have family members, friends, or neighbors reported substance abuse?

8. Reaction of Client to Caregiver

 Is the client willing to discuss the problems with the case manager?
 Is the client willing to discuss problems or injuries with the caregiver or in the caregiver's presence?
 Is the client fearful of caregiver or situation? Does he/she defer questions to the caregiver? Does the client act anxious to please the caregiver? Does he/she look to the caregiver for approval?
 Consider whether the client attempts to defend the perpetrator.
 Does the client deny any wrongdoing by the caregiver?
 Does client's account differ from that of the caregiver? Is the client vague about events?
 Does the client display unexplained paranoia? Does he/she seem cautious of physical contact?
 Does the client exhibit the following: cowering behavior, tearfulness, agitation, thumb-sucking, regressive behavior, restlessness, or pacing?
 Has law enforcement been to the home on a Domestic Violence call? When, how often, and what were the findings?

9. History of Family Relationships

 Does the family show interest or no interest in the client's problems or well-being? If so, which family members?
 Does the family have a history of problem-solving and working together through conflict and adversity?
 Did the client abuse or neglect the caregiver when the caregiver was a child?
 Does the caregiver perceive he/she was neglected or abused as a child?
 Is there a history of role-related guilt or anger?
 Does the client have a criminal history? For what?
 Does the client have a history of multiple marriages? Divorce?
 Is there a history of agency involvement with the client or caregiver? APS? CPS? Other (what)?
 Consider the dynamics of a dysfunctional family.
 Consider learned behavior, parenting, discipline, and caregiving skills.

B. Environmental Factors

1. Structure of the Home

 What kind of dwelling does the client live in? House, apartment (duplex, high rise building, single unit)?
 Is the apartment located in a complex? For the elderly, low income, multiple family?
 Where in the residence does the client live? What floor?
 What is the size of the residence? Number of rooms, bedrooms, bathrooms? Does the client share a bedroom? Where does the client sleep? Does the client have privacy? Does the client have access to all areas of the house?
 Does the client live in his/her own home or the home of someone else? How many people live in the home? Is it overcrowded?

 Consider the structure. How old is the building? What is the building constructed of (brick, wood, other materials)? Is the roof leaking? Are there cracks in the walls or floors?
 Consider security. Are there doors? Windows? Are locks broken on the screens, doors, or windows? Do the windows and doors contain broken panes or torn screens?
 What are the fire and safety hazards? Are any wires exposed? Are paper, cardboard, and other flammable materials used in unsafe areas? Are there smoke detectors?
 Is there heating and cooling? What is the source of heat? Consider the placement of the chimney or space heaters. Who checks the vents? For example, gas, kerosene, and electric. Is the source of heat safe for the client? Is there a fireplace? Who takes out the ashes, brings in the wood? Who fills and lights the heater?
 Consider the yard. Is there high grass, a rotted porch, or uneven steps? Is the yard littered or junky? Does the trash attract flies or vermin? Is it a health hazard?
 If the client is handicapped, is the home accessible and properly equipped? Does it accommodate a wheelchair? Can a bed- or wheelchair-confined person get out of the house?
 Is there enough space for the disabled client? Can they access it? For example, cluttered room, non-ambulatory client on the second floor.
 Is the home sanitary? Does the home appear clean and well-cared for?
 Where is the home located in relation to shopping, transportation, medical services, and opportunities for socialization?

2. Sanitation

 Is the home well maintained, clean, neat, and orderly?
 Are there animals in the house that result in a health hazard? Are the animals allowed to defecate or urinate in the house? Is there an excessive number or animals in the house? Are there fleas?
 Is there evidence of human waste?
 Is there an odor (urine, stool, garbage) in the house?
 Are there piles of garbage, trash, clutter, or papers?
 Is the client's room clean? What about in relation to the rest of the home?
 Is food kept in a safe and sanitary manor? What is the condition of the cabinets, refrigerator, and countertops?
 Are dirty dishes stacked in the sink, on counters, or kitchen table?
 Does the home have plumbing (bathroom, kitchen)? Indoor or outdoor? Is the plumbing in working order? Are the sinks suitable or unsuitable?
 Is there access to running water? Is the water contaminated?
 Is there an infestation of any kind? To what extent?
 Does the client realize they are living in an unsanitary or unsafe environment?
 What does the client think of his/her environment? Do they want changes? Will they accept changes?

3. Utilities

 Consider heating and cooling. Is the client warm in the winter? Is the client cool in the summer?
 What kind of heating system does the client utilize? Is it safe for the client? Can he/she manage it alone? Who assists, how do they assist, and how often do they assist?

 Does the client have any medical condition that would necessitate special attention to the heating/cooling system?
 Does the home have running water, electricity, ventilation, indoor working toilets/sinks/bathtub/shower? If not, how does the client overcome these deficiencies?
 Do the utilities work? Are the bills paid? Are the bills overdue? Is there a history of cutoffs? Who is paying the bills?
 Do the stove and refrigerator work?
 Does the client have a telephone? Does it work? Does the client have condition/situation that necessitates the need for phone service? Does the client know how to use the phone to summon help?
 Does anyone else illegally use power from the client?
 Does the client have a medical treatment that requires electricity (example: oxygen machine)?

4. Support System

 Who provides support? What are their names and relationship with client (family, friends, agencies, church, paid caregivers)?
 How often is assistance given? Who does what? (CLTC, family, Home Health, neighbors, etc.) When? How often? How dependable is this assistance?
 Is the family in the same geographical area as the client? If not, how far away do they live and do they visit? How often? Are they interested in the client's well-being and are they willing to help? Are they aware of the client's problem or situation?
 Are there inappropriate caregivers (e.g., too young, incapacitated by substance abuse, mental/physical illness, or handicap)?
 How often is the client in contact with his/her support systems? Who visits? How often?
 Does the client receive socialization/stimulation? Is the client isolated?
 If the client is an incapacitated elder, is he/she left unattended for long periods of time?
 Is there a lack of regular and timely assistance with personal care (bathing, toileting, dressing, eating, ambulation)?
 Does the client live near community resources?

C. Caregiver Factors

1. Mental and Emotional Health of the Caregiver

 Is there documented proof of a diagnosed mental illness or that caregiver is a person with intellectual disabilities?
 What is the caregiver's level of functioning and does he/she understand the duties to be performed?
 Does the caregiver receive treatment or take medication for the mental illness?
 Does the caregiver exhibit violent behavior?
 Does the caregiver exhibit inappropriate reaction to stress (threaten the client, threatens suicide, etc.)?
 Does the caregiver show signs of confusion, depression, poor reasoning, or impaired judgment?
 How does the caregiver cope with the client, the client's illness or impairment, and/or the client's situation?

 Does the caregiver have unreasonable expectations of the client?
 Does the caregiver understand the client's illness or impairment?
 What is the relationship of the caregiver to the client?

2. Physical Health of the Caregiver

 Does the caregiver have a physical/functional impairment? If so, explain.
 Does the caregiver have a chronic illness? If so, explain. Is it controlled? How? Is it ever uncontrolled? When and how?
 Can the caregiver meet his/her own needs? If not, explain.
 Can the caregiver perform Instrumental Activities of Daily Living? (Can he/she self-medicate, use the telephone, prepare meals, shop/run errands, manage finances, and arrange or provide transportation?) If not, why, and who assists?
 Can the caregiver meet the physical needs of the client? If not, explain.
 Are the caregiver's health problems under control and are they being treated? Explain.
 Does the caregiver have a hearing or vision impairment? Is it corrected and is the correction successful?
 Does the caregiver maintain good hygiene? Are his/her body, nails, and hair clean?
 How is the caregiver's appearance? Does he/she show attention to dress? Does he/she dress appropriately for the weather?
 Can the caregiver **read and write?**

3. Substance Abuse

 Does the caregiver have a documented drug/alcohol problem?
 Does the caregiver receive treatment for a drug/alcohol problem?
 Does the caregiver have a criminal history (arrests or convictions) of drug and alcohol use?
 Describe specific or documented use of alcohol or illegal substances (include reports from other professionals, family members, neighbors, friends, etc.).
 Is there the presence of alcohol containers? Where? (In the refrigerator, in plain view, in the yard, in the trash, etc.)
 Is there a presence of illegal substances or paraphernalia in plain view?
 Does the caregiver abuse prescription medications?
 Does the caregiver mix prescription or over-the-counter medications with alcohol or other drugs?
 Does the caregiver take the client's or another person's prescription medications?
 Is the caregiver reported to abuse alcohol/drugs chronically or occasionally?
 Does the caregiver **admit** that he/she has a drug/alcohol problem?
 Is there a family history of drug/alcohol abuse?

4. Financial Resources of Caregiver

 Is the caregiver employed? Where? Full- or part-time? Number of hours per day? What hours (day, evening, night)?
 What is the caregiver's income? Source?
 What bills does the caregiver pay?
 How does the caregiver pay the client's bills or use the client's income?

 Does the caregiver have the client's Power of Attorney? Since when?
 Is the caregiver the Conservator for the client? Since when?
 Is the caregiver the client's rep payee? For what? Since when?
 Is the caregiver dependent on the client for income, a place to live, or other necessities of life?
 Does the caregiver share any accounts with the client? What accounts?
 Has the caregiver transferred any property or other assets from the client?
 Is the caregiver aware of the client's will and is the caregiver a beneficiary in the will?
 Does the caregiver seem over-interested in the client's finances/financial situation?

5. Caregiver Tasks

 Specifically, what task(s) does the caregiver perform?
o Personal care?
o Shopping?
o Transportation?
o Supervision?
o Meal preparation?
o Financial management?
 How often does the caregiver perform the task(s)? Does the caregiver have any assistance performing the task(s)? What kind (family, friends, agency)? How frequent is the assistance?
 Does the caregiver perform the task(s) sufficiently to meet the client's needs?
 Does the caregiver have experience in performing the task(s)? Has the caregiver had formal training to perform the task(s)?
 Does the caregiver have the knowledge he/she needs to perform the task(s)?
 Does the caregiver perform the task(s) willingly or does he/she complain/blame the client?

6. Reaction of Caregiver to Client

 Does the caregiver threaten (with violence, placement, or loss of privileges); humiliate (make the client feel foolish, hurt his/her pride or dignity); intimidate (make afraid); or harass (torment, trouble, worry with repeated questions, etc.) the client?
 Does the caregiver blame the client for the present situation? Does the caregiver blame the client for his/her own problems?
 Is the caregiver impatient with the client? Does the caregiver verbally snap at the client or act unduly rough when physically assisting the client?
 Does the caregiver ignore the client's requests for help or attention? Does the caregiver socially isolate the client? Leaves them in a room alone, won't allow visitors, won't allow them to leave the house or participate in activities outside the home? Denies them access to newspapers, TV, etc.? Denies affection? Never a kind word or physical touch?
 Does the caregiver constantly scold the client for behavior the client cannot help? Spilling things, toileting accidents, etc.?
 Does the caregiver deny that the client has a problem? Does he/she say the client is "just being mean" or that the client acts in a certain way to irritate the caregiver?
 Does the caregiver treat the client like a child?

D. Environmental Factors

7. Caregiver Support System

 Does the caregiver have support from family, neighbors, friends, other agencies, church? How often? Paid or volunteer?
 Is the caregiver accepting of help from others? If so, who? If not, why?
 Has the caregiver asked for help from others (family, friends, agencies, church) and been turned down? Why?
 Does the caregiver have family in the area that can help? Who, and to what degree?
 Is the caregiver aware of programs, services, and resources that may be available to help with the client or situation?
 Is the caregiver able to seek and apply for programs, services, and resources?
 Are the caregiver's expectations of assistance realistic?
 Is the caregiver accepting of DSS involvement?

8. History of Family Relationships

 Is there a history of family violence? (This may or may not be documented with law enforcement through domestic violence complaints).
 Does the caregiver have a history of marital conflict (multiple separations from spouse or multiple divorces)?
 Does the caregiver have a history of broken relationships (same- or opposite-sex)?
 Do other family members get along with the caregiver? Do they have positive or negative things to say about the caregiver?
 Is the caregiver resentful of family members (financial situation, social situation, careers, etc.)?
 Does the caregiver feel abused, exploited, and/or unappreciated by other family members?
 Does the caregiver have a martyr complex? Does the caregiver feel he/she is sacrificing his/her life for the welfare of the client?

9. Ability of Caregiver to Protect Client from Perpetrator
(Complete only if caregiver is not perpetrator)

 Does the caregiver recognize abuse/neglect/exploitation?
 Is the caregiver unaware of abuse/neglect/exploitation?
 Does he/she take action to stop the situation, or is he/she unmotivated to stop or change the situation?
 Does the caregiver deny abuse/neglect/exploitation? Does he/she refuse to cooperate with actions to protect the client?
 Is the caregiver mentally/physically able to protect the client from harm or exploitation?

10. Caregiver Cooperation with DSS

 Discuss the level of cooperation between DSS and the caregiver. Note if the caregiver acknowledges that a problem exists and is willing for services to be provided to the client.
 Does the caregiver want to participate in the Case Management Plan? To what extent?
 Is the caregiver motivated to follow through with the recommended services and plan?
 Does the caregiver attempt to block access to the client or the home? Will it be necessary to seek legal remedies to gain access to the client or the home?

 Does the caregiver understand that a problem exists? How does this affect the caregiver's cooperation?
 Does the caregiver understand the role of DSS and the reasons for intervention?

11. Overcrowding

 How many people live in the home? Are they related?
 How many rooms (total) and how many bedrooms? Is the space adequate for the number of people living in the house?
 How many people sleep in each bedroom? Do they share beds?
 Does the client have his/her own bedroom? Bed? Does the client sleep alone?
 If the client does not have a bed, where does the client sleep?
 Does the client have any privacy (for sleeping, bathing, changing clothes)?
 Is the environment such that it is conducive to a calm atmosphere? Is the TV loud and turned on all the time? Is there loud music constantly? Are there children/adults in and out of home making noise?

E. Special Perpetrator Factors

12. Perpetrator who is not the Caregiver

 Does the perpetrator live in the home with the client? If not, where does the perpetrator live?
 How does the perpetrator have access to the client? Describe the times the perpetrator would be in contact with the client.
 Is the perpetrator related to the client? How? If not, what is the relationship?
 Does the perpetrator have a history (documented or undocumented) or alcohol or drug use/abuse? To what extent?
 Does the perpetrator have a history (documented or undocumented) of physical or sexual abuse?
 Is the perpetrator mentally ill? Does the perpetrator receive treatment? Is the perpetrator compliant with treatment plan?
 Is the perpetrator a person with intellectual disabilities? To what extent? Does the perpetrator receive services to address this?
 Does the perpetrator show signs of cognitive impairment? If so, describe.
 Does the perpetrator work or is he/she unemployed? Is the perpetrator financially dependent on the client? To what extent?
 Is the perpetrator aggressive? Does the perpetrator deny or acknowledge his/her wrongdoing? Does the perpetrator try to prevent access to the client?
 Is the perpetrator willing and able to change his/her behavior? Is he/she cooperative with DSS?

F. Active Circumstances (complete only if the perpetrator is not the caregiver)

1. Physical Abuse, Sexual Battery

 What are the active circumstances (physical abuse, sexual abuse, lack of supervision)?
 Does the client require medical attention for his/her injuries? What kind of attention (emergency room, personal physician, surgery, etc.)?
 Does the client have a sexually transmitted disease? What type?

 Is the client pregnant?
 If the client has been sexually assaulted, is there trauma to the cervix, vulva, penis, perineum, or anus?
 How much supervision does the client require? Is the client bed-confined and being left alone? Is the client wandering? When? How often?
 Is the client being left locked in a room or house?
 Is the client being left restrained to a bed or chair?
 Does the caregiver use corporal punishment with the client? Describe.
 Does the caregiver/client give a logical explanation for the injuries?

After completing the Caregiver/Perpetrator Tab, continue to the Interpretation Tab.

1. Select an overall rating of the client's risk (high, medium, or no/low).
2. Check the factors that most influenced your rating.
3. Enter the strengths of the household that may decrease risk.
4. Enter any other relevant information
5. Enter the date the client's rights and responsibilities were explained.
6. Click OK.
7. The Risk Assessment will appear in the grid.
8. Commit the Risk Assessment in CAPSS.

232 ASSIGNING THE RATING TO THE RISK ASSESSMENT

The Risk Assessment is a decision making tool that guides the APS Investigator to assign a rating of High, Medium, or Low to the case. If the Investigator assigns a rating of High indicating that there is evidence that the allegations are true, the case should be substantiated and the alleged victim should be under protective custody and a Safety Plan must be completed at the bottom of the Risk Assessment ensuring the safety of the Vulnerable Adult. If services need to be provided to the Vulnerable Adult and there is evidence that the allegations are true, the Investigator should assign a rating of Medium and the case should be substantiated moving the case to Treatment Services. The APS Supervisor must close the Assessment Service Line and open the Treatment Service Line on the same day to avoid an over-lap of program services. If the rating is Low, the case may be unsubstantiated and closed after all referrals to other services have been completed.

233 THE SAFETY PLAN (COMPLETED WITHIN 2-24 HOURS TO FOCUS ON SAFETY)

A safety threat is serious harm that is currently occurring. Safety must be assessed at the initial and subsequent visits. If there is a safety threat, APS must respond within 2-24 hours and the APS Investigator and Supervisor must make a determination of the appropriate response time to the safety threat. Safety Planning is designed to address the current danger present that affects the well-being of the adult including the presence of current serious harm or the likelihood of serious harm. Assessing safety assists the Investigator in identifying what safety threats need to be controlled.

A Safety Plan is a specific and concrete strategy for controlling threats of imminent harm to a Vulnerable Adult and/or supplementing protective capacities of the caregiver, if appropriate. The Safety Plan is implemented immediately when the caregiver's protective capacities are not

sufficient to manage immediate safety threats during the investigation. A Safety Plan is an immediate solution to ensure the Vulnerable Adult's safety and must be put into place within 2-24 hours of identifying the need. The Safety Plan is created in an effort to provide an immediate response to eliminate unsafe conditions and allow the alleged victim when possible, to remain in his/her home during the investigation. However, a Safety Plan does not transfer legal custody of the Vulnerable Adult.

During the initial assessment period, the Case Manager must take into consideration any reasonable requests from the Vulnerable Adult or family members which does not place the client's health or well-being at risk. If the Case Manager identifies indicators and family dynamics that will place the Vulnerable Adult at risk, the case must be staffed with the APS Supervisor and legal team to decide what legal action is appropriate for the case (i.e. EPC, Ex-Parte, court intervention through Family Court, etc.). The Case Manager and APS Supervisor must not base their decision solely on the fact that the Vulnerable Adult and/or family members have refused DSS intervention. Their decision must be based on the safety and well-being of the Vulnerable Adult.

A Safety Plan is not necessary for every investigation reported to Adult Protective Services alleging abuse, neglect, self-neglect or exploitation. A Safety Plan is used in situations where threats of safety are identified that require immediate attention.

- For example, the Vulnerable Adult is bedbound with what appears to be stage three decubitus ulcers on his back and thighs; the caregiver appears to be unconcerned about the client's medical condition or lacks knowledge of the level of care needed.

A safety issue may be identified at the initial contact or at any time during the investigation or life of the case. In order to adequately assess the safety to the Vulnerable Adult and the degree of intervention necessary for his/her protection, the APS Case Manager must consider the following:

- the health of the Vulnerable Adult;
- the degree of his/her vulnerability;
- the caregiver's protective capacity;
- if there is a real caregiver;
- Does law enforcement or EMS need to be called to assess the alleged victim;
- Is the Vulnerable Adult's behavior detrimental to his/her well-being?
- Does the Vulnerable Adult have relatives in the area who may agree to provide immediate assistance?

Documentation of all Safety Plans must be completed in CAPSS in the Risk Assessment tool, in the factor which identifies the safety issue, beneath the collateral information. All immediate actions must be documented along with the date and time. Actions taken by the Case Manager such as calling Law Enforcement resulting in the client being placed in Emergency Protective Custody, securing food, coordinating with EMS, relocating the Vulnerable Adult with his/her consent should be documented in CAPSS. The assistance of Law Enforcement must be secured immediately if an adult is in imminent danger in his/her present environment and he/she refuses the agency's assistance. It is the responsibility of the APS Case Manager to remain with the alleged victim until the client's safety has been secured. The APS Case Manager must continue to assess

the situation for other urgent actions needed like petitioning the court for protective services and Ex-parte Removal of the Vulnerable Adult.

234 CRITICAL STAFFINGS

APS Supervisors are required to complete Staffings (structured meetings) with their Case Managers to ensure that Case Managers are provided with direction and guidance on how to process the investigation. Staffings should be completed on an as needed basis throughout an investigation. However, the following Staffings are critical and mandatory throughout the duration of each individual case: After Initial Contact Staffing, Transfer Staffing, Transfer Staffing to Another County, Staffing with Legal Department, Interagency/Multi-Agency Inter-Disciplinary Staffing, and Case Decision Staffing.

235 AFTER INITIAL CONTACT STAFFING

After initial face to face contact has been made with each alleged victim, within five (5) business days, the Case Manager must staff with the APS Supervisor to inform the Supervisor of the status of the case and receive directions and guidance on how to process the investigation. The Staffing must be completed on a **Case Transfer and/or Case Staffing** (DSS Form 3062)**,** entered into CAPSS by the APS Supervisor and uploaded into the electronic case file. The Case Manager must complete the recommendations of the staffing and enter the accomplishment of each task into the narrative in CAPSS. The following is the accepted outline of a Critical Staffing:

Supervisory Staffing: (Enter whatever kind of staffing is completed).

Participants: (Enter the names of the persons who were present at the Staffing).

Allegations: (What the allegations are as listed on the Intake Summary Sheet).

Current Situation: (What the Investigator discovered in response to the allegations).

Recommendations: (The Supervisor must list the tasks for the Case Manager to complete).

236 TRANSFER STAFFING

When cases are transferred from Investigators to the Treatment Services Case Managers, the Supervisor will have to complete a **Case Transfer and/or Case Staffing** (DSS Form 3062) to inform the new Case Manager of the circumstances surrounding the case. Tasks are outlined under Recommendations from Staffing informing the Case Manager(s) of the tasks that they are expected to complete and the time frame in which they are to be completed. Cases can also be transferred amongst workers as the APS Supervisor deems appropriate. All documentation including the Initial Contact narrative, collateral contact narratives, medical information, financial information and arrangements must be completed. The Risk Assessment and Case Decision must be entered into CAPSS and all recommendations from Staffings with the APS Supervisor must be completed before the case is transferred to the Treatment Services Case Manager.

237 TRANSFER STAFFING TO ANOTHER COUNTY

Before an investigation is transferred to another county, the primary county must have a Staffing with the receiving county APS Supervisor and complete a **Case Transfer and/or Case Staffing (**DSS Form 3062) to ensure the receiving county is aware of all of the circumstances surrounding the case and what the primary county has completed up until the Staffing date. All documentation must be entered into CAPSS and in the case file in the appropriate order.
When transferring a case to another county due to jurisdiction reasons, certain procedures must be followed. After Initial Contact has been made with the alleged victim and the county where the accepted Intake Report has been assigned determines and verifies that the client has returned to his/her permanent residence, the case may be transferred to the county where the alleged victim is permanently located. The Initial Contact must be made and entered in CAPSS. The APS Supervisor must staff the case with the Supervisor in the county where the case will be transferred. However, if the Vulnerable Adult remains in the county where he/she is located at the time of the accepted Intake Report, then the case will stay in that county. The roles of involved parties are as follows:

Responsibilities of the Case Manager where the case is initially assigned

1. Make Initial Face to Face contact with the alleged victim at his/her present location according to the time frames that are outlined in APS Policy. Respond rapidly.
2. Enter Initial Face to Face contact into CAPSS along with any other narratives.
3. Staff with APS Supervisor re: status of the Vulnerable Adult, current situation and desire to transfer case to another county.
4. Determine and verify that alleged victim is permanently located at another residence in county where case is to be transferred.
5. Ensure electronic and hard case files are updated and in order according to APS Policy.

Responsibilities of the APS Supervisor in assigned/primary county

6. Staff with Case Manager under immediate supervision.
7. Review electronic and hard case files.
8. Contact and staff with APS Supervisor in county where case is being transferred within five (5) business days of the date that the Intake Report was accepted.
9. Annotate Transfer Staffing in CAPSS and complete a **Case Transfer and/or Case Staffing (**DSS Form 3062)

Responsibilities of APS Supervisor where case is being transferred

10. Staff with APS Supervisor in county where case is being transferred from.
11. Reassign case in CAPSS and assign to new county and Case Manager.

Responsibilities of the new Case Manager

12. Make monthly face to face contact with client.

13. Complete recommendations of immediate APS Supervisor.
14. Continue to process APS Investigation according to APS Policy.

238 STAFFING WITH LEGAL DEPARTMENT

All cases that have court involvement must be staffed with the county legal department before the court hearing. All court summaries and court paperwork must be completed before the Case Manager and APS Supervisor schedules a staffing with the county legal team. Legal Staffing sheets should be marked clearly.

239 INTERAGENCY/MULTI -AGENCY INTER-DISCIPLINARY STAFFING

Information about clients, may be discussed during Staffings with other agencies when the purpose is to secure/coordinate services for the benefit of the clients. The case record may be present as needed for reference. Members of formal Interdisciplinary Teams sign confidentiality pledges when they become team members. All counties are required to conduct interagency Staffings with community partners to ensure maximum service delivery to the Vulnerable Adult.

240 CASE DECISION STAFFING

After the completion of the Risk Assessment and within forty-five (45) days of the on-set of the investigation, the Case Manager and APS Supervisor must complete a Case Decision Staffing to determine the outcome of the investigation. The Case Decision Staffing must be entered into CAPSS by the Supervisor stating the results of the investigation, if the allegations were substantiated or unsubstantiated. If there is evidence that the alleged victim is a Vulnerable Adult and that abuse, neglect and exploitation has occurred or has the potential to occur, the Investigation should be substantiated. If there is no evidence that the alleged victim is a Vulnerable Adult and no evidence of abuse, neglect or exploitation, the Investigation may be unsubstantiated. The Case Decision Staffing must include recommendations from the Supervisor to direct the Case Manager on how to proceed with the case after the Case Decision.

241 THE CASE DECISION

Case Decisions are made after the completion of the Risk Assessment and during a Case Decision Staffing. Case Decisions will be documented on or before forty-five (45) days following the date of the Intake Report. Cases that have unusual situations may take longer than forty-five (45) days. Should the decision take longer, fifteen (15) days may be extended to the Case Decision date by the County Director. The reason for the extension must be documented in the case narrative in CAPSS with documentation of a Staffing with the APS Supervisor and the County Director. The Case Decision must be entered under the Decision Tab by the APS Supervisor. If the case is Unsubstantiated it may be closed. However, if the client needs services from another agency or from another section of DSS, the referrals must be made before the case is closed. If the case is substantiated, the Assessment Service Line must be closed and a Treatment Service Line must be opened.

The above information will be entered into CAPSS in the Case Decision Tab. See Adult Protective Services Policy and Procedure Manual, Chapter 2, SECTION 200, Investigations Policy, 240, **CASE DECISION STAFFING** for further guidance.

1. The Case Decision is due forty-five (45) days from the date the intake/referral is received. Reminder: If an adult is taken into custody by EPC or Ex-Parte action and in order to provide investigative and case planning information to the Family Court at the forty (40) Day Merits Hearing, the Case Manager should complete the investigation as quickly as possible.

2. If the Case Decision cannot be made within forty-five (45) days, permission to extend the Decision Date must be made by the County Director in a Staffing with the APS Supervisor and Case Manager prior to the due date and thoroughly **explained** by the Case Manager in the narrative in CAPSS. Reasons to extend the case decision date includes but is not limited to the following: Delay in locating and interviewing important collaterals, alleged victim or alleged perpetrator; delay in receiving medical records to properly assess client; delay in receiving substantial reports such as financial documents that influence the case decision; and delay in receiving key evidence from law enforcement that is vital to the case decision.

3. When completing the Case Decision screen, be sure to address each allegation that was made in the Intake Report as well as any new issues you discovered during the Investigation.

    a. Example: A report is received with allegations of abuse and exploitation. No abuse was found, but exploitation is documented. Both allegations need to be addressed.

    b. Example: A report is received with allegations of exploitation. No exploitation is found but neglect is documented.

4. Be sure to complete all the screens under the Case Decision and answer **all** of the questions asked in the Case Decision process.

APS Case Manager Responsibilities

1. Case Manager receives an Intake Report and initiates an investigation.
2. Face to face contact is made with the alleged victim and client is assessed for safety and services.
3. Client is interviewed alone and collaterals are interviewed.
4. In cases that involve abuse/neglect by a Caregiver, Perpetrators are also interviewed by the APS Investigators.
5. Medical records and other documents are secured by the APS Investigator.
6. The Risk Assessment is completed within forty-five (45) days of the Intake report by the APS Investigator.
7. After Initial Contact Staffings is completed, the Decision Staffing is completed. Other Staffings are completed as they are relevant to the completion of the case.
8. Case Managers must ensure that all narratives are entered into CAPSS.
9. Case Managers must complete the Case Decision screen ensuring that all questions are answered on to prevent errors on Clean Up Report.

APS Supervisor Responsibilities

10. APS Supervisor must ensure that all Staffings are completed.
11. Supervisor must review completed Risk Assessment and annotate in CAPSS that review is completed.
12. Supervisor must enter Decision Staffing in CAPSS.
13. Supervisor must review completed hard and electronic case files and annotate review in CAPSS.
14. Supervisor must close case if case is unsubstantiated.
15. Supervisor must close Assessment line and open Treatment Services line if case is substantiated.
16. Supervisor must coordinate Transfer Staffing if necessary.

County Director Responsibilities

17. Participate in Staffing to grant extension of Case Decision when relevant. Makes decision to extend case decision date. Case Decision date may only be extended for fifteen (15) days.

242 EMERGENCY PROTECTIVE CUSTODY (EPC)

A Law Enforcement Officer may take a Vulnerable Adult in a life-threatening situation into Emergency Protective Custody if:

(1) there is probable cause to believe that by reason of abuse, neglect, or exploitation there exists an imminent danger to the vulnerable adult's life or physical safety;

(2) the vulnerable adult or caregiver does not consent to protective custody; and

(3) there is not time to apply for a court order.

When a law enforcement officer takes protective custody of a Vulnerable Adult, the officer must transport the Vulnerable Adult to a place of safety which must not be a facility for the detention of criminal offenders or of persons accused of crimes. The Adult Protective Services Program has custody of the Vulnerable Adult pending the family court hearing to determine if there is probable cause for protective custody.

The APS Investigator will initiate an assessment upon Law Enforcement placing an alleged victim into Emergency Protective Custody and the Investigator must notify the County Legal Department via telephone or e-mail within two (2) hours that the EPC has occurred. The Investigator will secure a copy of the incident report from the law enforcement officer stating that the alleged victim is placed into Emergency Protective Custody. If a copy of the incident report cannot be secured, a signed copy of, **Emergency Protective Custody of a Vulnerable Adult (**DSS Form15109) may be completed and signed by the officer. The attorney for DSS will file a petition within one business day of receiving notification of the Emergency Protective Custody action. The Family Court will hold a hearing within 72 hours of the Vulnerable Adult being placed in Emergency Protective Custody. The DSS attorney will represent DSS at the hearing. The purpose of the hearing is to determine if there was probable cause for law enforcement to take the adult into emergency protective custody. If the APS assessment reveal a need for continued custody by DSS,

the petition will also request that the adult remain in DSS custody, services be coordinated and a Merits Hearing be held within forty days.

243 EMERGENCY PROTECTIVE CUSTODY PROCEDURE

This procedure outlines the roles and responsibilities of involved parties when a Vulnerable Adult is placed into Emergency Protective Custody (EPC) by a Law Enforcement Officer**.**

Law Enforcement Officer Responsibilities

1. Places a vulnerable adult into Emergency Protective Custody.
2. Transports a vulnerable adult to a place of safety. The officer must transport the vulnerable adult to a place of safety which must not be a facility for the detention of criminal offenders or of persons accused of crimes.
3. Notifies DSS. When a law enforcement officer takes protective custody of a Vulnerable Adult, the Law Enforcement Officer must immediately notify the Adult Protective Services Program and the Department of Social Services in the county where the Vulnerable Adult was situated at the time of being placed into protective custody.

This notification must be made in writing or orally by telephone or otherwise and must include the following information:

(a.) the name of the Vulnerable Adult, if known, or a physical description of the adult, if the name is unknown;
(b.) the address of the place from which the Vulnerable Adult was removed by the officer;
(c.) the name and the address, if known, of any person who was exercising temporary or permanent custody of or control over or who was the caregiver of the Vulnerable Adult at the time the adult was taken into protective custody;
(d.) the address of the place to which the vulnerable adult was transported by the officer;
(e.) a description of the facts and circumstances resulting in the officer taking the Vulnerable Adult into protective custody.

APS Case Manager Responsibilities

1. Initiates an investigation.
2. Notifies the County Legal Department within two (2) hours by telephone or e-mail that the EPC has occurred.
3. Obtains copy of Law Enforcement Incident Report or a signed copy by Law Enforcement of **Emergency Protective Custody of a Vulnerable Adult** (DSS Form 15109).
4. Ensures that Probable Cause court paperwork is completed in a timely manner.
5. Make referral to Legal Case Management System. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 3, SECTION 300, Treatment Services Policy, 333, **THE LEGAL CASE MANAGEMENT SYSTEM** for further guidance.

APS Case Manager and APS Supervisor Responsibilities

6. Staff case with County Attorney to determine whether or not DSS needs continued custody of the client.

County DSS Attorney Responsibilities

7. Files petition with Family Court within one work day of notification of EPC.

8. Ensures Guardian ad Litem and Guardian ad Litem Attorney and Attorney for Vulnerable Adult is appointed within ten (10) days of the filing of the petition.

Family Court Responsibilities

9. Holds a hearing within seventy-two (72) hours of the vulnerable adult being taken into EPC. The family court shall hold a hearing to determine whether there is probable cause for the protective custody within seventy-two hours of the Department of Social Services filing the petition, excluding Saturdays, Sundays, and legal holidays.
10. Appoints Guardian ad Litem, Guardian ad Litem Attorney and the Attorney for the Vulnerable Adult.

244 EX-PARTE REMOVAL ORDER

When a Vulnerable Adult is at substantial risk of being abused, neglected, or exploited and consent cannot be obtained to provide services or placement, DSS may petition the family court for an order to provide the necessary services. In an emergency situation involving imminent danger an Ex-Parte Complaint will be presented to the court by the attorney representing the DSS county. In those cases requiring emergency protective services or emergency removal of the Vulnerable Adult from the place the adult is located or residing, the Adult Protective Services Program may seek ex-parte relief. The court may expedite the ex-parte proceeding to any extent necessary to protect the vulnerable adult. The family court may order ex-parte that the Vulnerable Adult be taken into emergency protective custody without the consent of the Vulnerable Adult or the guardian or others exercising temporary or permanent control over the Vulnerable Adult, if the court determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent danger to the vulnerable adult's life or physical safety. The court also may order emergency services or other relief as necessary to protect the Vulnerable Adult.

245 THE PROBABLE CAUSE HEARING

The Probable Cause hearing will commence within seventy-two (72) hours after an alleged victim is placed into Emergency Protective Custody. At this time, the judge will determine if there is probable cause for an alleged victim to be in the custody of the Adult Protective Services program. Sometimes, the judge will rule that there is no need for the alleged victim to be in the custody of DSS; but, the case file is to remain open to provide services to the client. Client's case files may be taken to court for reference if needed unless instructed by the DSS attorney not to do so. It is not necessary to have a Probable Cause hearing if the Family Court judge issues an ex-parte order of custody.

246 THE MERITS HEARING

A Merits Hearing must be held forty (40) days after the filing of the petition (the adult coming into care of DSS). The court will appoint a Guardian ad Litem and attorney for the client. Notice will be given to interested parties.

The Case Manager will conduct a Comprehensive Evaluation and write a report. The report will cover the items addressed in S.C. Code of Laws, SECTION 43-35-45(C).

Before the Merits Hearing, the Adult Protective Services Program must conduct a Comprehensive Evaluation of the Vulnerable Adult. The original copy of the report should be turned over to the legal department and the legal department will ensure that the report is filed with the clerk with copies submitted to the required interested parties. A copy of the Comprehensive Evaluation report will be provided to the court, the Guardian ad Litem, and the attorney for the client at least five (5) working days before the hearing. The evaluation must include, but is not limited to:
(1) The Vulnerable Adult's current address and with whom the Vulnerable Adult is residing;
(2) a list of all persons or agencies currently providing services to the Vulnerable Adult and the nature of these services;
(3) a summary of services, if any, provided to the Vulnerable Adult by the Adult Protective Services Program;
(4) if needed, a medical, psychological, social, vocational, or educational evaluation;
(5) Recommendations for Protective Services which would serve the best interests of the Vulnerable Adult; however, when these services are to be provided by another state agency, these recommendations must be developed in consultation with the other agency. A copy of the evaluation must be provided to the court, the Guardian ad Litem, and the attorney at least five working days before the hearing on the merits. Reasonable expenses incurred for evaluations required by this subsection must be paid by the Adult Protective Services Program which must seek reimbursement for these evaluations, where possible.

At the hearing on the merits, the court may order the Adult Protective Services Program to provide Protective Services if it finds that:
(1) the Vulnerable Adult is at substantial risk of being or has been abused, neglected, or exploited and the Vulnerable Adult is unable to protect herself or himself; and
(2) Protective Services are necessary to protect the Vulnerable Adult from the substantial risk of or from abuse, neglect, or exploitation.

247 THE FULL HEARING

Legal action in nonemergency situations begins with a full hearing. The action is necessary when a Vulnerable Adult is at substantial risk to be or has been abused, neglected, or exploited and consent to provide services cannot be obtained. The attorney representing the county office will draft a petition and file it with the court. Notice will be served on interested individuals. Within ten (10) days of the petition, the court will appoint a Guardian ad Litem and attorney for the client. The Case Manager will conduct a comprehensive evaluation and prepare a report covering the items addressed in S.C. Code of Laws, SECTION 43-35-45(C). A copy of the report will be provided to the court, the Guardian ad Litem, and the attorney for the client at least five (5) working days before the hearing. Reasonable expenses incurred for the evaluations required by this subsection must be paid by the Adult Protective Services Program.

248 UNABLE TO LOCATE VULNERABLE ADULT

A diligent search must be provided to locate the Vulnerable Adult to include but is not limited to the following actions: contacting family members if provided on the report; contacting the reporter; contacting hospitals; checking with neighbors; checking with the postal service; contacting law enforcement and interviewing the client’s landlord, if applicable. The Case Manager must

document all diligent searches in CAPSS, staff with the APS Supervisor and complete the Risk Assessment and Case Decision indicating the Case Manager was unable to locate the client.

249 SECURING ACCESS TO THE VULNERABLE ADULT

If consent cannot be obtained for access to the Vulnerable Adult or the premises, the investigative entity may seek a warrant from the family court to enter and inspect and **photograph the premises and the condition** of the Vulnerable Adult. **Videotaping is not allowed**. The county Attorney will ask the court for the warrant based on information from the Case Manager and the court shall issue a warrant upon a showing of probable cause that the Vulnerable Adult has been abused, neglected, or exploited or is at risk of abuse, neglect, or exploitation. Refer to S.C. Code of Laws, SECTION 43-35-45(A).

250 SECURING ACCESS TO INFORMATION

During the course of an investigation, it may become necessary to view documents such as bank records, medical reports, etc. The institution holding the documents may provide them after a verbal request or may require that the request be written. A written request must include the relevant section of the statute (S.C. Code of Laws, SECTION 43-35-20). If the institution does not respond to the written request, an **Administrative Subpoena** (DSS Form 1504) may be issued to require that the documents be brought to the office or any designated location. Subpoenas may also be issued requiring the appearance of a person. DSS Form 1504 must be completed by the APS Case Manager or Supervisor and signed by the County Director or his/her designee.

251 CASES INVOLVING TWO VULNERABLE ADULTS

When there is a situation involving the abuse or neglect of two Vulnerable Adults living in the same household (i.e. husband/wife, sister/brother; sister/sister and/or brother/brother) there must be two separate intakes and two separate cases. The APS process must be completed with a thorough investigation in both cases.

252 INVESTIGATIONS INVOLVNG MULTIPLE COUNTIES

Usual investigation procedures and time frames will apply even though several counties may be involved in an assessment. Unusual situations will require cooperation and agreement among county offices. The following guidelines will apply:

A. Should the alleged abuse, neglect, or exploitation happen in the county of the adult's usual residence (where the client pays rent, .taxes and/or receives mail) and the client is hospitalized in another county, where the adult is currently located will be the primary assessment county (case management county). The primary county where the client is hospitalized will make initial face to face contact, interview the client and complete any appropriate forms.

B. Should the alleged abuse, neglect, or exploitation take place in a county where the adult is visiting, the county where the client is currently located will be the primary assessment county.

253 ASSESSING A VULNERABLE ADULT AGING OUT OF FOSTER CARE BY COURT ORDER INTO ADULT PROTECTIVE SERVICES

When assessing a youth aging out of Foster Care and it appears protective services are still necessary, the Foster Care/Intensive Foster Care & Clinical Services (IFCCS) Case Manager and his/her supervisor will staff the case with the Adult Protective Services Case Manager and Supervisor if it is thought that the individual will need Adult Protective Services. An invitation to participate in this staffing should be sent to all other state agencies or entities providing services to the youth to include but not limited to DDSN, DMH, Intensive Foster Care and Clinical Services (Continuum of Care), Vocational Rehabilitation, SC School for the Deaf and Blind and any other relevant individuals or organizations with knowledge of the child's needs. The following items must be included in the staffing: a) a discussion of services and needs that have been identified on the **P.A.T.T.Y.: Providing Assistance To Transitioning Youth Program** (DSS Form 30206). b) an assessment to determine if the youth will need a guardian with court granted responsibility and authority to manage his/her health, well-being, personal and financial needs; and c) consideration of the need for an extension of foster care.

The staffing will take place in advance of the individual's 17th birthday so that the Adult Protective Services staff can determine the individual's needs as an adult and develop an appropriate case plan. If the Adult Protective Services staff determines that custody will be necessary when the individual becomes an adult, a report must be made by the current Case Manager and/or Supervisor to the Intake Hub and once APS receives the report, they will initiate action under the Omnibus Adult Protection statute. The Adult Protective Services staff will complete an assessment to determine the need for custody under the Adult Protective Services statute. ***Court Orders cannot be received which attempt to transfer custody of adults into the Adult Protective Services Program through proceedings brought under the Children's Code.***

254 ADULT DAY CARE PROGRAMS

DSS investigates alleged incidents in Adult Day Care Programs not operated by or contracted for operation by the Department of Mental Health (DMH) or Department of Disabilities and Special Needs (DDSN).

255 INVESTIGATIONS OF REPORTS INVOLVING DDSN PROGRAMS AND SERVICES

DSS and DDSN have entered into a Memorandum Of Agreement (MOA) that provides guidance and direction to each agency as it pertains to investigating allegations of abuse, neglect and/or exploitation in programs and services operated or contracted for operation by DDSN when the suspected perpetrator is an employee of SCDDSN or its contractors or when the suspected perpetrator is unknown. In addition to any requirement to investigate under the law, DDSN may request an independent or joint investigation by DSS of any suspected abuse, neglect and/or exploitation in any of its programs and services as set out in the MOA entered into between the two agencies. Upon the completion of any APS Investigation by DSS of allegations of abuse, neglect and/or exploitation in DDSN programs or services, DSS shall provide a written response to DDSN in regards to the results of the Investigation to include whether the report was

substantiated or not substantiated for abuse, neglect or exploitation and whether any other concerns were noted that should be addressed by DDSN.

256 HEALTH CARE CONSENT ACT

The Department does not secure custody of adults for the sole purpose of giving consent for medical treatment. Relatives, guardians, and persons named as the health care power of attorney may give consent for medical treatment of impaired adults who are unable to give informed consent. In the absence of relatives, a guardian, or health care power of attorney, the health care provider should follow procedures in the Adult Health Care Consent Act: S.C. Code of Laws, § 44-66-10 et seq.

257 PENALTIES

According to the S.C. Code of Laws, SECTION 43-35-85 the following penalties may apply to persons involved with abuse, neglect and exploitation of Vulnerable Adults:

(1) A person who knowingly and willfully abuses a Vulnerable Adult is guilty of a felony and, upon conviction, must be imprisoned not more than five years.

(2) A person who knowingly and willfully neglects a Vulnerable Adult is guilty of a felony and, upon conviction, must be imprisoned not more than five years.

(3) A person who knowingly and willfully exploits a Vulnerable Adult is guilty of a felony and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than five years, or both, and may be required by the court to make restitution.

(4) A person who knowingly and willfully abuses or neglects a Vulnerable Adult resulting in a great bodily injury is guilty of a felony and, upon conviction, must be imprisoned not more than fifteen years.

(5) A person who knowingly and willfully abuses or neglects a Vulnerable Adult resulting in death is guilty of a felony and, upon conviction, must be imprisoned not more than thirty years.

(6) A person who threatens, intimidates, or attempts to intimidate a Vulnerable Adult subject of a report, a witness, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned for not more than three years.

(7) A person who willfully and knowingly obstructs or in any way impedes an investigation conducted pursuant to this chapter, upon conviction, is guilty of a misdemeanor and must be fined not more than five thousand dollars or imprisoned for not more than three years.

258 APS CASE MANAGER RESPONSIBILITIES

1. Conducts at least one face to face interview per month with the Vulnerable Adult and enters into CAPSS within five (5) business days but no later than by the end of the month in which the visit was conducted.

2. Reviews monthly APS Batch Reports to assist in managing caseload.

3. Keeps the CAPSS file current.

4. Enters in CAPSS within thirty (30) calendar days of all case narratives documenting a routine event (i.e. monthly contact to review/monitor service delivery, assess client functioning, non-eventful sharing of information, etc.).

5. Enters in CAPSS within ten (10) calendar days of the contact all case narratives documenting a Critical Incident (i.e. injury, placement/address change, change in medication, injury, arrest, legal status change, etc.)

6. Enters in CAPSS within five (5) business days documenting an initial face-to-face contact with the client to avoid a "flag"/edit on your Monthly Case Management report, but no later than by the end of the month in which the visit was conducted.

259 APS SUPERVISOR RESPONSIBILITIES

Supervision is a management function that has a direct and crucial role in case management. The APS Supervisor should direct, plan, staff, evaluate, motivate, and communicate with staff. Some of the specific duties APS Supervisors perform include:

1. Ensures that Case Manager per caseload ratio is maintained. The standard ratio is 1:20. It is recommended that APS Case Managers carry a caseload of no more than 20 cases each.

2. Ensures that an electronic case and a hard file is created for each Intake Report that is accepted and assigned to the county office. Assigns accepted Intake Reports to county APS staff and ensures that response times according to typologies are successfully met.

3. Arranges a schedule for Supervisory Staffings to ensure each report has been staffed after the Initial Contact, for the Case Decision and as needed. Ensures documentation on **the Case Transfer/Case Staffing** (DSS Form 3062), and ensures the Staffing is documented in CAPSS.

4. Conducts a Supervisory Review after the Case Manager has completed the Risk Assessment and prior to Case Decision to ensure that all areas of the report have been adequately assessed, that recommendations from the Staffing have been addressed, confirms that the case narrative(s) are up to date and supports the case manager's recommendations, and documents supervisory review in CAPSS.

5. Staff all Critical Incidents with Case Managers and documents the Staffing in CAPSS. Examples of Critical Incidents include but are not limited to: EPCs, emergency removals, injuries to the client, hospitalization of the client, suicide attempts by the client or caregiver, client or caregiver threats to harm another, client whereabouts unknown, death of the client or caregiver, etc. The APS Supervisor completes the **Critical Incident Reporting Form** (DSS Form 3010). Refer to

the DSS Human Resources Policy and Procedure Manual, 137, **Critical Incident Reporting Policy and Procedures** for further guidance.

6. Reviews the electronic file in CAPSS and the paper file prior to case closure and documents that the case has been reviewed in CAPSS.

7. Monitors the Case Managers workload to include assistance or instruction in prioritizing workload if and when necessary. Ensures that new Case Managers are assigned cases according to their ability to manage their caseload.

8. Reviews CAPSS generated reports such as APS Batch Reports and Clean up reports with the Case Manager to help manage the caseload and meet performance outcomes.

9. Monitors Case Manager training hours to ensure that staff meet twenty (20) recommended training hours with ten (10) mandatory hours in Adult Protective Services subject matter.

10. Review monthly APS Batch reports to manage and supervise APS staff and caseloads. APS Supervisors will review Batch Reports monthly to assist them in maintaining the quality and integrity of cases ensuring that Vulnerable Adults are safe and receiving the best care. Weekly reports are viewed to assist in the management of meeting and maintaining performance outcomes.

260 APS COUNTY DIRECTOR RESPONSIBILITIES

1. The County Director approves all late or misplaced entries in CAPSS.
2. The County Director staffs with the APS Supervisor and Case Manager to authorize the extension of case decisions.
3. County Director ensures that every county has at least one Case Manager who is fully certified in adult protective services.

261 CONFIDENTIALITY OF ADULT PROTECTIVE SERVICES RECORDS

Adult Protective Services records may not be viewed by members of the public. All requests from individuals asking to either review or copy the file shall be referred to the county legal department for appropriate response. According to **S.C. Code of Laws SECTION 43-35-60:** ***Sharing of report information by investigative entities; public confidentiality,*** unless otherwise prohibited by law, a state agency, an investigative entity, and law enforcement may share information related to an investigation conducted as a result of a report made under this chapter. Information in these investigative records may be shared between investigative entities only. Information must not be disclosed publicly.

262 CASE FILE MANAGEMENT

An organized case file ensures a uniform approach for entering information into CAPSS. This process will assist the Case Manager to readily retrieve information enabling the Case Manager to better meet the client's needs. Timely and complete case records also ensures continuity of service delivery when there is a change of Case Managers. Case records serve as a basis for reports

required by either State or Federal laws. Timely documentation in CAPSS will ensure immediate access to case information and ensure the electronic case file is comprehensive and complete.

APS Supervisors will ensure the creation of the initial case file in CAPSS that is attached to an accepted Intake Report. A hard file will be created according to the APS Policy **Organization of Adult Protective Services Case File** and a single case record will be maintained for each client to provide a continuing record of the service to the client. When the amount of material compiled in an ongoing service case necessitates the use of more than one file folder, each folder must be marked as a volume of the single case record. CAPSS is the official electronic file. Staff and Supervisors must utilize the forms and tabs in the system to ensure that the electronic file is comprehensive and complete.

263 CONTENTS OF THE CASE RECORD

A complete case record contains all required documents and related information, such as correspondence, case narratives, and documentation of all case activity pertaining to the person or family unit requesting or receiving services. Complete case records should reflect that the Case Manager has a thorough understanding of the client's problems, has explored appropriate resources, and has followed through on a sound plan to meet the needs of the client. Case Managers are not required to print narratives, risk assessments, and service plans from CAPSS. However, when the above forms are printed from CAPSS, each page must be signed and dated reflecting the date they were printed.

264 ADULT FACE SHEET

The **Adult Services Face Sheet Client and Household Members** (DSS Form 1564), is used in all Adult Services type cases when the client receives direct services from the Department. The form allows the Case Manager to maintain demographic information in a central location which will assist the Case Manager in identifying resources for the client.

265 ORGANIZATION OF ADULT PROTECTIVE SERVICES RECORDS

The Case Manager must file documentation in chronological order with the most recent information on top in the following order (within each tabbed section, documentation would be filed in chronological order, rather than by type; i.e., subsequent Service Plans would be filed as they occur, rather than together with the initial Service Plan). Note: Documents must be secured in the file. Once the prongs cannot adequately secure the documents, the case manager should create a new volume to the case. Ensure that an up to date face sheet is in the most recent volume.

SIDE 1 CASE MANAGEMENT

A. **Adult Services Face Sheet Client and Household Members** (DSS Form 1564) (put on top/ most current date case opened).
B. **Social Services Block Grant Services Rights and Responsibilities** (DSS Form 3795).

SIDE 2 WORKER ACTIVITY AND CONTACTS (Each page must be initialed by Case Manager).

SIDE 3

A. INTAKE AND ASSESSMENT (On top)

-Adult Services Intake Summary Sheet (most recent on top)
-Risk Assessment Forms (most recent on top)
-Client/Family Assessment Summary (Support Services)
-Any Investigative Information
-pictures of abuse/neglect
-interviews/statements
-police reports
-**Notification to Law Enforcement** (DSS 1506)
-copies of warrants

B. COURT AND LEGAL INFORMATION

-Referral to LCMS
-Court Information Sheet
-Petitions
-Subpoenas
-Court Orders
-Court Summaries/Updates
-Other Court Information (Probate, Criminal Court)

SIDE 4 SERVICES INFORMATION

A. Case Plan (most recent on top)
-Service Plan/Treatment plan (most recent on top)
-**Case Transfer and/or Case Staffing Form** (DSS Form 3062)
-**Case Evaluation/Case Closure Summary** (DSS Form 1599)

B. **MEDICAL INFORMATION**

-Medical Records
-Psychiatric Records
-Psychological Evaluations
-CLTC Contracts/Forms
-**HIPPA Privacy Practices Acknowledgement** (DSS Form 4000)

SIDE 5 HOMEMAKER SERVICES

- **Request for Homemaker Services** (DSS Form 1537)
- **Homemaker Services Rendered** (DSS Form 1541)

SIDE 6 A. CORRESPONDENCE (on top)

-All correspondence not included in the above sections

B. **FINANCIAL INFORMATION**

-Payee Information

-SSI, Social Security, Medicaid

266 CONTENTS OF THE CASE NARRATIVE

At a minimum, the case narrative should contain the following:
1. The purpose of the contact or case activity;
2. The person or persons with whom the contact occurred and the relationship to the client;
3. The case management intervention delivered;
4. The location where the activity took place (Sources provided) or (site visits with the Vulnerable Adult);
5. The outcome of the contact/activity; and
6. The follow-up needed/plan (Future plans for working with the Vulnerable Adult. i.e. assessment of needs, monitoring service plan, etc.)
Note: All case narratives or forms printed from CAPSS and placed in the hard case file must be initialed and dated by the Case Manager.

267 REPORTING CRITICAL INCIDENCES AND FATALITIES INVOLVING VULNERABLE ADULTS

Any incident that endangers the life, health, or physical safety of a Vulnerable Adult in the **Custody of DSS** or **Known to DSS** must be reported up the Case Manager's chain of command and reported on the **Critical Incident Reporting Form** (DSS Form 3010). Refer to the South Carolina Department of Social Services Human Resources Manual, Policy, 137, **Critical Incident Reporting Policy and Procedures** for further instructions and guidance on the procedure for the initial, rapid reporting of Critical Incidents to senior management. Clarification is provided on Identification of Critical Incidents, Critical Reporting Procedures, Confidentiality of Critical Incident Communications and Definitions.

268 CASE CLOSURE

APS Investigations may be closed after Case Decisions are completed and it has been determined that the Investigation is unsubstantiated because there is no evidence of abuse, neglect or exploitation and/or the client has not been deemed a Vulnerable Adult or is no longer in need of Protective Services from DSS. Refer to Adult Protective Services Policy and Procedure Manual, Chapter Two, SECTION 200, Investigations Policy, 241**, THE CASE DECISION** for further guidance.

Referenced Documents
S.C. Code of Laws, Title 43, Chapter 35: Omnibus Adult Protection Act
Adult Services Policies and Procedures Manual (11/18/2002)
Social Services Block Grant Services Rights and Responsibilities (DSS Form 3795)
Know Your Rights (DSS Brochure 2416)
Notice of HIPAA Privacy Practices (DSS Booklet 4017)
Notice of HIPAA Privacy Practices Acknowledgement (DSS Form 4000)
Adult Protective Services Medical Status Report (DSS Form 1568)

Civil Rights ToolKit found on the DSS SharePoint Unite page (11/21/2016)
Notification to Law Enforcement (DSS Form 1506)
Emergency Protective Custody of a Vulnerable Adult ((DSS Form 15109)
Case Transfer and/or Case Staffing Form (DSS Form 3062)
Administrative Subpoena (DSS Form 1504)
P.A.T.T.Y.: Providing Assistance To Transitioning Youth Program (DSS Form 30206)
S.C. Code of Laws, Title 44, Chapter 66: Adult Health Care Consent Act
Critical Incident Reporting Form (DSS Form 3010)
Adult Services Face Sheet Client and Household Members (DSS Form 1564)
Case Evaluation/Case Closure Summary (DSS Form 1599)
Request for Homemaker Services (DSS Form 1537)
Homemaker Services Rendered (DSS Form 1541)
Critical Incident Reporting Form (DSS Form 3010)
Human Resources Manual, Policy, 137, Critical Incident Reporting Policy and Procedures
NCPEA: National Committee for the Prevention of Elder Abuse Website
HELPGUIDE.ORG
South Carolina DSS Human Resources Manual
Adult Protective Services Risk Assessment (DSS Form 1565) Electronic Version
Adult Protective Services Policy and Procedure Manual, Chapter Two, SECTION 200, Investigations Policy, 241**,** THE CASE DECISION

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 3 Treatment Services

Revision Number: 17-03 **Effective Date: 11/31/2017**

Review Date: 12/10/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual
CHAPTER 3 Treatment Services

Revision Number: 17-03 **Effective Date: 11/31/2017**

Review Date: 12/10/2017

300 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. The Adult Protective Services (APS) Program has the responsibility to provide Protective Services, otherwise known as Treatment Services, to Vulnerable Adults in the care of the Department of Social Services.

AUTHORITY. After determining that an alleged victim is a Vulnerable Adult, a South Carolina family court judge has the authority to issue a court order from a Merits Hearing that requires the APS Program to provide Protective Services to a Vulnerable Adult. S.C. Code of Laws, SECTION 43-35-45 (E) provides that at the hearing on the merits, the court may order the Adult Protective Services Program to provide Protective Services if it finds that:
(1) the Vulnerable Adult is at substantial risk of being or has been abused, neglected, or exploited and the Vulnerable Adult is unable to protect herself or himself; and
(2) Protective Services are necessary to protect the Vulnerable Adult from the substantial risk of or from abuse, neglect, or exploitation.

PURPOSE. Protective Services (Treatment Services) promotes the intervention and protection of Vulnerable Adults from abuse, neglect, self-neglect, and exploitation. The mission of the Adult Protective Services Program is to protect Vulnerable Adults from abuse, neglect and exploitation by investigating and providing temporary assistance until long term community services can be secured.

INTENT. Protective Services ordered pursuant to S.C. Code of Laws, SECTION 43-35-45 (F), must be provided in the least restrictive setting available and appropriate for the Vulnerable Adult and non-institutional placement must be used whenever possible. It is the intent of the Adult Protective Services Program to provide respectable assistance that minimizes or eliminates risk while supporting the Vulnerable Adult's self-worth and dignity.

SCOPE OF TREATMENT SERVICES. The scope of APS Treatment Services includes assessment of the Vulnerable Adult's needs and services through the completion of a Needs Assessment and Service Plan. Treatment Services entails service coordination including county level multi-agency inter-disciplinary Adult Protective Services Coordination Team meetings with community partners who provide long term services to Vulnerable Adults. Emphasis is placed on

the delivery of services to the Vulnerable Adult in which review and monitoring are essential components.

310 INTRODUCTION

The mission of the Adult Protective Services program is to protect Vulnerable Adults from abuse, neglect, self-neglect and exploitation by investigating and providing temporary assistance until long term community services can be secured. When a thorough APS Investigation does not reveal a need for adult protection, the Investigative case will be closed. However, when the APS Investigation reveals that the client is a Vulnerable Adult who has been abused, neglected, or exploited or the Vulnerable Adult is at substantial risk of being abused, neglected, or exploited and the Vulnerable Adult is unable to protect herself or himself, Adult Protective Services are provided and a Treatment Services case is opened.

320 DEFINITION

The following definitions are used in APS Treatment Services:

320.01 Protective Services

According to S.C. Code of Laws, SECTION 43-35-10 (9), Protective Services means those services whose objective is to protect a Vulnerable Adult from harm caused by the Vulnerable Adult or another. These services include, but are not limited to, evaluating the need for Protective Services, securing and coordinating existing services, arranging for living quarters, obtaining financial benefits to which a Vulnerable Adult is entitled, and securing medical services, supplies, and legal services.

Refer to the APS Policy and Procedure Manual, Chapter 1, Section 100, Intake Services Policy, 133, **DETERMINING IF THE REPORT MEETS THE CRITERIA OF ABUSE, NEGLECT, SELF-NEGLECT OR EXPLOITATION** for additional terms and definitions associated with abuse, neglect and exploitation.

330 POLICIES

331 CASE MANAGEMENT COMPONENTS

Documentation in CAPSS must be completed in a specified manner once a Treatment Services line has been opened. When the APS Treatment Services Case Manager enters a narrative in CAPSS, he/she will begin by labeling the narrative with a Case Management Component. These four (4) components categorize the subject that the narrative discusses. The following terms define the content and activity that is associated with each component:

Assessment - This component includes activities completed while performing a thorough assessment of an individual to determine service needs including activities that focus on needs identification to determine the need for any medical, educational, social or other services. Such assessment activities include the following:

- Gathering individual history;
- Identifying the needs of the client and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, service providers and educators, other knowledgeable individuals in the community such as an unrelated caregiver, minister or others who have information about the Vulnerable Adult.

The Assessment component should be labeled at the top of the narrative in CAPSS when describing the above activities. The case management component "**Assessment**" is used when the Case Manager is gathering information to complete the Needs Assessment in CAPSS.

Case Planning - This component is used when the Case Manager is documenting the activities in CAPSS after following up with the provider(s) who are actually providing the service(s) to the client. This component involves the development (and periodic revision) of a specific Service Plan based on the information collected through the assessment, which specifies the goals and actions to address the medical, social, educational and other services needed by the Vulnerable Adult. This component includes activities such as ensuring the ***active*** participation of the Vulnerable Adult and working with the representative or the authorized health care decision maker and others to develop goals. The Case Manager also identifies a course of action to respond to the assessed needs of the Vulnerable Adult. This component is also used to gather all service contracts and address service activities which are to be added into the Vulnerable Adult's Service Plan. The "**Case Planning**" component should be used prior to the completion of the Service Plan.

Referral/Linkage - Referral and related activities, such as scheduling appointments for the Vulnerable Adult, helps the client obtain needed services. This includes activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve objectives specified in the case plan. The "**Referral & Linkage**" component denotes all referrals made by the agency on behalf of the client. A CAPSS narrative entry may state that "*The Case Manager made referral to CLTC for Mr. Lawton to receive assistance with his ADLs."*

Monitoring/Follow-up - This component is used to indicate contact with the client ***after*** the Needs Assessment and Service Plan are completed in CAPSS. This component is guided by the tasks on the client's most recent Service Plan. This component includes activities and contacts that are necessary to ensure the Service Plan is implemented effectively and the needs of the Vulnerable Adult are being addressed. "**Monitoring/Follow-up**" may include activities with the Vulnerable Adult, family members, service providers or other entities/individuals. These activities will assist the Case Manager in determining if the services outlined in the Service Plan are meeting the needs of the Vulnerable Adult. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 3, Section 300, Treatment Services Policy, 349, **FOLLOW THROUGH SERVICES** and 350, **RECORDING FOLLOW THROUGH SERVICES** for further guidance and directions.

332 ASSESSING THE NEEDS OF A VULNERABLE ADULT FOR TREATMENT SERVICES

When a thorough APS Investigation determines that the alleged victim is a Vulnerable Adult who is in need of Protective Services due to abuse, neglect, self-neglect or exploitation or there is a substantial risk of abuse, neglect, self-neglect or exploitation, a Treatment Services case is opened to assess the needs of the client and to identify the services that will reduce risk factors and establish safety and stability for the Vulnerable Adult.

APS Supervisor Responsibilities

1. Close Assessment line.
2. Open Treatment Services line on same day Assessment line is closed.
3. If there is court involvement, a new referral to the Legal Case Management System (LCMS) must be made in the Treatment Services line. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 3, Section 300, Treatment Services Policy, 333, **THE LEGAL CASE MANAGEMENT SYSTEM** for further guidance.
4. Assign Treatment Services case to APS Case Manager.
5. Complete Transfer Staffing and note in CAPSS. Upload completed **Case Transfer and/or Case Staffing** (DSS Form 3062) in CAPSS.

APS Case Manager Responsibilities

6. Make face to face contact with the Vulnerable Adult at least once a month.
7. Case Manager will make semi-monthly contact with the provider and/or family member who is providing services to the client.
8. Complete Needs Assessment in Treatment Services line in CAPSS within ten (10) **business** days of the Case Decision.
9. Complete Service Plan ten (10) business days after completion of the Needs Assessment.
10. Complete Summary to court every six months.

333 THE LEGAL CASE MANAGEMENT SYSTEM

In order to initiate a legal action, a referral must be made by the Case Manager. It is the responsibility for the local legal staff to update LCMS. In order to make a referral of an APS case to LCMS, the APS Case Manager/Supervisor or designee should follow this procedure:

1. Open the client's case in CAPSS.
2. Select the program service line to be referred (Assessment or Treatment).
3. Click on "Legal."
4. Click on "Update."
5. Select the LCMS Referral Type (Urgent or Non-Urgent.
6. Click "Commit."

The Case Manager will know that the referral was successful, if the LCMS Referral Sent Date appears in CAPSS within thirty (30) minutes of entry. This action is a one-time referral needed by the Case Manager. If the initial referral is made in the Assessment Service line, another referral must be made in the Treatment Service line after closing the Assessment Service line. No other

action is needed by the Case Manager. Any time court action is initiated, a referral to LCMS must be made immediately by following the above steps. LCMS must be informed as to which service line the court data is forwarded, i.e. Assessment or Treatment Services line.

334 THE APS NEEDS ASSESSMENT

The APS Needs Assessment must be completed within **ten (10) business** days of the Case Decision. The purpose of the Needs Assessment is to assess the medical, social, educational, safety, risk and other needs of the Vulnerable Adult. The Needs Assessment will outline what needs the Vulnerable Adult has that will eliminate his/her risk and safety factors. The Needs Assessment is completed by the Case Manager in the Treatment Services line in the Risk Assessment Tab. The Vulnerable Adult's needs and risk must be reassessed by completing the Needs Assessment every 4 to 6 months in CAPSS or when there is a significant change in the client's life. This assessment must include specific behavioral descriptions of what collaterals have witnessed or what the Case Manager has observed, as well as the client's perception of the situation. The contacts with collaterals must be documented in CAPSS under the "Assessment" component in the Activity Notes prior to the completion of the Needs Assessment.

The Needs Assessment must contain but is not limited to the following:
Medical and/or mental condition (The assessment may require obtaining evaluations completed by service providers);
Physical Needs (and/or ability of the adult client to perform activities of daily living); must be taken into account when rating each factor.
Social and/or emotional status;
Housing and/or physical environment;
Family and/or support system;
Vocational and/or educational needs;
Independent living skills and/or abilities;
Level of functioning.

335 THE NEEDS ASSESSMENT INTERVIEW

The following information is a guide for conducting a Needs Assessment interview:

Nature of the Needs Assessment: For every person eligible for social services, it is important that there be an assessment of the need for services. The purpose of the Needs Assessment is to enable the Case Manager to understand and individualize the client's social need(s), and to identify relevant factors in a particular situation. A Service Plan is always completed with the Vulnerable Adult when the client and the Case Manager agree that a specific service(s) will help the client obtain a predetermined goal. This material is designed to suggest items of information that might be used in the Needs Assessment of the client by the Case Manager.

Guide for the Needs Assessment: A Needs Assessment and Service Plan can best be developed within a climate which permits the client to freely discuss problems, helps the Case Manager understand what the problems are and what they mean to the client, and permits the sharing of

pertinent information which may provide clues to underlying needs which are affecting the client adversely.

The Initial Interview: The Case Manager and the client start forming opinions of each other during the first interview. It is important for the Case Manager to convey a feeling of acceptance and empathy through which a mutual confidence may be established between the Vulnerable Adult and the Case Manager. Such a climate allows the Vulnerable Adult to disclose both facts and feelings, and permits the Case Manager to assume an effective helping role. Establishing and maintaining a good relationship with the client through the use of skillful interviewing techniques enables the Case Manager to gain knowledge about the client's strengths and weaknesses which are related to the client's risks and needs, and his/her ability and readiness to accept and use the agency's service(s).

Things to Avoid During the Needs Assessment Interview

It is essential for a Case Manager to refrain from:

a. Imposing moral judgements upon the Vulnerable Adult enabling the client to feel free to discuss personal feelings about pertinent matters without fear of disapproval.

b. Asking accusing questions which only arouse fear and suspicion, not cooperation.

c. Asking abrupt or tricky questions, as they are inappropriate in a Needs Assessment interview.

d. Doing all of the talking.

Things to Do During the Needs Assessment Interview

Clients soon recognize the attitude of their Case Manager and tend to respond best when they feel the presence of a real desire to understand and to help; therefore, the Case Manager should:

a. Conduct the Needs Assessment interview in an atmosphere of acceptance and openness.

b. Ask questions to obtain specifically needed information, and to direct the client's conversation from fruitless to fruitful channels.

c. Let the client talk. Sometimes the client will not only state the concern(s), but will also suggest a course of action to overcome the risk(s). In such a case the client's suggestions can be supported and strengthened by the Case Manager. The fact that the client regards it as his/her own solution makes the client more likely to follow through with it.

d. Respect the client's right to make decisions unless the client is unable to act in his/her own behalf.

e. Case Managers should be aware of, and make appropriate referrals to all community resources. The Case Manager should know what services are offered, how and to whom they are available, what demands are made upon the seeker, and other formal aspects of the service delivery plan. In

addition, the Case Manger need to have knowledge of the delivery system. The Case Manager need to know what actually happens when a client tries to avail himself/herself of a particular resource. In other words, the Case Manager should have the pulse of the community at his/her fingertips and should update the inventory of resources with information learned in day by day contacts. Entailed here is firsthand knowledge amassed from actual contact with the resource(s). The Case Manager should become personally acquainted with related services so that he/she has adequate knowledge when suggesting various resources to the Vulnerable Adults.

The Needs Assessment Interview

Normally, the Needs Assessment is formulated by inquiry and client response. Careful consideration of all questions and responses should result in a reasonable, accurate assessment of the client's concerns(s) and/or need(s).

Identifying and Stating the Concerns(s) and Needs(s)

In order to develop a strategy for dealing with a concern or need, it is helpful for the Case Manager and client to have some understanding of what is producing it. Identification is a joint undertaking by the Case Manager and client, usually guided by the Case Manager's inquiries; i.e., With what concerns(s) does the client think he/she wants help with? How and when did the concern(s) begin? What has the client done or tried to do about the concerns(s)? What other people are involved in the concern(s)?

Factors Related to Client's Concerns and/or Needs

In identifying the particular concern/need to be dealt with, the Case Manager should discuss many of the following topics with the client:

a. **Referral Source.** Did the client come to the agency and request service(s) of his/her own accord? Did someone else request service(s) for the client? If so, who requested the service(s) and what is his/her relationship to the client?

b. **The Family.** What is the composition of the immediate family: their names, ages, relationship to the client? What are the strengths and weaknesses which have bearing on the client's needs(s)? If family members are not living in the home, where do they live? Are persons other than close family members related to-the client's concerns and service needs? Learn relevant information about them.

c. **Client's Financial Functioning and Household Management.** What is the client's financial circumstance (as it relates to his/her need for social services)? What is the client's capacity to earn income, his/her attitudes and feelings toward himself/herself with respect to job opportunity? What are the client's physical and mental capabilities for employment? Does the client have previous training and work experience? What is the client's attitude toward his financial status? What is the pattern for household management? What are the client's patterns for using credit and available income in meeting necessities such as food, clothing, shelter, and health?

d. **Living Arrangements.** Does the client live alone? Who takes responsibility for planning for him/her? Who sees the client regularly? Can relatives, friends, or volunteers be enlisted if needed? If client does not live alone, how many people reside in the home with the client? What are the relationships? What are their responsibilities? If home itself constitutes a risk, what change in living arrangements is advisable?

e. **Institutional Care.** If the individual is being released from institutional care, why? What level of care is being recommended by the physician? How long has the client been in an institution? What was the original reason for admission? Does the client wish to leave the institution? How do relatives feel about the client's release? What advantages or problems do they anticipate? What affect will the client's return have on the family situation if the client is to live with them? What changes and adjustments will be required? What other living arrangements are needed and/or desired? What resources and services will be necessary to carry out the plan? Does the client need assistance in locating appropriate living arrangements? What can relatives, friends, and others do about the move? Are interim plans indicated such as adult foster home, residential home care, or with relatives, before attempting independent living?

f. **Legal Protection.** If the individual is totally unable to manage personal affairs, or if limitations create serious hazards, what steps are taken to prohibit abuse, neglect, or exploitation? Is there someone interested in the client who could be recommended as guardian, if one is needed, and who would be able to give personal attention?

g. **Health Functions.** What is the client's physical and mental condition according to the client and the Case Manager's observation? Is the client receiving medical care? Does the client require some assistance in securing medical care? Has the client's handicap been diagnosed by a physician? What are the client's complaints? How long has the client had the handicap? What form of treatment is required such as medicine, diet, injections, laboratory follow up, dressings, amount of bed rest, special exercise(s), etc.? If disability is mental, how does it affect the client's behavior, appearance, or ability to care for himself/herself?

h. **Social Functioning.** If the service(s) required for the client is related to problems of social functioning, information will be needed such as the client's delegated role, client's inter-relationship with members of the immediate family and with other important persons associated with the client problem(s), client's relationship to the community including relationship to individuals, family members, organizations and groups, and attitude toward family members and the community.

Analyzing the Dynamics of the Social Situation.

Before identifying alternative goals, objective(s), tasks, and strategies for the change which appears desirable for the client, the Case Manager must elaborate the initial statement of the problem(s) in a more detailed analysis of the dynamics of the problematic situation. The Case Manager needs to know how the pieces of the picture identified in the statement of the problem(s) or the need(s) fit together. In doing this, the Case Manager will not be directing efforts at pinpointing any single cause. Rather, the aim will be to develop an understanding of how various elements in the situation are operating to produce or maintain given behavioral or social conditions. As the Case Manager identifies the problematic situation, and the roots thereof, he/she

must keep in mind the factors which impede the client's ability to cope with life tasks and determine why various resources previously attempted failed to provide the appropriate effect.

Establishing Goals, Objectives and Plans. On the basis of the Case Manager's understanding of the dynamics of the problem, he/she, with the client, must establish goal(s), and objective(s) for the planned change and decide upon tasks with respect to the objective. Aspects of goal and objective setting that are important to problem solving are feasibility and priorities.

a. Feasibility. The planned change goal to which the Case Manager and client shall be working must be feasible and relevant to the client's problem(s) or need(s). An unrealistic goal will lead to frustration, apathy, and withdrawal from any planned, changed effort.

b. Priorities. Defining of priorities is basically about sorting through the value of one's needs. Priorities are not just a matter of long-term versus short-term goals. Goals should be given preference by the greatest need and available resources. Alleviating immediate distress and providing for the basic necessities such as food, housing and medical care have always been a priority in serving our clients.

Determining Tasks and Strategies. All of the steps in the Needs Assessment discussed earlier will affect the decisions the Case Manager makes regarding a course of action for a planned change effort. Identification and statement of problem, analysis of the dynamics of the situation, and the selection of goals, objectives, tasks, and targets provide help in three (3) specific areas: (1) determining actual and potential needs of the client, action, and target systems with respect to method and outcome of the goal; (2) suggesting points of entry in dealing with the problem, and (3) indicating resources the Case Manager will be able to utilize, and the kinds of relationships to be established.

Intervention. A Case Manager's activities can be characterized under one of three (3) approaches to intervention which encompass all case management functions. These approaches are called education, facilitation, and advocacy.

1. Education. The educational approach involves the responsibility of the Case Manager to assume a number of roles such as teacher, expert, and consultant. Typical activities in which the Case Manager might engage are giving information and advice, providing feedback, teaching skills, and demonstrating behavior.

2. Facilitation. This will encompass such activities as eliciting information and opinions, facilitating expression of feelings, interpreting behavior, discussing alternative courses of action, clarifying situations, providing encouragement and reassurance, and practicing logical reasoning, etc.

3. Advocacy. This approach allows the Case Manager to assume a role of advocate on behalf of the client. The objective of this strategy is to help the individual obtain needed resource(s) or service(s), to obtain a policy change or concession from a resistant, disinterested individual or agency, and in many cases to monitor the activities of a program in which the client participates when the service is offered through another agency or community resource.

Stabilizing the Change Effort. The final consideration in problem assessment is anticipating what new problem(s) or need(s) might arise as a result of the change effort, and what can be done to see that the change is maintained once it is achieved. Changing one aspect of the client's social situation will have consequences for other aspects, and new problems may be brought to light. This is why helping to develop the coping and problem solving capacities of clients should always be one of the client's underlying goals.

Continued Needs Assessment. Contacts between the Case Manager and the client should be as frequent as necessary to carry out the agreed upon tasks, and to assess progress in relation to achieving or maintaining the designated goal/objective with the client. Therefore, the Needs Assessment continues throughout the process. While the initial assessment serves as a blueprint, it must be modified as ideas are tested out and new information and data are gathered. The Case Manager must continually reassess the nature of the problem, the need for supporting data, and the effectiveness of approaches chosen.

336 RATING THE NEEDS ASSESSMENT

The Needs Assessment is a decision making tool that guides the Treatment Services Case Manager to assign a rating of High, Medium, or Low on the assessment. All factors rated high or medium on the Needs Assessment must be transferred to the Service Plan in the form of obstacles and objectives. This will include identifying the individual's strengths and available resources which may be drawn upon to address the client's identified need(s), as well as problem areas which may hinder needs from being met. The focus must remain on risk/safety, medical, social, educational and other needs while completing subsequent re-assessment processes.

337 THE SERVICE PLAN

The Needs Assessment Tool must be completed prior to the development of the Service Plan.
The purpose of the Service Plan is to address the risk identified by the Needs Assessment tool and improve well-being; thus, enhancing the Vulnerable Adult's quality of life. The client and/or caregiver must be involved in the development of the Service Plan. The Service Plan will address the risk factors identifying problems, medical, social, educational and other service needs of the Vulnerable Adult. The Service Plan can be updated at any time based upon the change in the needs of the client. The initial Service Plan must be completed within ten (10) **business** days of the Needs Assessment Tool, and completed annually thereafter. The factors that were rated as medium or high on the Needs Assessment must be addressed in the Service Plan in the form of goals, obstacles, objectives and tasks. The following terms and examples will assist the Case Manager in developing a functional Service Plan that is meaningful and will reduce risks to the client:

Goal: A goal is a broad spectrum, and provides an indication of program intentions. The goal focuses on eliminating risk, safety and enhancing well-being while improving the quality of life of the Vulnerable Adult.

Example: To assess risk and provide services to meet the needs of the client.

Obstacle: An obstacle is a barrier or constraint that stands in the way of literal or figurative progress.

Example: Ms. Smith has diabetes; her glucose level is extremely high.

Objective: An objective is measurable, defined, operational, simple steps, and specific. It should be behavioral, specific, relevant, and time-limited.

Example: Ms. Smith will receive services to bring her glucose level down to a manageable level.

Task: A task refers to a clearly defined piece of work, sometimes of short or limited duration, assigned to or expected of a person.

Example:
1. Ms. Smith glucose level will be checked three times per day.
2. Ms. Smith will be provided diabetic diet for her meals.

The Service Plan shall address, as appropriate, the following needs relative to the client:

- Level of functioning;
- Medical status;
- Emotional status;
- Family dynamics;
- Individual/family support system;
- Current living environment;
- Elimination of risk;
- Financial status;
- Educational or vocational placement;
- Community involvement;
- Socialization and relationships with others;
- Services received or needed from others.

Subsequent updates and reviews can take place at any time when there is a significant change, i.e. hospitalization, death of a spouse or a child, change in caregiver, medical condition, etc. in the client's situation during the life of the case. These changes to the Service Plan must be discussed with the client and all parties involved with the client for input.

The Service Plan must document specific tasks that each service provider, family member, caregiver, etc. has agreed to provide to the Vulnerable Adult with the frequency, and ending date specified on the plan. Services are planned with the client to the extent that he/she is able to participate. The primary focus is on the client's protection and safety.

A planning conference or county level multi-agency inter-disciplinary Adult Protective Services Coordination Team meeting is necessary to arrange a support system for the client. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter Two, SECTION 200,

Investigations Policy, 239, **INTERAGENCY/MULTI-AGENCY INTER-DISCIPLINARY STAFFING** for further guidance.

In addition to case management services from the Department, services from other state and local agencies may be needed. The Case Manager can enlist relatives, friends, neighbors, or church members to assist the client's receipt of holistic services and to eliminate unsafe conditions. This does not include releasing confidential and/or personal information to unauthorized individuals in this process. All contacts with the individuals stated above must be documented in the Activity Notes in CAPSS using the "Case Planning" component. Clients with sufficient income and/or assets should contribute financially to the provision of services to their benefit. The technical instruction to create a Service Plan is located in the CAPSS Users Guide.

338 ARRANGING FOR THE PROVISION OF SERVICES

When arranging for the provision of services to clients, the Case Manager must be aware of individual differences and consider the specific needs of the person with whom he/she is working. This is especially true in the provision of services to persons with physical and/or mental limitations, either directly or by referral. DSS staff need to be aware that each person comes with his or her own concerns and with varying abilities to cope or adjust. Others have been unable to face their issues realistically and have developed feelings of frustration, anger, shame, guilt or anxiety. Services provided must be those designed to help maximize their remaining capacities and to function within their limitations while respecting their right to self-determination.

APS Supervisor Responsibilities:

1. Makes available to its staff, resource directories which will inform staff members of services offered on state, regional and local levels
2. Updates resource file.

APS Treatment Services Case Manager & Client

3. APS Treatment Services Case Manager and client determines which concern/need is most urgent (the one with which the client is most concerned, is willing and ready to accept help and resource is available).

APS Treatment Services Case Manager

4. Interviews Vulnerable Adult, establishing a positive relationship, enabling individual to identify problems and/or the Case Manager to sense them.
5. Determines eligibility for services and authorizes services.
6. Determines which provider/resource has service(s) most appropriate to meet client's particular Needs.
7. Contacts provider/resource to substantiate availability of service(s) for client.
8. Describes what the provider/resource has to offer the client and encourages him/her to accept the service(s).
9. With client's permission, provides information about individual to the agency or organization which will be helpful in the, provision of service (s) and make referral for services.
10. Determines if client needs transportation to service access. If necessary, assists in providing or arranging for this service.
11. Follows up on referral to see that client receives services from provider/resource.

12. If individual is ineligible for DSS services, makes referral to appropriate resource, follow up on services.
13. Annually, re-determines client's SSBG eligibility.

339 CERTIFICATION OF CITIZENSHIP/MEDICAID ELIGIBILITY

Changes under the Federal Deficit Reduction Act of 2005 requires all individuals to provide proof of citizenship and identity when applying for Medicaid benefits after July 1, 2006. The Deficit Reduction Act set forth changes in federal law impacting Medicaid administered by the South Carolina Department of Health and Human Services. This section outlines the procedure to follow when an adult needs to apply or be reviewed for Medicaid eligibility:

APS Treatment Services Case Manager Responsibilities

1. Contact the client or client representative to determine whether identifying information is available to verify citizenship.
2. Contact the Medicaid eligibility worker for assistance to obtain information about your client. (original document must be presented).
3. Completes Medicaid Application as required.
4. Use data match from government agencies like Social Security Administration, Veterans Administration, etc. to obtain identifying information.
5. Contact the Community Residential Care Facility or the Nursing Home Social Worker for clients in placement. Admission information serves as a resource.

Note: If other forms of documentation cannot be obtained, documentation may be provided by a written affidavit from two citizens not related to the applicant who have specific knowledge of the citizenship status. The applicant must submit an affidavit stating why the documents are not available.

Note: For clarification concerning appropriate forms of identification to verify citizenship, refer to DHHS form 1233A @http://medsweb.clemson.edu/formlisting.htm.

6. Receives referral and determines client's SSBG eligibility.

340 SERVICE COORDINATION

After arranging the necessary services, it becomes the Case Manager's responsibility to coordinate with service providers, i.e. CLTC, Personal Care Aids, Home Health, Social Service Aids, family members, personal care physician (PCP), friends, etc. and build a support system or keep the existing support system in place. The Case Manager will maintain a minimum of one (1) semi-monthly contact with a service provider/caregiver on behalf of the client and one (1) monthly face to face visit with the Vulnerable Adult. The monthly face to face contact with the Vulnerable Adult must be made with the client in his/her home or residence to ensure the client's overall protection. During these contacts the tasks outlined on the Service Plan must be reviewed with the client and/or caregiver for status updates. Service coordination on behalf of our clients must be conducted under the "Referral & Linkage component." The Case Manager must document in writing to the service providers what services he/she is requesting for each client. The Case Manager must document in CAPSS contact with service providers with details of the services provided to the APS client on a monthly basis. Monthly contacts with service providers under the "Monitoring and Follow-up" component, must be conducted to ensure providers are following through with

their service agreement with our clients. The Case Manager must document tasks on the Service Plan individualized for each client. These tasks must be agreed upon by all parties, i.e. client, service providers, caregiver, etc. The Case Manager must be an advocate to obtain these services for which the client is in need of to eliminate unsafe conditions and/or to provide a better quality of life. The case should be re-assessed using the Needs Assessment Tool in CAPSS in the Treatment Services line. If there is an overall rating of "Low," the case should be staffed with the Supervisor for possible closure.

341 MEDICAL CONSENT

Adults are entitled to make decisions about their own medical care unless the court has ordered certain care or given the Agency authority to consent to medical care for the client. Consent for routine medical services may include:

· a prescribed visit to the doctor's office to relieve symptoms associated with illnesses, prevention and relief of suffering by means of early identification, and

· comprehensive medical assessment and treatment of pain and other problems, physically, mentally, and psychosocial.

Examples of routine visits may include visits to an internist, urologist, cardiologist, ophthalmologist, orthopedic doctor and etc.

Clients may have an advance directive, i.e. (Health Care Power of Attorney and Living Will). If the client has a Health Care Power of Attorney and or a Living Will this information must be shared with the Case Manager to assist the client with services.

Clients who have not made advance directives and are able to understand should be encouraged to make these directives about the type of care they want should they become unable to consent. Clients should be encouraged to appoint a Health Care Power of Attorney where appropriate.

In the absence of a Court Order, DSS has no authority to agree to the withholding of medical treatment, food, or water.

The Department does not secure custody of adults for the sole purpose of giving consent for medical treatment. Guardians, and persons named as the Health Care Power of Attorney may give consent for medical treatment of impaired adults who are unable to give informed consent. In the absence of a designated decision-maker, the health care provider should follow procedures in the Adult Health Care Consent Act.

342 THE SIX MONTH REPORT TO THE COURT

After the court orders custody of the Vulnerable Adult to DSS or otherwise orders Protective Services, the Case Manager must evaluate the client's situation and submit a written report to the Court at least every six months. The report will address the client's continued need for court ordered services. These reports should be submitted to the county legal department which should then be responsible for ensuring that the appropriate parties/individuals are provided copies as is the Court. The report must be documented in LCMS so that information is transmitted to CAPSS. Before submitting the Six Month Report the Adult Protective Services Case Manager must conduct a comprehensive evaluation of the Vulnerable Adult. The evaluation must include, but is not limited to:

(1) The Vulnerable Adult's current address and with whom the Vulnerable Adult is residing;

(2) a list of all persons or agencies currently providing services to the Vulnerable Adult and the nature of these services;

(3) a summary of services, if any, provided to the Vulnerable Adult by the Adult Protective Services Program;
(4) if needed, a medical, psychological, social, vocational, or educational evaluation;
(5) Recommendations for Protective Services which would serve the best interests of the Vulnerable Adult; however, when these services are to be provided by another state agency, these recommendations must be developed in consultation with the other agency.
A copy of the evaluation must be provided to the court, the Guardian ad Litem, and the Attorney at least five (5) working days prior to the due date. Reasonable expenses incurred for evaluations required by this subsection must be paid by the Adult Protective Services Program.

343 SPECIAL PROVISIONS

Special provisions may be included in Family Court Orders in response to the petition (complaint) or on the Court's initiative. Examples are, restraining provisions against persons who would interfere with service to the client, or the client's placement and authorization for routine and emergency medical care. In addition, the Court may find that the client is financially able to pay for third party services, and may order payment from the financial resources of the client. In exploitation cases, the Court may order that the financial records be made available for inspection. The Case Manager will request that the attorney representing the county office to make efforts to prevent the inclusion of provisions which would restrict the Department in service delivery, or would require additional court appearances by the Department for a change in plans. Case Managers should not ask the court for special provisions which conflict with APS Policy, state and federal regulations.

344 PROBATE COURT

Some issues that arise will not all be able to be resolved in Family Court. Some issues require the authority of Probate Court. Each county has a Probate Court and their operational procedures vary from county to county. Case Managers must be familiar with the procedures of the court in their county.

345 PROBATING ESTATES

The Probate Court is responsible for probating the estates of all deceased persons. All funds and bills of deceased persons will be turned over to the Probate Court. DSS can and should recover the cost of services ordered for the care and protection of the Vulnerable Adult from the estate.

346 GUARDIANSHIPS AND CONSERVATORSHIPS

The Probate Court may appoint a Conservator to manage the financial affairs of an incapacitated adult or appoint a Guardian for custody of the person. It is not appropriate for DSS staff, or county offices, to serve as Conservators or Guardians of clients. It would be appropriate to facilitate the appointment of a trusted relative or friend of the client. Guardians and Conservators must make annual reports to the Probate court and may be removed by the court if good cause is demonstrated in a hearing.

347 COMMITMENTS

APS Case Managers should always engage the Department of Mental Health to assist with the appropriate placement of clients with intellectual disabilities. Involuntary admissions to facilities for the mentally ill, alcohol/drug abusers and persons with intellectual disabilities are handled by the Probate Court. Case Managers may need to facilitate emergency involuntary admissions of mentally ill clients or clients abusing alcohol/drugs by completing the initial application at the Probate Court. County DSS Directors may petition the Court for involuntary admission of clients with intellectual disabilities who are in need of treatment.

348 CONTACTS WITH CLIENTS DURING TREATMENT SERVICES

The Case Manager conducts at least twice a month contacts for which one of these contacts must be a face-to-face interview with the client in his/her residence. The other contact may be conducted via telephone or with a service provider who is also visiting the client's residence on at least a monthly basis.
The face-to-face visit MUST include but not limited to a description of:

1. Living conditions of the home and food supply;
2. Medical condition of client;
3. Medication Needs;
4. Caretaker;
5. Client's ability to do ADL;
6. Medical and Social Needs;
7. Emotional state;
8. Financial state;
9. Status of Service Plan (tasks).

Clients residing in nursing homes or Residential Care Facilities must receive at least one (1) monthly face to face visit for the purpose of review of their plan of care unless court order otherwise.

All service providers must be contacted on a monthly basis to obtain the status of treatment services outlined on the client's service plan.

APS Treatment Services Case Manager Responsibilities

1. Case Managers will conduct monthly contact with the service providers as required in accordance with the service plan and/or client circumstances. Ensure that all contacts are entered into CAPSS before the last day of the month the actual visit occurred to avoid errors on CAPSS generated reports.
2. Case Managers will complete all Activity Notes and forms that are available on CAPSS within policy timeframes. Acceptable paper versions for the hard case file must be printed from CAPSS in order to be considered valid and signed/initialed by the Case Manager.
3. Case Managers will maintain current case files within APS policy standards in CAPSS.

4. Case Managers will enter in CAPSS before the last day of the action month all Activity Notes documenting a routine event (i.e. monthly contact to review/monitor service delivery, assess client functioning, non-eventful sharing of information, etc.)
5. Case Managers will enter in CAPSS within five (5) **business** days of the contact all case narratives documenting a critical event (i.e. injury, placement/address change, hospitalization of a caregiver, change in medication, arrest, status change, etc.)

Refer to the Adult Protective Services Policy and Procedure Manual, Chapter Two, SECTION 200, Investigations Policy, 258, **APS CASE MANAGER RESPONSIBILITIES** for further guidance.

349 FOLLOW THROUGH SERVICES

Follow through services include but are not limited to monitoring the client in placement for three (3) to six (6) months, continuing to assess the risk and safety of the Vulnerable Adult, evaluating the ability of the service providers to meet the goals and objectives on the Service Plan, Re-directing funds to the placement resource and documenting the client's progress in CAPSS. Follow through services enables the Case Manager to provide the client with continuing support and encouragement while effectively utilizing the resources that have been procured for the client to reduce risks. The Case Manager and client can evaluate the client's movement toward his goal(s) and the need for other services by completing follow through. The Case Manager must have a clear understanding of his/her continuing role and responsibility for follow through in the case as well as the role assumed by the other agencies providing services to the client. The extent of follow through depends on many factors such as the client's need for supportive care, the nature of the client's needs and plans for dealing with them, services being received from other agencies, and the understanding between the two agencies as to the nature and extent of cooperative efforts. When the Department is referring a client to another agency for service(s) and there is no need for continued Department involvement, the Case Manager is still required to follow through on the referral. Follow through also assures the most reliable decision for termination of the case. At any point when service is to be discontinued by the Department or other service providers, the agency planning to discontinue the service should notify the APS Treatment Services Case Manager in advance. This is particularly important when the client has been unable to use the service. This policy enables the appropriate agency to help the client evaluate the risk(s) and consider other plans immediately.

350 RECORDING FOLLOW THROUGH SERVICES

Referrals, Service Plans and related activities must be made an integral part of the client's case record. This is particularly important with follow through services. All changes in Service Plans, the resources to which the client was referred, and the results achieved must be thoroughly documented in CAPSS. Recording these activities in CAPSS documents the client's progress or the lack thereof and allows the Case Manager to adjust the Service Plan as needed.

351 RELIEF OF CUSTODY

When the client's safety is no longer dependent on being in custody of the Department, the Family Court will be petitioned for relief of custody. Ex-Parte Orders do not expire at the end of forty (40) days. It is always necessary to return to court to be relieved of custody given to DSS by a court order. The agency must be relieved of custody of a client before the case can be considered for closure. It is not appropriate for the Department to seek or for the Family Court to provide that custody of a Vulnerable Adult be granted to another adult. Nor should the agency ask the Family Court to be granted temporary access to a Vulnerable Adult's funds when DSS no longer has custody of the Vulnerable Adult. Funds should be re-directed to placement resources prior to case closure.

352 CASE CLOSURE

Treatment Services cases will be closed when unsafe conditions (safety and risk) have been eliminated and the clients' safety and well-being no longer depends on the involvement of Adult Protective Services. A re-evaluation of the Needs Assessment must be completed by the Case Manager which indicates that the risk(s) have been reduced and the rating is "low." When the objectives and tasks on the Service Plan have been achieved by the client and his/her support system, caregiver or agency partners (i.e. DDSN, DMH, CLTC), the case must be staffed with the APS Supervisor for case closure. The Case Manager must ensure that **the Case Evaluation/Case Closure** (DSS Form 1599) is completed. This form requires the signatures of the APS Case Manager, the APS Supervisor and the client. If the client is unable to sign, a representative for the client may sign for him/her. Otherwise, the Case Manager should write on the form that the client was unable to sign and indicate in the CAPSS narrative the reason(s) why the client could not sign. The client is to receive a copy of this form ten (10) days before case closure. The case must be left opened for ten (10) days and then closed.

The Vulnerable Adult's or family member's refusal to answer the door or cooperate with the agency's requests to allow the Case Manager into their home is not a valid reason for closure of an APS case. If the client is in DSS custody or receiving services through court order, the agency will need to be relieved of custody by the court before the case is staffed for closure. A True certified copy of the court order signed by the Presiding Family Court Judge and stamped by the Clerk of Court must be filed in the case file prior to case closure.

The Case Manager must be mindful of the clients preferred life style and not impose his/her values on the client. Clients have freedom of choice in personal appearance, keeping pets, lovers and other matters which society leaves to individual choice. Adults have rights of self-determination and choice. Eccentric behavior does not necessarily endanger the client. The Case Manager's concern is with behavior and living arrangements that present danger to the client. Services must be provided in the least restrictive setting possible. All financial resources must be obtained and all financial arrangements must be completed with placement resources before a case is closed. The financial arrangements must be completed and the case must be monitored for at least three (3) to six (6) months to ensure that the Vulnerable Adult is stable before case closure.
The case must be closed out in CAPSS through the program services tab and the Treatment Services line. The case file must be submitted to the APS Supervisor for case review. Preference is given to in-home services with out of home placement services as a last resort.

Referenced Documents:
S.C. Code of Laws, Title 43, Chapter 35: Omnibus Adult Protection Act
Adult Services Policy and Procedure Manual (11/18/2002)
Case Transfer and/or Case Staffing (DSS Form 3062)
Adult Protective Services Risk Assessment (DSS Form 1565) Electronic Version
DHHS form 1233A
Adult Health Care Consent Act

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual
CHAPTER 4 Placement Services

Revision Number: 17-04 **Effective Date: 12/18/2017**
Review Date: 12/18/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 4, Placement Services
Revision Number: 17-04 **Effective Date: 12/18/2017**

Review Date: 12/18/2017

400 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. Vulnerable adults who have been adjudicated into the custody of the South Carolina Department of Social Services will be provided appropriate living arrangements. Preference where the vulnerable adult will live must be given to community based living situations over institutional settings. In home or community based services should be utilized whenever appropriate and available to meet the vulnerable adult's needs. However, if a vulnerable adult in DSS custody is placed into a facility, that facility must be licensed.

AUTHORITY. When Protective Services are ordered pursuant to S.C. Code of Laws, SECTION 43-35-45(F), these services must be provided in the least restrictive setting available and appropriate for the vulnerable adult.

PURPOSE. The purpose of Placement Services aims at ensuring that vulnerable adults in the care of the agency reside in an environment that is safe and secure from abuse neglect and exploitation where their daily needs are being met.

INTENT. It is the intent of the Adult Protective Services (APS) Program to promote safe environments for vulnerable adults who are in the care of the agency by placing them in settings that are least restrictive and maintains their highest level of independence, self-respect and dignity.

410 INTRODUCTION

Most adults prefer to remain in their own homes rather than going into a facility or alternative placement and the philosophy of the Adult Protective Services program is to provide and arrange in-home services to delay or prevent out of home placement. However, out of home placement becomes necessary when clients' needs cannot be met through long term services in the community. When adults have fragile support systems and extensive medical issues that make it difficult for their needs to be met in the community, out of home placement becomes necessary. Sometimes clients may ask the Department to assist them in arranging for placement or he/she may agree to placement when the case manager makes him/her aware that it is an available option. Ultimately, when the client's daily needs can no longer be met in the home, it may be necessary to place the client out of the home through a court order. These clients may also include clients the agency has obtained custody of through Emergency Protective Custody or Ex-Parte Removal Order. If an adult is incapacitated and cannot make decisions for himself/herself, the agency must have custody of the vulnerable adult to make placement of the client outside of the home.

420 DEFINITIONS

The following terms and definitions are commonly used when placing clients in alternative settings:

420.01 Activities of Daily Living

Activities of daily living (ADL) are routine activities that people do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

420.02 Community Training Homes

The Department of Disabilities and Special Needs provides licensure to Community Training Homes which are residential homes for individuals with Intellectual Disabilities or similar disabilities. Placement is made through the local agency of the Department of Disabilities and Special Needs.

420.03 Community Residential Care Facilities

Community Residential Care Facilities (CRCFs) are licensed by the Department of Health and Environmental Control (DHEC). Every CRCF is routinely inspected and is required to post their Department of Health and Environmental Control license in a conspicuous location in the facility. These are facilities which offer room and board and a degree of personal assistance with activities of daily living for a period of time in excess of twenty-four consecutive hours for two or more adults unrelated to the administrator within the third degree of consanguinity. Included in this definition is any facility (other than a hospital) which offers, or represents to the public that it offers a beneficial or protected environment specifically for the mentally ill, drug addicted, or alcoholic, or provides or purports to provide any specific procedure or process for the cure or improvement of that disease or condition. Some home health services may be provided to residents of community residential care facilities.

420.04 Instrumental Activities of Daily Living

Instrumental Activities of Daily Living (IADL) are activities related to independent living and includes shopping, cooking, managing medication, using the phone and able to look up numbers, doing housework, laundry, driving or using public transportation and managing finances.

420.05 Level of Care (LOC)

Skilled Care and Intermediate Care are the two levels of nursing home care. Skilled care is for individuals with more severe functional deficits who require more hands-on assistance than individuals at the intermediate level of care.
Community Long Term Care (CLTC) staff determines the level of care needed through an assessment.

Skilled Nursing Care is health care given when a person needs skilled nursing staff (registered nurse (RN) or licensed practical nurse (LPN)) to manage, observe, and evaluate care. Skilled nursing care requires the involvement of skilled nursing staff in order to be given safely and effectively.

Intermediate Care is provided by skilled professionals such as registered or licensed practical nurses, and therapists, under the supervision of a physician. Medicare Part A does not cover intermediate care in nursing homes.

420.06 Licensed Facilities

DSS places clients only in facilities which have been licensed by the Department of Health and Environmental Control.

The South Carolina Department of Health and Environmental Control has the responsibility for licensure and certification of skilled and intermediate long term care facilities. Once a facility is licensed, the Department of Health and Environmental Control provides certification services for the Medicaid program in order to determine that the facility meets conditions for payment specified by Medicaid.

420.07 Nursing Homes

Nursing Homes are also referred to as skilled nursing facilities which are for clients who require twenty-four (24) hour monitoring and medical assistance. Nursing homes provide intensive, long-term medical care to clients with serious health conditions in a fully staffed and monitored facility. Complex Care Nursing Homes provide specialized treatment services for patients who have multiple medical conditions.

Nursing homes are licensed by the Department of Health and Environmental Control. Those participating in the Medicare and Medicaid programs are also certified for these programs by the Department of Health and Environmental Control. Nursing homes also provide Rehabilitation Services for short term convalescents. **The names of these facilities can be found on the Dept. of Health & Environmental Control's (DHEC) website.**

420.08 Plan of Care

Plans of Care are completed for individuals being admitted to Community Residential Care Facilities. The Plan describes the assistance in activities of daily living needed by the individual, the medical regimen, requirements for being seen by health care providers, and desirable recreational/social activities. Agencies placing clients in RCFs are required by state law to develop and monitor Plans of Care on the clients placed.

The client's Service Plan must include the same objectives on the Plan of Care to enable the case manager to monitor the development of the plan during visits. This information must include a

description of the problem, objectives for the client, specific duties/tasks to be directly provided, services to be provided through referrals and time frames and any special arrangements.

420.09 Private Homes

There is no licensure requirement or authority for private homes where one adult unrelated to the home owner is placed to receive room, board and some personal care. The Adult Protective Services Program recommends that clients in the custody of the agency not be placed in such a setting. However, vulnerable adults who are still able to make their own decisions must be respected in determining where he/she would like to be placed.

430 POLICIES

431 THE PLACEMENT PROCESS

Placement Services involves the client moving from his/her home or usual residence into an alternate housing arrangement which is usually a licensed facility but may be the home of a relative. **If a vulnerable adult in DSS custody is placed into a facility, that facility must be licensed.** The case manager must complete all activities necessary to ensure that the client is stable and adjusted in his/her placement.

432 PRE-PLACEMENT REQUIREMENTS

Before any client is placed in an alternative setting, all possibilities to maintain the client in-home must be fully explored. When out of home placement is the only alternative, clients are placed at the appropriate level of care where their needs can be met. When the need for placement becomes apparent, or is requested by the client, a determination must be made about the Level of Care needed by the client.

Ambulatory clients usually can be placed in community residential care facilities. A medical statement must be completed by a physician on clients going into residential care facilities. The statement must demonstrate that the client's needs can be met in the facility and that the client is free of contagious or infectious disease.

Non-ambulatory clients often need nursing home care and will need to be assessed by Community Long Term Care (CLTC). The Case manager will need to ensure that the client's level of care is determined. **Level of Care** is determined by the Vulnerable adult's primary care physician, medical provider or CLTC. CLTC will complete a thorough assessment on the Vulnerable adult to determine the LOC.

Responsibilities of the APS Case manager

1. Maintains an updated listing of Community Residential Care Facilities (CRCF), nursing homes, and Intermediate Care Facilities (ICF). The licensing information is listed @: http://www.scdhec.gov/. **Seek a placement resource for the client.**

2. Ensures that the client is prepared to enter alternative placement by making sure that the client has a read Tuberculosis (TB) Tine skin test, a physical examination by a medical doctor and a completed level of care by CLTC.
3. Verifies through the Medicaid case manager that the Nursing Home Medicaid or OSS Medicaid applications are completed and approved. Note: If the Nursing Home and/or OSS Medicaid application(s) have not been completed, the APS case manager must assist the client and/or family member with completing the Medicaid application within ten (10) business days of opening the case record. **This is completed on all APS clients that may qualify for Medicaid, whether the agency has custody or does not have custody of the client.** If the agency does not have custody and the client and/or family refuses Medicaid assistance it must be documented in CAPSS. If the agency has custody of the client and the client and/or family refuses Medicaid assistance then the agency has the option to go to court to get an order requiring cooperation or to enforce an existing order.
4. Ensure that the client has an identified physician/mental health provider.
5. Obtain medical records for the vulnerable adult to assist the case manager in placing the client in the appropriate placement to meet the client's needs.
6. The case manager must complete the placement tab in CAPSS.
7. Ensures that the client's income is redirected to the facility/placement resource and that the client's bill is in good standing with DSS as well as facility business managers. Follow up as necessary with legal department to get court to enforce.
8. Document in CAPSS all activity on the case including placement, the Needs Assessment to verify that the placement meets the client's needs physically, mentally, socially, psychologically, and medically.
9. Monitors/Updates the Plan of Care for APS clients who are residing in licensed facilities.

433 FINANCIAL ASSISTANCE

Clients going into residential care facilities may have resources and income to pay the facility bills or contribute towards their own care. If the Family Court determines that the vulnerable adult in DSS custody is financially capable of contributing payment for services ordered pursuant to S.C. Code of Laws SECTION 43-35-45 (I), then payment by or from the financial resources of the vulnerable adult should be ordered.

However, many clients will need financial assistance and the case manager must assist the client in applying for the Optional State Supplement (OSS). Clients going into nursing homes may need assistance from Medicaid and the case manager will need to assist the client in completing the Medicaid Nursing Home application. If there are no family members available to assist with completing the Medicaid application, it may be necessary for the case manager to become the client's Medicaid representative. The case manager will need to complete the Healthy Connections Medicaid form entitled **Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Review and Appeals** (DHHS Form 1282). In the event that the vulnerable adult has no financial resource, Emergency Funds may be requested from the Adult Advocacy Division at the state office to temporarily secure the client in a safe environment until long term community services can be secured. Refer

to the Adult Protective Services Policy and Procedure Manual, Chapter 6, Emergency Fund Services Policy for further assistance.

434 SELECTION OF A FACILITY

If the client has friends or interested family members, they should be involved in the placement decision, especially in the selection of the facility. In the absence of close friends or relatives, the case manager will need to take the client to visit residential care facilities. This will allow the client to make a choice and minimize the fear of the unknown. If there is no vacancy in the preferred facility, the client may wait for a vacancy or go to another facility until a vacancy occurs at the preferred facility. The client's medical records and other confidential information cannot be shared with anyone other than the service provider by the case manager.

435 SIGNING APPLICATION FORMS

Facilities, especially nursing homes, have detailed application forms that they require to be completed and signed upon admitting a client. If the client is cognitively capable and understands what he/she is signing then the client can sign the application forms. If not, it is appropriate that a relative or extended family member of the client sign the forms. In the absence of a representative willing to complete and sign the forms, and the client is not in DSS custody, the case manager must staff the case with the county attorney to complete paperwork in order to obtain custody of the client so that the case manager can complete and sign the application on the behalf of the vulnerable adult. If the client is already in the custody of the Department of Social Services, the case manager can complete and sign the forms in order for the client to be admitted. In both of these circumstances, the case manager should ensure the following statement is on every page: "any liability assumed is subject to limitations of the rules, regulations, policies, and procedures of the South Carolina Department of Social Services and state and federal law governing the participation of the Agency in social service programs." This statement must be written on the form rather than written on a separate sheet of paper and attached. Failure to write this statement on the forms may cause the facility to hold the case manager responsible for the client's bill.

436 PLAN OF CARE

The South Carolina Code of Laws, SECTION 44-7-350, requires that agencies placing clients in community residential care facilities develop individual Plans of Care for each client in coordination with the facility administrator, or designee, and the client. The Plan must be developed and signed by the client, the case manager, the administrator, or designee, within seven (7) days of the client's admission into the community residential care facility. The Plan of Care describes the following: activities of daily living with which the client needs assistance, the medication regimen, desirable social activities, requirements and arrangements for visits by health care professionals. In addition, the Plan of Care includes provisions for monitoring the Plan by the placing agency. The Plan must outline the responsibilities of the placing agency and the facility in meeting the client's needs. The client's ability to sign admission forms does not relieve the Department of the responsibility for developing the Plan of Care.

The Plan must be completed in CAPSS under the Service Plan tab or written on the **Service Agreement Attachment** (DSS Form 15103A) and uploaded into the electronic case file. The client, the facility administrator, or designee, and the case manager will agree to the tasks, etc. to be recorded on the Service Plan/Service Agreement and each will sign it. The administrator will sign in the space under the client's signature. The case manager will return a Xerox copy of the Service Plan/Service Agreement to the administrator for filing in the client's record at the facility. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 3, Treatment Services Policy, Section 337, entitled **THE SERVICE PLAN** for further guidance and direction.

Should a designated representative be obtained for the client after the client is placed, the representative may assume responsibility for monitoring the Plan. The APS case manager may then notify the facility in writing that the agency will no longer participate in reviewing or monitoring the Plan as the representative has agreed to assume this responsibility.

437 DISPOSAL OF PERSONAL AND REAL PROPERTY

When the agency has determined that a vulnerable adult who is in the legal custody of DSS is not expected to return to independent living in the community or residing in the community with the assistance of a caregiver, a decision must be made on how to dispose of the personal property that is not allowed to go to the long term placement resource with the vulnerable adult. This policy does not apply to the situation in which the vulnerable adult has someone who holds a power of attorney or where the vulnerable adult has a probate court guardian or conservator. A vulnerable adult, with the help of family and friends, can make arrangements to dispose of the vulnerable adult's personal property. However, in some cases no one is available to help the vulnerable adult and it becomes the responsibility of the case manager/supervisor to assist the vulnerable adult in disposing of the items. In these situations, the case manager/supervisor will adhere to the following procedures:

Vulnerable adult is not in DSS custody

In situations where DSS is providing protective services to a vulnerable adult and the client is not in DSS custody, DSS shall not assume responsibility for the disposal of the client's property. If the client is able to make decisions about the disposition of the client's property, the case manager may facilitate disposing of the property in accordance with the client's wishes. *Note: Where it is apparent during the agency's provision of protective services that the client's health is deteriorating, the client may need to be placed in a facility and the possibility of returning home or to the community is remote, as soon as possible, the case manager/supervisor should initiate a conversation with the vulnerable adult about the disposal of the property.*

If the client is unable to make decisions regarding the disposal of his/her property, the case manager should determine if the client has a family member who is willing to assume the responsibility. The case manager must document in CAPSS the client's decision to allow that family member to dispose of the client's property. Since DSS is not responsible for disposing of the property, DSS does not need to inventory the property.

Vulnerable adult is in DSS Custody

In situations where DSS has custody of the vulnerable adult:

1. The case manager/supervisor will ensure that the vulnerable adult is in the legal custody of the agency. The court order granting custody to the agency must be included in the client's file. Case dictation must reflect the reason(s) for the belief that the vulnerable adult will not be able to or is unlikely to return to his/her home/community. Reference to medical documentation should be included in the dictation
2. The case manager/supervisor will make every effort to determine the client's wishes regarding the property and document such efforts. The case manager shall offer the client's family court attorney and the client's Guardian Ad Litem (GAL) the opportunity to participate in those discussions and document those conversations. When the case manager determines the client's wishes, the case manager must have the client document his/her wishes in writing or by signing the case manager's notation. The case manager will communicate the client's wishes to the client's attorney and the GAL.
3. If the client is unable to direct the disposition of his/her property, the case manager/supervisor must ask the client if the client wishes to designate someone, such as a close family member, to assist with the disposal of the vulnerable adult's personal property. The case manager shall offer the client's attorney and the GAL the opportunity to participate in those discussions. If the vulnerable adult designates a suitable person to dispose of the personal property and that person agrees to assume responsibility, the case manager should have the client document in writing the name of the chosen individual. The case manager should notify the client's attorney and the GAL in writing. If the vulnerable adult is unable or declines to identify a suitable person, the case manager notifies the client's attorney and the client's GAL of this fact as well.
4. If the client is unable to dispose of his/her property and no suitable designee is identified, the case manager/supervisor is responsible for having the client's property and assets inventoried. The case manager shall provide written notice to the client's attorney and the GAL before the date of inventory and invite them to witness the inventory.
5. The case manager will make an inventory of the property in the presence of a witness. **In all instances** in which DSS conducts the inventory, a witness must be present throughout the inventory process. The witness shall not be an employee of DSS or relative of a DSS employee. The case manager and the witness will sign and date the inventory sheet. The inventory sheet must be placed in the client's file.
6. The case manager's dictation in CAPSS must also reflect the case activity regarding disposal of the client's property.
7. In limited circumstances, such as when the client's personal property is sizable or of unusually high value, the county director with the approval of the Adult Advocacy Division at the state office may contract with a third-party entity to provide inventory services. The results of the inventory shall be included in the client's file.
8. The case manager/supervisor will **not** sell or arrange for the sale of the vulnerable adult's property. The case manager/supervisor may refer to a financial services agency to assist with stabilizing the vulnerable adult's financial status until long term financial arrangements are secured. In the alternative, see the provisions below regarding involvement of the probate court.
9. When the inventory indicates that the client's assets consist only of personal property valued at less than $2500, the case manager shall conduct a staffing with the DSS county

attorney and the attorney shall petition the family court to allow DSS to assume responsibility for disposing of the vulnerable adult's property. Upon receipt of a court order allowing the disposal of the vulnerable adult's assets, the county director, with the approval of the Adult Advocacy Division at the state office, may contract with a third-party entity to dispose of the property. All proceeds not paid to the third party entity for disposal services should go toward the client's placement expenses. The case manager's dictation must reflect the case activity regarding disposal of the client's property, including the use of the third-party entity.

Note: If the case is still pending in family court, the vulnerable adult's attorney and GAL shall be informed of the manner in which the vulnerable adult's property was disposed.

When the inventory indicates that the client's assets consist of personal property valued at $2500 or above or when the client's assets include real property, such as a house and including rental property, or other titled property (such as vehicles, campers, boats) the case manager shall conduct a staffing with the DSS county attorney who shall determine whether it is appropriate for him/her to initiate a probate action for appointment of conservator to manage and/or dispose of the vulnerable adult's assets or whether a non-DSS attorney should be secured in accordance with the "Purchased Legal Services" policy as referenced below.

10. The Adult Protective Services Policy and Procedure Manual, Chapter 3, Treatment Services Policy, Section 346, entitled **GUARDIANSHIPS AND CONSERVATORSHIPS** references protective proceedings in the probate court. This section states that the probate court may appoint a conservator to manage the financial affairs of an incapacitated adult and/or appoint a guardian to manage the custodial affairs of the incapacitated adult. Both the guardian and conservator may be removed by the court if good cause is demonstrated in a hearing.

    Note: It is not appropriate for DSS staff or county offices to serve as conservators or guardians of clients. It would be appropriate for DSS staff to facilitate the appointment of a trusted relative or friend of the client. Conservators must make annual reports to the probate court.

    If the case manager/supervisor believes the vulnerable adult is in need of a probate court conservator or guardian, the case should be staffed with the DSS county attorney. If there is a need for probate court involvement, the probate court matter is separate and apart from the APS family court case.

    According to the Adult Protective Services Policy and Procedure Manual, Chapter 6, Emergency Fund Services, Section 622, entitled **PURCHASED LEGAL SERVICES**, the Adult Protective Services' Emergency Fund can be used to secure legal representation for the vulnerable adult/incapacitated person in a probate court proceeding. The attorney retained in this situation represents the vulnerable adult/incapacitated person, not DSS. Prior approval must be obtained from the Adult Advocacy Division at the state office before the attorney begins work on the case. The Agreement for Legal Services Form (DSS Form 3060) is used to secure prior approval from the Adult Advocacy Division. This form and instructions are found in the Master

Forms Index on the Intranet.

Note:

The DSS county attorney, not the case manager/supervisor, is responsible for securing representation for the vulnerable adult in a probate court proceeding under the Purchased Legal Services Agreement. However, the case manager/supervisor may assist by completing Form 3060.

11. Information regarding the payment of non-DSS attorneys to represent incapacitated persons in probate court proceedings is found in the Adult Protective Services Policy and Procedure Manual, Chapter 6, Emergency Fund Services, Section 623, entitled **ATTORNEY FEES**. This section sets forth the hourly rate at which the attorney will be paid for services rendered for the vulnerable adult/incapacitated person in probate court. It also sets forth the legal expenses that will be reimbursed for the representation as well as the DSS forms that are required to be completed.
12. Case managers/supervisors should not manage the vulnerable adult's money or financial assets. However, when a vulnerable adult is in protective custody, the agency can petition the family court for temporary access to a client's finances for the purpose of ensuring that the vulnerable adult's funds are redirected to his/her placement resource. Additionally, special consideration should be given if there is a need for the agency to use the client's funds to pay his/her mortgage, property taxes or insurance premiums, until long term financial measures are secured through the client's designated relative, a conservator or a guardian.

438 PLACEMENT IN ANOTHER COUNTY

Applications for Medicaid, Optional Supplement, and Social Services are taken by the county office where the client resides. If the client is placed in another county, the economic services case is transferred to the county office where the client resides in the facility. The Adult Services case will also be transferred if DSS does not have custody and the client will need services while in the facility. Plan of Care cases not involving custody will be transferred. A staffing with the supervisor must be completed via telephone and/or in-person, the **Case Transfer and/or Case Staffing** (DSS Form 3062) must be completed, the case file must be in the appropriate order, and all dictation in CAPSS must be up to date before the case is transferred to another DSS county office. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 2, Investigations Policy, Section 237, entitled **TRANSFER STAFFING TO ANOTHER COUNTY** for further guidance.

439 PLACEMENT OF A CLIENT IN A LICENSED FACILITY OUT OF STATE

It is recommended that we assess all placements within South Carolina, and within the vicinity where the client has family, friends, and community support systems. **Placing a client out of state in which he/she has no family ties is a last option.**

This section describes the process for an out of state placement of a client:

1. The case manager should re-evaluate the need(s) of the client to ensure that proper care and treatment is necessary to relocate the client out of state.

2. The APS case manager should determine if the placement is appropriate and be familiar with the regulatory provisions set forth by the receiving state.
3. The Plan of Care should be updated and staffed with the county supervisor and county attorney.
4. If the county determines that the planned re-location is in the best interest of the client, then the case manager should discuss the Plan of Care with the client, family, and the facility administrator or designee of the receiving state.
5. The county attorney should petition the court to seek relinquishment of custody, relief of providing services, and request case closure. Once the court order has been signed and dated by the judge, the case manager should proceed to finalize the relocation plans for the client.
6. The case manager must make sure there is an active payer source (Medicare and/or Medicaid Application completed and income resources re-directed) in place for the client being placed out-of-state. The case cannot be closed until an active payer source has been identified and in place.
7. Once the case is legally closed the case manager should update and close the case in CAPSS if there are no financial obligations pending. Cases should not be closed until financial obligations are resolved.

440 SERVICES TO CLIENTS IN FACILITIES

Services to clients in community residential care facilities will be guided by the activities agreed upon and recorded on the Plan of Care. When clients are placed in nursing homes, the case is closed after a time is allowed for the client's adjustment (minimum of 3 months and an active payer source is in place) and for the agency to conclude any business being conducted on the client's behalf. However, cases will not be closed if DSS has custody or is under a court order to provide a particular service to the client. This procedure outlines activities engaged in prior to the placement of a client. Refer to Chapter 4, Placement Services Policy, Section 432, entitled **PRE-PLACEMENT REQUIREMENTS**.

APS Case Manager Responsibilities

1. If client is believed to need nursing home care, secures a level of care determination from Community Long Term Care.

2. Assists client or relatives in completing necessary applications for financial assistance (OSS or NH Medicaid). The case manager may need to complete the application for the client. Note: The case manager can become the client's Medicaid representative if the client is in agreement with this and must complete the **Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals** (DHHS Form 1282).

3. If client needs placement in a community residential care facility rather than a nursing home, assists the client in securing a medical statement.

4. Takes client who needs residential care placement to visit residential care facilities if no friends or relatives are able to accompany him/her.

5. Arranges for client to be transported to the selected facility or transports client if no friends or relatives are available.

6. If client was placed in a residential care facility without friends or relatives being actively involved, develops a Plan of Care with the client and facility administrator or designee.

7. Monitors Plan of Care for clients in residential care facilities who are under DSS care.

8. Closes case on client placed in a nursing home after a period of adjustment (minimum of 3 months) if the client is not in custody.

- Case manager should have monthly contacts with the facility to monitor the placement;
- Needs of the client must be documented in the Needs Assessment.
- Service needs must be transferred to the client's Service Plan and include objectives for the client, specific duties/services to be provided by the facility-through referral, and time frames and any special arrangements.
- Service needs should be for a specific time frame to be accomplished before the case is closed.
- Monthly contact with the facility administrator, facility social worker and/or medical staff, the client and service providers must be made during this 3 month period.
- If the client's income has not been redirected or the Medicaid has not been approved during this 3 month monitoring period the case CANNOT be closed in CAPSS or transferred to another county until the financial arrangements have been made and in place for the facility to receive payment.
- If the client is placed by a family member and the agency has an open case on the client, the case manager must ensure that the financial arrangements are made and there is an active payer source (Medicaid/Medicare) in place for the facility to be paid before case closure.
- Documentation must be entered in CAPSS to show that the case manager made collateral contact with the facility administrator and responsible family member in reference to the client's financial arrangements on how the facility will be paid.

441 RELOCATION GUIDELINES FOR COMMUNITY RESIDENTIAL CARE FACILITY (CRCF) RESIDENTS

The following guidelines are provided for agencies to assist residents of community residential care facilities (CRCF) in relocating when the CRCF closes (these guidelines do not apply in emergency and imminent danger closures). These agencies are the Department of Health and Environmental Control (DHEC), the Department of Health and Human Services (DHHS), the Department of Social Services (DSS), the Department of Mental Health (DMH), and the Department of Disabilities and Special Needs (DDSN) and the State Long Term Care Ombudsman (SLTCO). The guidelines were developed to enhance communication, provide a coordinated response in relocation situations and to outline the duties and responsibilities of agencies in meeting the needs of these vulnerable adults. This protocol does not replace agencies' internal policies and procedures for addressing the needs of residents in emergency and imminent danger situations. It provides for interagency communication and a coordinated response when residents need assistance to be moved.

These guidelines have been put into place in an effort to ensure that the rights of the residents, including the right to free, informed choice of placement and to be fully informed in matters concerning them, are protected.

NOTE: In all relocation situations, it is the professional ethical and moral responsibility of agency staff: 1) to assume responsibility and to take actions to protect residents when problem situations are encountered in CRCFs; 2) to assist any resident of a CRCF whether the resident was placed by an agency involved, by the resident him/herself or with assistance from another source; and 3) to assist any resident regardless of the resident's income or payment source for residential care. It is the responsibility of staff to protect and to meet the needs of all vulnerable adult residents and to be supported by their agencies in carrying out their professional ethical and moral responsibilities. Further, agencies placing clients in CRCFs should place only in facilities that are licensed and in good standing as defined by DHEC's Division of Health Licensing.

These relocation guidelines should be utilized in conjunction with the closure, notification of closure or potential closure of a CRCF by an owner/operator, when circumstances may exist which could jeopardize the health and well-being of residents, when financial circumstances exist which may place residents at risk of relocation or at any other time an agency believes it may be in the best interests of residents to move. (These guidelines do not replace those guidelines which apply in cases of facility violations or licensing violations/problems).

442 ROLES AND RESPONSIBILITIES OF COMMUNITY AGENCIES DURING RELOCATION OF RESIDENTS FROM CLOSED FACILITIES

A Relocation Oversight Committee (ROC) will be established and will be comprised of the State Long Term Care Ombudsman (SLTCO); DHHS Optional State Supplementation (OSS) program representative, Community Long Term Care (CLTC) program representative, Integrated Personal Care (IPC) program representative and Medicaid eligibility program representative; DHEC Division of Health Licensing (DHL) representative; DMH and DDSN representative; and representatives from the DSS state office for Adult Protective Services. A Relocation Team to

conduct the resident relocation activities will be established by the Relocation Oversight Committee and will be led by the State or Regional Long Term Care Ombudsman.

The Relocation Oversight Committee (ROC) may be convened in the following circumstances:

1. DHEC may convene the ROC upon notification that a CRCF is to be or may closed;
2. Any of the other agencies upon notification that a CRCF is to be or may be closed;
3. The ROC will be convened in either a face to face meeting or via telephone conference when notified that DHEC has sent a letter indicating that a facility with more than 15 residents is no longer in good standing with DHEC and/or when any member of the committee or staff has received notification that a facility with more than 15 residents may be closed;
4. DHHS OSS staff when a facility's OSS participation has been terminated or when OSS holds the check or funds for some other reason;
5. State Long Term Care Ombudsman upon notification that a CRCF is to be or may closed;
6. Any agency when circumstances may exist which could jeopardize the health and well-being of residents or financial circumstances exist which may place residents at risk of relocation.

The Relocation Oversight Committee (ROC) will develop a checklist of activities to be completed and identify appropriate agency assignments. Agency assignments should include the following:

- The Relocation Team should meet with the administrator of the facility as soon as possible to outline/remind the administrator of his/her responsibilities to residents in terms of care and relocation, the existence and purpose of the ROC and team, etc.
- Determination of OSS status: DHHS.
- Direct contact with residents and residents' families: sponsoring agencies (DMH, DDSN, DSS, and Ombudsman).
- Determine if on-site coordination is required and notify the ROC so the ROC can agree upon an on-site lead agency and plan.
- Determine if ROC should be asked to form an emergency team; creation of an emergency team may be triggered by 1) the size of facility balanced by the experience and/or good performance of administrator (15 or more residents alert will go to ROC); 2) conditions of facility and/or staffing; 3) diagnosis and/or care needs of residents (ex. number with mental illness, number meeting nursing home level of care, etc.); 4) OSS/Category 85 residents; 5) number of residents without family supports , responsible parties or other supports; 6) if the facility is experiencing change in ownership, operational control or financial difficulties which could cause confusion in management to the extent if affects daily operations; 7) history of administrator (licensure history, experience of agencies with administrator over time, etc.); 8) law enforcement has been called to the facility; 9) any other situation or condition which could severely impact the health and/or safety or violate the rights of the residents. ROC will convene either face-to-face or via conference call to decide if emergency

team should be formed; person/agency recommending emergency team shall be allowed to present basis for team. If ROC decides not to form an emergency team at that time, it may reconsider this decision at any time, especially if conditions at the facility worsen. Likewise, if a team is formed and it becomes apparent that a team is not needed, it can be disbanded by the ROC. The emergency team will provide on-going reports back to ROC. The emergency team will consist of agencies with residents in the facility, the Ombudsman, DHHS, P&A and DSS. Leadership of the team will rotate by the percentage of involvement of an agency (number of residents served) payment source or combination thereof or number of residents in need of level of care determinations or who lack family supports or responsible parties.

- Notify local law enforcement that the facility may or is closing, if appropriate.
- Verify appropriateness of placement, referrals for level of care assessment for nursing home or other care options: Relocation Team.
- Notify Protection and Advocacy for People with Disabilities to protect the rights of resident: Relocation Team or sponsor.
- File appropriate complaints, regarding problems at the facility or with the administrator with LLR.
- Complete assessment for level of care determination: CLTC.
- Develop a check list to ensure that the resident satisfies all requirements (ex. Medical exams/tests such as tuberculin screening or physical examinations, Medicare coverage, etc.) and has all information needed (ex. Personal needs allowance records, representative payee, etc.) for relocation or transfer: Sponsor and Relocation Team.
- Assist in finding services at neighboring facilities: Sponsor and Relocation Team.
- Assist with inventory, packing and transfer of residents' belongings: Sponsor and Relocation Team.
- Assure that no resident is moved out of state (especially a SC Medicaid recipient) unless there is a comprehensive explanation of the repercussions which may be encountered in regards to transfer of Medicaid, service providers, etc.
- Ensure appropriate transfer of residents' medical records, medications, Medicaid cards, etc., to new facility: Sponsor and Relocation Team.
- Assist in coordinating residents' transportation to the new facility: Sponsor and Relocation Team.
- Notify the Social Security Administration concerning the actions taken for transferring residents. The notification will include the name and address of the facility and its administrator, a list of residents to be moved, and the addresses of the new facilities. The Social Security Administration will notify the facility to officially instruct the facility administrator to forward the resident's SSA/SSI checks, refunds, etc., to the client's new location/facility. When facility operators fail to forward resident's funds, the State Long Term Care Ombudsman should report to law enforcement; DHEC Division of Health Licensing; Department of Labor, Licensing and Regulation; Board of Long Term Health Care Administrators; the Social Security Administration; and the State Attorney General's Office: Ombudsman.

- The Ombudsman or the sponsoring agency will follow-up with each resident after the relocation is complete and will notify the Relocation Team or Committee if there are problems or concerns with the new placement.
- Protection and Advocacy will convene the Relocation Oversight Committee after relocation if Protection and Advocacy believes there are problems or concerns with the relocation or the new placement of any of the residents.

The Protocol for the relocation of residents will be determined on a case –by-case basis. The protocol will consist of the following:

- The Regional Long Term Care Ombudsman will obtain a complete onsite census of the facility with a face sheet that reflects responsible party and the address and telephone of the responsible party, and will ensure that the Relocation Team receives the census and face sheet. Confidential information concerning residents, such as full name, Medicaid number and other identifying information will not be shared via email.

- The Relocation Team or the resident's sponsor will ensure that the facility and/or the responsible party are informed of the resident's relocation rights and status. This communication will be made via letter form. NOTE: Regardless of case status, the county DSS office that placed a client in a facility in another county is responsible for that client and will provide assistance with relocation and meeting the client's needs.
- The Relocation Team will be responsible for assisting residents with no agency sponsor in choice of appropriate and desired placement.

- An on-site visit may be made by members of the Relocation Team.

- Any time there is need for immediate action, a member of the Relocation Team may contact DHEC and nay other appropriate agency for assistance. Any member of the Relocation Team may also notify the Relocation Oversight Committee or request that the Relocation Oversight Committee be reconvened.

- Any agency which helps in the relocation of a resident will notify the Relocation Oversight Committee as each resident is moved and will provide the new address and phone number for each resident so that appropriate follow-up may be done (including ensuring that all property and benefits of the resident have moved with the resident).

When appropriate, all state agencies will notify their divisions/departments and subordinate entities, and may also notify their counterparts in surrounding states, of actions taken or closures so that those entities or states will not refer clients to the facility from which residents were relocated. Agencies are also encouraged to notify hospitals and/or other entities or persons who make referrals or placements to the facility in question. Final: March 19, 2007.

Referenced Documents:
S.C. Code of Laws, Title 43, Chapter 35: Omnibus Adult Protection Act
Adult Services Policies and Procedures Manual (7/1/1996)
http://www.scdhec.gov/hr/licen/hlpwe.htm
S.C. Code of Laws, Title 44, Chapter 7
Service Agreement Attachment (DSS Form 15103A)
Agreement for Use of Legal Services (DSS Form 3060)
Attorney Time Sheet (DSS Form 1507)
Case Transfer and/or Staffing (DSS Form 3062)
Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications/Reviews and Appeals (SC DHHS Form 1282)
Relocation Guidelines for Community Residential Care Facility (CRCF) Residents (3/19/2007)

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 5, Resource and Referral Services
Revision Number: 17-05 **Effective Date: 10/30/17**

Review Date: 12/15/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 5, Resource and Referral Services
Revision Number: 17-05 **Effective Date: 10/30/17**

Review Date: 12/15/2017

---

500 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. The Adult Protective Services (APS) Program has the responsibility to provide Protective Services, otherwise known as Treatment Services to persons who have been deemed as a vulnerable adult in need of protection. After a thorough Needs Assessment has identified the risk and safety factors and an individualized Service Plan has been developed, services will be coordinated by the APS case manager by identifying resources and making referrals to service providers.

AUTHORITY. S.C. Code of Laws, SECTION 43-35-45 (E) stipulates that at the hearing on the merits, the court may order the Adult Protective Services program to provide protective services if it finds that:
(1) the vulnerable adult is at substantial risk of being or has been abused, neglected, or exploited and the vulnerable adult is unable to protect herself or himself; and
(2) Protective Services are necessary to protect the vulnerable adult from the substantial risk of or from abuse, neglect, or exploitation.

PURPOSE. The purpose of this chapter on Resource and Referral Services is to assist the APS case manager on how to procure resources and make appropriate referrals to service providers to ensure that the vulnerable adult receives appropriate services to minimize the risks of abuse, neglect and exploitation.

INTENT. It is the intent of the Adult Protective Services Program to ensure that vulnerable adults under the care of the agency receives appropriate services that minimize risk factors that contribute to abuse, neglect and exploitation. Resource and Referral Services should be coordinated with the vulnerable adult, service providers, family members and the agency staff.

SCOPE OF RESOURCE AND REFERRAL SERVICES. The scope of Resource and Referral Services include the case manager identifying and developing resources in the community. With the participation of the vulnerable adult and family members, service providers must be sought that will address the client's needs as identified from a thorough Needs Assessment and an individualized Service Plan. This chapter assists the APS case manager with the dynamics of how to build Community Partnerships, how to develop active local resource logs, and how to make appropriate referrals to service providers.

510 INTRODUCTION

County APS case managers and supervisors are responsible for being knowledgeable about community, state and federal resources in their local area. They will maintain cooperative relationships with community partners and service providers to assure maximum use is made of all local resources. Each county APS office is responsible for maintaining a file of all known resources in their county. Case managers will also be knowledgeable about the services that are offered by the Department of Social Services. To know which resource or service would benefit the client, the case manager must have complete knowledge of the client's situation which is gained through a thorough Needs Assessment. Clients will come to our Division with a variety of risk and safety issues. The Adult Protective Services Program will offer temporary assistance until long term community services are secured.

520 POLICIES

521 IDENTIFYING RESOURCES

In planning for the vulnerable adult, service options may be limited. The APS staff (case manager and supervisor) must have a thorough knowledge of all available resources. They must know what is actually offered in terms of everyday living, routines and personal care. Also, the county case managers can assist with helping to measure the impact and effectiveness of community resources whether existing or newly created. One way to identify community resources is to have staff, in group discussions and serious study, look at the community, its people, organizations and resources, to see what is available and how these resources can be used to the best advantage for the vulnerable adult. Many benefits can be received from discovery of new resources and communities frequently find that bringing risk and safety issues to the attention of the public or certain parts of the public sets in motion the action needed to improve or correct the situation. Knowledge of existing resources can be gained through Interagency/Multi-Agency Inter-Disciplinary Staffings. Refer to Adult Protective Services Policy and Procedure Manual, Chapter 2, Investigations Policy, Section 239, entitled **INTERAGENCY/MULTI-AGENCY INTER-DISCIPLINARY STAFFING** for further guidance. Soliciting ideas from client groups as to what they see as resources can also be helpful. Other possibilities for identifying resources may include studying how other communities have found resources for meeting needs of clients with similar problems and searching the internet.

522 THE RESOURCE FILE

A Resource File is indispensable if the Department is to help clients take full advantage of the services and facilities available in the community. The Resource File should be organized and kept up to date. Each county office is responsible for making available to its staff, resource directories which will inform staff members of services offered on state, regional and local levels. This might involve directories of nearby counties and regions, as well as those applicable only to the county or community concerned, since the area in which different services are available will vary considerably and services provided in one area might also be available to counties many miles away. Supervisors should see that service workers are familiar with the directories and know how

to use them. Directories should be kept up to date, substituting new ones for old and making changes as new information is received. These directories may be a part of or used in conjunction with the Resource File.

523 RESOURCE UTILIZATION

It may be found that some resources are used extensively while others are rarely, if ever, used. This can create the impression on the part of the latter group that the need for their help is non-existent or very small, while too many demands may cause a resource to "dry up." Some review of referrals and utilization of resources should be made from time to time in order to avoid overworking some resources and to make widespread use of all resources available.

524 BASIC PRINCIPALS OF MAKING REFERRALS

Case managers will not provide direct services other than case management; however, he/she must know where to get the needed services from and how to make referrals to obtain the services for the vulnerable adult.
Once it has been determined through the Needs Assessment and the Service Plan what services the vulnerable adult is in need of, the case manager must locate the resource(s) and make referral(s) to the service provider(s) on behalf of the vulnerable adult.

APS Case Manager Responsibilities:

1. Case manager and client determines which problem is most important.
2. Determines eligibility for services.
3. Determines client's SSBG eligibility.
4. Determines which provider/resource has service(s) most appropriate to meet client's particular needs.
5. Identifies and contacts provider/resource to confirm availability of service(s) for client.
6. Describes what the provider/resource has to offer to the client and encourages the client to accept the service(s).
7. Secure long term resource and makes referral for services.
8. With client's permission, provides information about individual to the agency or organization which will be helpful in the provision of service(s).
9. Determines if client needs transportation to access services. If necessary, assists in providing or arranging for transportation services.
10. Follows up on referral to ensure that client receives appropriate services from provider/resource.

525 RESPONSIBILITIES OF THE APS CASE MANAGER

The APS case manager have the following responsibilities in serving clients:

1. Assist the client in exploring possible solutions to problems;
2. Help the client to decide which problem needs an immediate solution;

3. Inform the client of the appropriate services within the Department, community or state which may be available to him/her. This includes Department provided services such as Food Stamps, Medical Assistance, Aid to Families with Dependent Children, etc.;
4. Discuss with the client the services and agency to which he will be referred for services;
5. With the client's permission, make referrals to the appropriate agency, community, and state resources;
6. Explain in detail to-the client why the information about him/her that will be shared with service providers is required and needed;
7. Explain to the client the agency's role and involvement in the services to which he/she is being referred.

Referenced Documents:

Adult Protective Services Policy and Procedure Manual (11/18/2002)

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 6, Emergency Fund Services
Revision Number: 17-06 Effective Date: 12/23/2017

Review Date: 12/23/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 6, Emergency Fund Services
Revision Number: 17-06 Effective Date: 12/23/2017

Review Date: 12/23/2017

600 PURPOSE AND SCOPE OF PROGRAM:

RESPONSIBILITY. It is the responsibility of the Adult Protective Services (APS) Program to promote the safety and well-being of the vulnerable adults in the care of the agency.

AUTHORITY. According to S.C. Code of Laws Section 43-35-40 (E), the APS Program may be required by court order to provide protective services to a vulnerable adult who is unable to protect or provide care for himself/herself. While providing this protection, it may be necessary for the APS Program to make emergency financial provisions to ensure the safety and well-being of the vulnerable adult until long term community services are secured.

PURPOSE. The purpose of Emergency Fund Services is to provide stability and safety for vulnerable adults in the care and custody of the agency who are unable to provide financial resources to obtain temporary services.

INTENT. The intent of Emergency Fund Services is to provide temporary emergency financial assistance for vulnerable adults in the care of the agency until long term financial resources are secured.

SCOPE OF THE EMERGENCY FUND SERVICES. The scope of Emergency Fund Services include procedures for obtaining Emergency Funds. This chapter outlines how to obtain homemaker and sitter services. Procedures for procuring probate court fees, other fees and services are outlined herein.

610 INTRODUCTION

The Adult Protective Services Emergency Fund may be used to purchase services when resources needed to secure the services are not otherwise available to the vulnerable adult. A variety of bills may be paid on behalf of the client. However, the Emergency Fund cannot be used to purchase long term placements, pay hospital bills nor any services funded by an existing pay source that's already available to the client.

The Emergency Fund budget is limited and it is not intended to provide long term financial support to the client. Community resources and the client's income and resources must be used before a request is made for emergency funds. The case manager must ensure that applications such as Medicaid have been completed and submitted for benefits the client is not receiving but may be eligible for. The case manager is responsible for assessing all financial resources that may exist before requesting emergency funding. The case manager should interview the client/collaterals to verify what financial resources may be available. Examples are Veteran's Allotment, Social Security, Railroad Retirement, Disability, etc.

Requests for reimbursement for transportation, hotel provisions and food for the vulnerable adult must be requested separately from homemaker or sitter services.

620 PRIOR APPROVAL TO ACCESS THE EMERGENCY FUND

Prior approval must be received from the Adult Advocacy Division in the state office to access the Emergency Fund. When requesting prior approval, it will be necessary to explain the circumstances of the situation including the following: Why is it an Adult Protective Service case? Why is it an emergency? What resources are available now? What is the plan for future payment for bills? Did the county APS staff gather information about the client's income, follow through with the seventy-two (72) hour hearing and include in the petition the appropriate language in order to obtain temporary access to the client's funds for his/her care?

Responsibilities of the APS Case Manager

1. Contact your regional APS performance coach via e-mail explaining what the emergency entails (a summary/statement of the situation) and the amount of the funds requested.
2. After the case manager or APS supervisor has had a discussion with his/her APS performance coach in reference to the specifics of the case situation, the case manager completes at least the top portion of the **Request For Payment Authorization Adult Protective Services Emergency Fund** (DSS Form 1577).
3. Forward the DSS Form 1577 attached with the prior approval e-mail request to the APS performance coach at the Adult Advocacy Division at the state office. No signature is required on the form for pre-approval.

All of the DSS forms mentioned in the Adult Protective Services Policy and Procedure Manual can be located with instructions in the Master Forms Index on the Intranet on the DSS Unite page.

621 SECURING THE EMERGENCY FUND REQUEST

The case manager must immediately follow up with the request for emergency funds by enacting the following instructions:

1. Within thirty (30) to sixty (60) days, the DSS Form 1577 must be updated because some of the requested information may not have been available at the initial submission of the DSS Form 1577. At this time, all of the required blank fields must be completed with all required signatures.

2. Information such as W-9 Tax ID, invoice, receipts, etc. must be submitted along with the updated DSS Form 1577.
3. The DSS Form 1577 must be uploaded to "Linked Files" for each client in CAPSS.

622 PURCHASED LEGAL SERVICES

The Adult Protective Services Emergency Fund may be used to provide legal representation before and during a court hearing concerning the safety of Adult Protective Services clients.

The attorney engaged represents the adult, not DSS. The proceedings usually are probate court hearings. Prior approval must be secured from the regional APS performance coach at the Adult Advocacy Division in the state office before the attorney begins work on the case. **Agreement for the Use of Legal Services** (DSS Form 3060) is used to secure prior approval.

623 ATTORNEY FEES

Attorneys are paid an hourly rate not to exceed the current hourly rate approved by the South Carolina Attorney General based upon that attorney's years of experience. The current fee structure as set out by the Attorney General's Office is:

Attorneys with 10 or more years of experience up to $150.00 per hour

Attorneys with 6 – 9 years of experience up to $110.00 per hour

Attorneys with 3 – 5 years of experience up to $90.00 per hour

Attorneys with up to 3 years of experience up to $80.00 per hour

In addition to the fee, certain expenses such as filing fees may be paid. The attorney will complete the **Attorney Time Sheet** (DSS Form 1507) after the work on the case is finished. All fees must be thoroughly documented on the DSS Form 1507. The completed DSS Form 1507 must be sent to the APS performance coach at the Adult Advocacy Division at the state office.

624 REPAYMENT OF EMERGENCY FUNDS

The client or the estate of the client may be required to reimburse the Emergency Fund for third party payments made on behalf of the client. Staff should request this language or similar language in all court petitions.

625 THE HOMEMAKER SERVICES PROGRAM

The Homemaker Services Program provides in-home services to eligible citizens of South Carolina. Homemaker services include a variety of in-home services geared to individual client needs. Frail elderly and disabled individuals are often unable to manage normal household chores such as grocery shopping, meal preparation and light housework. Without homemaker services, the clients would be forced to seek alternative living arrangements or be placed in a facility.

Through homemaker services, families receive valuable assistance in learning to manage households and budgeting.

Where abuse, neglect, or exploitation of adults is suspected or known, the homemaker may be of valuable assistance to the family and case manager in determining whether the home situation can be improved, other problems alleviated or whether the agency should consider alternative methods of care and protection.

No person shall be excluded from receiving homemaker services on the grounds of race, color, national origin, or religion. No qualified disabled individual shall, solely by reason of his/her disability, be excluded from the participation in, be denied the benefit of, or be subjected to discrimination under this program.

All persons receiving homemaker services must have an open APS Treatment Services case in CAPSS.

626 THE PRIMARY GOALS OF THE HOMEMAKER SERVICES PROGRAM

The primary goals of the Homemaker Services Program are to provide those services (free of charge to the clients) needed to assure adequate individual and/or family functioning by:

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency and out of home placement;

2. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

3. Preventing or remedying neglect, abuse or exploitation of adults unable to protect their own interests;

4. Preventing or reducing inappropriate institutional care by providing home-based care;

5. Providing services to individuals while awaiting referral or admission for institutional care.

627 THE HOMEMAKER'S ROLE

The role of the homemaker as a member of the service team may be one or more of the following:

1. Supplementing or taking over some of the duties of an overburdened family member when the demands of one member result in undue stress;

2. Protecting, or through her service, assisting in the identifying and correcting of hazardous living conditions;

3. Supporting, or through encouragement, helping clients maintain their own homes;

4. Teaching or through demonstration, assisting family members to continue or improve standards of living and increase understanding of responsibilities;

5. Motivating, or stimulating clients to make better use of what limited resources they have to meet their needs.

628 INITIATING HOMEMAKER SERVICES

The Department of Social Services employs homemakers and contracts with Qualified Licensed Providers to provide homemaker services.

The case manager is responsible for determining eligibility for homemaker services, providing a service plan which will include objectives for homemaker services related to each client's individual needs. The decision to use homemaker services in a given situation must be made objectively between the homemaker supervisor, which may be the APS supervisor and the APS case manager and should include assessment of the following:

1. The amount and kind of services needed to achieve the service goals;
2. The nature and degree of social problems in the situation;
3. The nature and degree of the individual's illness, disability, or infirmity, if any;
4. The extent to which the family or responsible person can and should retain responsibility;
5. The effect homemaker services will have on all members of the household and comparison of homemaker services with other possible plans.
6. Expected completion date of services.

If using a DSS homemaker, the case manager is also responsible for filling out **Request for Homemaker Services (**DSS Form 1537).

If using a contracted homemaker, the case manager is responsible for securing prior approval for homemaker services. The request must be in writing and the approval must be in writing from the Adult Advocacy Division in the state office before securing a contracted homemaker. The services provided by the contracted homemaker must be entered in CAPSS.

629 EXPLANATION TO THE CLIENT

When the decision has been made to offer homemaker services, the case manager explains the services to the client. If the client is not in a position to make a decision to accept homemaker services, the explanation is made to someone who can act in the vulnerable adult’s behalf.

630 THE TEAM CONFERENCE

After the APS case manager explains the service to the client or his/her representative and services for the client is agreed upon, the homemaker supervisor assigns a homemaker and a team conference is held. The team members are the case manager, the homemaker, the homemaker supervisor and the APS supervisor. The team conference will take into consideration the kinds of services needed for the vulnerable adult and the skills of the homemaker, the length and frequency of visits, the types of problems involved, goals established for the individual being served and distances traveled.

Responsibilities of the APS Staff

APS Case Manager

1. Presents to the homemaker an explanation of the client's situation and the service plan.

APS Case Manager and Homemaker

2. Agree on the tentative number of visits, including the time of arrival and the number of hours of service.
   a. The length of service must be flexible to allow for termination earlier or later than initially planned;
   b. Decides the time and date of introductory visit to the client's home.

Homemaker Supervisor

3. Emphasizes that the homemaker, case manager and the homemaker supervisor must have frequent team conferences concerning services the client receives.

631 THE INTRODUCTORY VISIT

The introductory visit is essential to the success of the service. The case manager or the homemaker supervisor must accompany the homemaker on the introductory visit. During the introductory visit, every client or his/her designated representative has the opportunity to accept or reject homemaker services. The services cannot be forced on an unwilling client.

Responsibilities of the APS Staff, Vulnerable Adult and Homemaker

APS Case Manager
1. Restates explanation of homemaker services program to client. This includes the need for communication between the homemaker, case manager and the vulnerable adult.
Vulnerable Adult, APS Case Manager, Homemaker
2. Agree on the goal, objective, tasks, frequency, and number of hours of homemaker services delivery;
APS Case Manager
3. Completes **Service Agreement** (DSS Form 15103) making sure that all parties understand what is recorded on the form;
Vulnerable Adult, APS Case Manager, Homemaker
4. Sign and date the completed DSS Form 15103;
Homemaker Supervisor
5. Sign and date the original DSS Form 15103 or DSS-15103-A when he/she reviews it.

632 DUTIES OF THE HOMEMAKER

The homemaker is responsible for participating in team conferences regarding the suitability of homemaker services, working cooperatively as part of the social service team, and for performing for the client specific duties agreed on by the client, the homemaker and the case manager. Homemakers do only those things the client is not able to do for himself. Heavy seasonal cleaning is not done by homemakers. DSS homemakers are paid by the Department to provide services in homes when vulnerable adults cannot afford to pay for services. Homemakers work with the case manager as a team toward achieving objectives and goals that have been set up for helping the client. Homemakers provide services for a specific purpose. The homemaker is responsible for reporting back to the homemaker supervisor if he/she believes that an assessment from the supervisor or case manager is warranted due to neglect issues or other concerns for the well-being of the vulnerable adult.

633 SPECIFIC DUTIES

The specific duties of the Homemaker will vary with each individual service plan and will be determined in advance by the homemaker and the case manager in cooperation with the vulnerable adult and/or others who are helping to plan for the client's care. As work with the client progresses, the homemaker or the case manager may observe the need for changing the specific duties of the homemaker. Such changes should be agreed on by the case manager, the homemaker, and the vulnerable adult, or others on behalf of the client. Specific duties of the homemaker may include, but not be limited to the following:

1. Routine cleaning, sweeping, dusting, changing bed linens, defrosting and cleaning the refrigerator, cleaning the range, light laundry, ironing, mending and mopping;

2. Meal planning, marketing, preparing and service; preparation of special diets; helping the client to understand the diet prescribed, and the value of adhering to it;

3. Providing recipes and information on money saving meals and prepare ahead dishes for the vulnerable adult;

4. Providing information on wise grocery shopping and correct use of food stamps;

5. Running errands to laundromat, drugstore, to pay utility bills, etc.;

6. Doing essential shopping;

7. Helping client follow treatment prescribed by the physician;

8. Assisting client with retrieving prescribed medication from the pharmacy and delivering medicine bottles to client, but **not administering the medication** by taking medicine out of bottles and giving the client the actual dosage of medication to take;

9. Providing transportation for access to homemaker services. If transportation is provided, it should be a vital part of homemaker services, such as grocery shopping or to the laundromat;

10. Teaching the most practical methods of managing household tasks;

11. Provide assistance, motivation, and stimulation to prevent physical and/or mental deterioration;

12. Providing emotional support and encouragement to individuals and their families who are overwhelmed by catastrophic illness or disability;

13. Working a budget with the vulnerable adult to show all income and expenditures.

634 INAPPROPRIATE HOMEMAKER DUTIES

The homemaker assumes a limited role in the client's household. Duties that are inappropriate for the homemaker to provide include but are not limited to the following:

1. Repairing electrical sockets or wall outlets;

2. Mowing lawns;

3. Replacing broken windows;

4. Repairing clogged drains;

5. Washing walls or windows;

6. Care of catheters or colostomies;

7. Administering medication;

8. Changing surgical dressings;

9. Cutting fingernails or toenails;

10. Providing transportation as a main service for medical purposes;

12. Doing heavy seasonal cleaning of the house.

635 TERMINATION OF HOMEMAKER SERVICES

The decision to terminate homemaker services is the responsibility of the case manager, the homemaker and the homemaker supervisor. Matters taken into consideration include information provided by the homemaker, original tentative plans for termination, and reassessment of the Needs Assessment and the Service Plan by the APS case manager. It is appropriate to discontinue services under the following conditions:

1. The goals of the service plan in regards to homemaker services have been achieved;

2. Service being rendered by the homemaker is no longer appropriate to meet the needs of the vulnerable adult;

3. There is mutual recognition that the client is becoming unnecessarily dependent on the service, is able to manage without the service, and continuation would mitigate independent functioning;

4. Because of physical danger, contagious disease, or disrespectful treatment, the homemaker's well-being is in jeopardy;

5. The client's family becomes able to care for him/her, the client is hospitalized, or is placed in residential care.

Preparation for termination of homemaker services should be planned as carefully and thoughtfully as initiation of service and with the consensus of those involved (the client, case manager, homemaker, and the supervisor). Termination should be gradual, reducing the number of homemaker visits over a period of time; but, with a termination date set and mutually agreed on by the client, case manager and homemaker. Such an agreement should be reached before the tapering off period, and the household should be taught to adjust to assuming full responsibility when homemaker visits have been discontinued.

Responsibilities of APS Staff, Vulnerable Adult and Homemaker

Client or someone acting in his/her behalf, APS Case Manager, APS Supervisor and Homemaker

1. Discusses termination of services and reason for termination.
   a. Plans termination date;
   b. Plans start and end dates of tapering off of homemaker services.

Homemaker

2. Tapers off services until terminated.

APS Case Manager

3. Sends termination of homemaker services notice to client.

4. Records in the client's record in CAPSS the termination date and the reason for termination with comments.

636 PERSONAL CARE ASSISTANTS (PCA)/SITTER SERVICES

The Department of Social Services (DSS) has contracted with Qualified Licensed Providers to provide sitter services to prevent or remedy further abuse, neglect, or exploitation of ill, injured, impaired, disabled or aged adults who are in the custody and/or care of DSS by ensuring the

recipients' safety and health until more permanent living arrangements are secured for the recipient.

Prior approval must be made for PCA/sitter services. The request must be in writing and the approval must be in writing from the Adult Advocacy Division in the State Office before securing a sitter. When requesting prior approval, it will be necessary to explain the circumstances of the situation including the following: reason for open Adult Protective Service case? Why it is an emergency and sitter services are needed? What period of service is needed? Medicaid status? Level of Care? Status of PPD? Income amount and status? Provide start/end time of services, start/end date of services, total number of hours needed and the total amount requested.

When the need for sitter services occurs after 5 pm, on weekend or holidays, the approval should be made by the APS on-call supervisor/county director for the county referenced. The supervisor should contact the APS performance coach in the state office on the next business day to staff and submit an email request for final approval.

Initial approvals may be granted for up to fourteen (14) days. If additional time is needed beyond the fourteen (14) days, a second request should be submitted two (2) days prior to the expiration of the first approval. Approval for PCA services must not exceed twenty (20) days.

Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 6, Emergency Fund Services Policy, Section 620 entitled **PRIOR APPROVAL TO ACCESS THE EMERGENCY FUND** and Section 621 entitled **SECURING THE EMERGENCY FUND REQUEST** for further guidance and direction.

637 HOW TO USE SITTER SERVICES

Options:

When the vulnerable adult is unable to remain in his/her home alone and community services do not meet service needs, please follow these instructions in the order given:

1) If feasible (home location does not present safety/risk concerns), allow APS clients to remain in their home with the personal care aide.

2) Provide a sitter at the hospital for clients in DSS care when requested to do so by hospital staff for the safety of the vulnerable adult.

3) Seek placement in a licensed facility for the APS clients in DSS custody and/or clients with an open APS case.

4) Request use of the Emergency Funds for private pay in a licensed facility (nursing home care, assisted living and community residential care home) for thirty (30) days at the Medicaid rate. You must have this worked out before requesting funds. Requests beyond thirty (30) days must be requested on a monthly basis as required. The appropriate Medicaid application must be filed prior to this request.

Last Option:

5) Placement in a motel using contracted sitter services for short term – fourteen (14) days until PPD is placed and read with a negative result. If the client is in a hospital setting at initial contact, request PPD to be placed.

- Placement of a vulnerable adult in a motel occurs only after all reasonable efforts to find other placement are exhausted and those efforts have been thoroughly documented in CAPSS. The APS case manager and supervisor must continuously re-evaluate the vulnerable adult's need to remain in the motel and the case manager must document continued efforts to find a more appropriate placement. The case manager must make arrangements for the client's daily needs to be met while at the motel including necessary medical services.

- The APS case manager must enter all authorizations for personal care assistant services into CAPSS under the support svcs/NYTD tab.

638 THE REPRESENTATIVE PAYEE

A representative payee is an individual or organization that is approved by the income source or administering entity to receive Social Security and or Supplemental Security Income (SSI) payments, retirement income or VA benefits. The Veteran's Administration appoints a fiduciary to manage the veteran's affairs if someone cannot manage or direct the management of his or her funds. Payees should use the funds for the current and future needs of the vulnerable adult and save any remaining funds for the client's personal use.

DSS county offices and staff should not serve as a representative payee for an APS client. The agency should maintain a list of individuals, providers or agencies willing to serve as the representative payee for APS clients. All cases requiring representative payee services should be referred to the provider or agency as soon as it becomes known to the case manager that the client's money is not being used for his/her care or the vulnerable adult is unable to manage his/her funds. If the client has a large amount of assets, the case manager must staff the case with the APS supervisor to secure an attorney in order to petition probate court to have a guardian or conservator appointed for the client. If an attorney can be secured by the VA to petition the probate court for the appointment of a guardian or conservator; emergency funds may be obtained to pay the filing fee of $150.00 for this action. Language can be added to the court order for reimbursement of these funds to the DSS upon completion of the appointment of the guardian or conservator.

If the client is placed in a residential care facility or nursing home, the administrator can be advised to apply to Social Security Administration (SSA) to become representative payee of the vulnerable adult's funds. The agency's responsibility is to monitor the activities of these agencies to ensure that they are managing the clients' funds appropriately as long as the agency remains involved with the client.

To apply to become representative payee, the provider should contact the SSA office to submit an application form entitled **Request to be Selected as Payee** (SSA-11-BK) and documents to

prove the client's identity. SSA requires that the payee application be completed in a face-to-face interview. The case manager should work within a limited time frame to locate a responsible individual or relative, provider or agency to manage the income.

During the referral process the case manager should direct the client to submit all bills and expenditures to the provider. The case manager should inform relatives to submit client's present income, debit card and check book to the provider. If the relative refuses, the case manager must consult with the DSS county attorney for assistance to intercept the client's income for the next month.

When the Agency receives a report that the vulnerable adult may need placement due to EPC, Ex- parte Order or Nonemergency Removal Order, the Service Provider or APS case manager must contact the nearest Social Security Administration Office. If the client is receiving SSI or SSA, the client's resources must be redirected to the facility. If the client is receiving retirement benefits or VA benefits and funds are direct deposited, the case manager must contact the provider to report payment sources for the client. The case manager must staff the case with the APS supervisor and the county attorney regarding the income, if the client is not cooperating.

The case manager must make sure that the necessary Medicaid applications are completed on behalf of the client for nursing home or residential care placement.

639 BURIAL EXPENSES OF CLIENTS IN AGENCY CUSTODY

DSS is not responsible for burial expenses of clients in the custody of the agency. Relatives usually take responsibility and clients often leave advance instructions and funds for burial. However, if the client left no funds and relatives do not claim the body and make burial arrangements, state law requires that the Board for Distribution and Delivery of Dead Human Bodies be contacted. The Board is comprised of professors of anatomy and surgery at South Carolina schools authorized by law to teach medical science and issue diplomas. If the client died in a hospital or other public institution, the designated staff of the hospital or institution will contact the board. If the client died in another location such as a nursing home or residential care facility, the coroner is notified and the county medical examiner or the deputy medical examiner will contact the board. If the board does not accept the body, it will be turned over to the coroner of the county where the death took place for disposition according to the policy of that county government.

Referenced Documents:
Adult Services Policy and Procedure Manual (11/18/2002)

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 7, Disaster & Emergency Preparedness
Revision Number: 17-07 **Effective Date: 12/29/2017**

Review Date: 12/29/2017

Table of Contents

South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual

CHAPTER 7, Disaster & Emergency Preparedness
Revision Number: 17-07 **Effective Date: 12/29/2017**

Review Date: 12/29/2017

700 PURPOSE AND SCOPE OF PROGRAM

RESPONSIBILITY. It is the responsibility of the Adult Protective Services (APS) Program to promote the safety of vulnerable adults in agency custody including during severe weather, natural disasters and emergency situations.

AUTHORITY. S.C. Code of Laws, SECTION 43-35-45 (E) provides that at the hearing on the merits, the court may order the Adult Protective Services Program to provide protective services if it finds that:
(1) the vulnerable adult is at substantial risk of being or has been abused, neglected, or exploited and the vulnerable adult is unable to protect herself or himself; and
(2) protective services are necessary to protect the vulnerable adult from the substantial risk of or from abuse, neglect, or exploitation.

PURPOSE. The purpose of this chapter is to provide guidance and direction for vulnerable adults in the care and custody of the agency and APS staff during severe weather, natural disasters and other emergency situations.

INTENT. It is the intent of the Adult Protective Services Program to promote the safety and well-being of vulnerable adults during severe weather, natural disasters and emergency situations.

SCOPE OF DISASTER & EMERGENCY PREPAREDNESS. The scope of Disaster & Emergency Preparedness includes the process and procedures to follow during severe weather, natural disasters and other emergency situations.

710 INTRODUCTION

The Adult Protective Services Program has developed the following APS Disaster & Emergency Preparedness Plan in an attempt to ensure the safety and well-being of vulnerable adults in agency custody and other high risk clients in agency care. It is important that this plan is followed and communications remain open between the local APS staff and the APS regional performance coaches during times of severe weather, natural disasters and other emergency situations. It is the responsibility of each county office to maintain and update the APS Disaster & Emergency Preparedness Plan as changes occur.

This plan has precise procedures and guidelines for staff to follow to ensure the safety of vulnerable

adults in the event the APS Disaster & Emergency Preparedness Plan needs to be activated. Local DSS offices are directed to coordinate with local state agencies, nonprofits, religious organizations, local governments, hospitals and clinics and transportation providers in order to enhance the provision of services during the course of a disaster and/or an emergency. Roles and responsibilities should be clearly defined.

The APS Disaster & Emergency Preparedness Plan addresses the procedures and guidelines for promoting the safety and well-being of clients in DSS care and custody who are high risk clients.

720 DEFINITIONS

The following terms and definitions are commonly used in a state of emergency, during severe weather and other natural disasters:

720.01 Severe Weather

This phrase is generally used to describe any destructive weather event. However, it mostly applies to localized storms, such as severe thunderstorms i.e., damaging wind, large hail, tornadoes, and hurricanes.

720.02 Watch

An official statement issued by the National Weather Service (NWS), meaning that a hazardous weather-related event is possible in the near future. Watches are issued for significant winter storms, flash floods, severe thunderstorms, tornadoes, high winds, hurricanes, etc. Winter storms and hurricane watches are typically posted 12-36 hours ahead of the storms expected arrival, while severe thunderstorm, tornado, and flash flood/flood watches may be issued only a few hours or less in advance. In general, watches are issued before a warning. The only exceptions are in flash floods, severe thunderstorms, and tornadoes—if these events are isolated a watch will not be issued, but just a warning. Otherwise, a watch will be issued.

720.03 Warning

An official statement issued by NWS offices, meaning that a hazardous weather-related event is imminent or already occurring. A warning means that there is a serious threat to life and property. Warnings are issued for significant winter storms, flash floods, severe thunderstorms, tornadoes, high winds, hurricanes, etc.

730 POLICIES

731 GENERAL PROVISIONS

A. The Disaster & Emergency Preparedness Plan should be given to each current Adult Protective Services staff member and reviewed in full.
B. Staff will keep the Disaster & Emergency Preparedness Plan in a place that is easily accessible in their office.
C. Each new employee should receive a copy of the plan from his/her supervisor and

should review it with the supervisor within the first week of employment.
D. The case record of custody and high risk clients in agency care should be marked and easily identified by all APS staff.
E. APS supervisors need to periodically review the Disaster & Emergency Preparedness Plan with their staff, especially during severe weather seasons.
F. Communication and preparedness are essential to making things run as smoothly as possible during severe weather, natural disasters and states of emergencies. Each APS county office is responsible for maintaining and making changes to the Disaster Preparedness Plan as the need for revisions arises. Any changes made to duties or obligations of the county office staff in the local Disaster & Emergency Preparedness Plan must first receive approval from the Adult Advocacy Division at the State Office.
G. Each county APS office will include in their Disaster & Emergency Preparedness Plan provisions for protecting computers and files from flooding and other possible damage or destruction during severe weather or natural disaster.

732 STATE OF EMERGENCY FOR SOUTH CAROLINA

When the President or Governor declares a State of Emergency for South Carolina, the following policies will be in effect for the Adult Protective Services Program.

Section I. County Office Staff Procedures

- Case managers and supervisors are responsible for knowing what their clients plan is and where they will be located during the hurricane.
- Case managers will communicate information about their clients, their client's plan, and their client's location to their regional APS performance coach upon request.
- Case managers will communicate information to their performance coach on **all** APS clients (those who are in an evacuation zone and those who are not in an evacuation zone) to include:
    - Number of open APS cases by county;
    - Number of clients in DSS custody by county;
    - Number of APS clients with sitters by county;
    - Number of clients in nursing homes/residential care facilities by county.
- When an evacuation is ordered, case managers will follow the procedures outlined below for clients in the evacuation zone(s).

A. Clients with Sitters

- If a client with a sitter is in an evacuation zone, coordinate with the state office to make arrangements to move that client and the sitter to a designated special needs shelter in the area or a motel in a safe area.
- If you need assistance with finding a hotel or getting transportation for your client, contact your performance coach.
- Communicate information to your performance coach to include:
    - Client's Name;
    - Sitter Service;

    - Sitter's Name;
    - Current Location;
    - Relocation Site and Address;
    - Date of Relocation;
    - Mode of Transportation for Relocation.
- Document in CAPSS where the client is being relocated, how they are being transported, and all other relevant information regarding their relocation.
- Once the evacuation order is lifted and conditions are safe for the client to return home, coordinate with the state office to make arrangements to move that client and the sitter back home.
- Communicate information to your performance coach to include:
    - Client's Name;
    - Sitter Service;
    - Sitter's Name;
    - Date of Move Home;
    - Mode of Transportation for Relocation.
- Document in CAPSS when the client is moved back home, how they were transported, and any other relevant information about their move back home.

B. <u>Clients Who Have Dementia with Sitters</u>

- Make arrangements to transport clients who have dementia and are in an evacuation zone along with their sitter to the closest DHEC Special Needs Shelter or a motel in a safe area (see "Clients with Sitters" section of this plan if evacuating to a motel). You can call your County Emergency Management Office to find out where the shelter is. If evacuating a client to a motel refer to the Adult Protective Services Policy and Procedure Manual, Chapter 7, Disaster & Emergency Preparedness, Section 732, **STATE OF EMERGENCY FOR SOUTH CAROLINA,** <u>Clients with Sitters.</u>
    - The client will need to take the following to the Special Needs Shelter (This information comes from DHEC's Special Needs Shelter brochure):
        - Enough medications for 7 days. Bring all prescription medication in the original containers even if the supply is low.
        - Enough medical supplies for 7 days. These are items that the client uses on a daily basis such as glucometers, syringes, dressings and bandages.
        - Medical equipment used at home such as wheelchairs, canes or walkers, hearing aids, and eyeglasses.
        - Breathing devices including oxygen concentrators, extra tanks or canisters.
        - Personal items like a toothbrush, toothpaste, deodorant, diapers and clothing.
    - Contact your APS performance coach if you need help securing transportation.
    - Communicate information to your performance coach to include:
        - Client's Name;
        - Sitter Service;
        - Sitter's Name;
        - Current Location;

    - Date of Relocation;
    - Relocation Site and Address;
    - Mode of Transportation for Relocation.
- Document in CAPSS where the client is being relocated, how they are being transported, and all other relevant information regarding their relocation.
- Once the evacuation order is lifted and conditions are safe for the client to return home, coordinate with the state office to make arrangements to move that client and the sitter back home.
- Communicate information to your performance coach to include:
    - Client's Name;
    - Sitter Service;
    - Sitter's Name;
    - Date of Move Home;
    - Mode of Transportation for Relocation.
- Document in CAPSS when the client is moved back home, how they were transported, and any other relevant information about their move back home.

C. <u>Clients in Nursing Homes/Residential Care Facilities</u>

- Clients in nursing homes and residential care facilities that are in an evacuation zone will follow the facility's emergency/evacuation plan.
- Call the facility and find out what their evacuation/emergency plan is.
- Communicate information to your performance coach to include:
    - Client's Name;
    - Facility Name;
    - Current Location;
    - Facility Emergency/Evacuation Plan;
    - Date of Relocation;
    - Relocation Site and Address;
    - Mode of Transportation for Relocation.
- Document in CAPSS for these clients what the facility's evacuation/emergency plan is and where the clients will be relocated.
- Once the evacuation order is lifted and conditions are safe for the client to return to the facility, call the facility to find out when the clients will be moved back to the facility.
- Communicate information to your performance coach to include:
    - Client's Name;
    - Facility Name;
    - Date of Move Back to Facility;
    - Mode of Transportation for Relocation.
- Document in CAPSS when the client is being moved back to the facility, how they are being transported, and any other relevant information about their move back to the facility.

D. Medically Fragile Clients in Their Homes

- Find out what medically fragile clients in evacuation zones plan to do. If family or friends are coming to get them, contact family members or friends to confirm and document in CAPSS where the client is being relocated and with whom, how they are being transported, and all other relevant information regarding their relocation.
- If they don't have an evacuation plan, make arrangements to transport them to the closest DHEC Special Needs Shelter. You can call your County Emergency Management Office to find out where the shelter is.
- The client will need to take the following to the Special Needs Shelter (This information comes from DHEC's Special Needs Shelter brochure):
    - Enough medications for 7 days. Bring all prescription medication in the original containers even if the supply is low.
    - Enough medical supplies for 7 days. These are items that the client uses on a daily basis such as glucometers, syringes, dressings and bandages.
    - Medical equipment used at home such as wheelchairs, canes or walkers, hearing aids, and eyeglasses.
    - Breathing devices including oxygen concentrators, extra tanks or canisters.
    - Personal items like a toothbrush, toothpaste, deodorant, diapers and clothing.
- Contact your APS performance coach if you need help securing transportation.
- Communicate information to your APS performance coach to include:
    - Client's Name;
    - Current Location;
    - Date of Relocation;
    - Relocation Site and Address;
    - Mode of Transportation for Relocation.
- Document in CAPSS where the client is being relocated, how they are being transported, and all other relevant information regarding their relocation.
- Once the evacuation order is lifted and conditions are safe for the client to return home, coordinate with the state office to make arrangements to move that client back home.
- Communicate information to your APS performance coach to include:
    - Client's Name;
    - Date of Move Home;
    - Mode of Transportation for Relocation.

Section II. State Office Procedures

- APS state office will assist with finding motel rooms in safe areas, securing transportation services for those who need it, and setting up relief for the sitters with sitter providers.
- APS state office will coordinate with sitter providers to assist with the evacuation of APS clients as needed.

- APS performance coaches will collect information on all APS clients by county from case managers to include:
    - Number of open APS cases by county;
    - Number of clients in DSS custody by county;
    - Number of APS clients with sitters by county;
    - Number of clients in nursing homes/residential care facilities by county.
- APS performances coaches will collect information from case managers on clients who are being evacuated from their homes, nursing homes, or residential care facilities as outlined in this plan. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 7, Disaster & Emergency Preparedness, Section 732, **STATE OF EMERGENCY FOR SOUTH CAROLINA,** County Office Staff Procedures for further guidance and direction.
- Performances Coaches will provide all collected information to the designated state office staff member who will keep the information in a document that can be provided to the governor's office and/or the DSS director upon request.
- Once the evacuation order is lifted and conditions are safe for the client to return home, APS performances coaches will collect information from case managers on clients who are being returned to their homes, nursing homes, or residential care facilities as outlined in this plan. Refer to the Adult Protective Services Policy and Procedure Manual, Chapter 7, Disaster & Emergency Preparedness, Section 732, **STATE OF EMERGENCY FOR SOUTH CAROLINA,** County Office Staff Procedures for further guidance and direction.
- Performances coaches will provide all collected information about client's returning home to the designated state office staff member who will keep the information in a document that can be provided to the governor's office and/or the DSS state director's office upon request.

733 APS STATE PROGRAM STAFF, OFFICES AND EQUIPMENT

Implement Disaster Response (At OPCON 1, 2, or 3)

- Review personal and office safety plans.
- Become familiar with local evacuation zones in coastal counties.
- Locate the nearest hurricane evacuation routes.
- Locate the nearest special needs shelter(s).
- Develop a plan to get clients with sitters to the closest special needs shelter.

If APS is alerted to the possibility of an impending disaster, staff in affected areas should follow these procedures before leaving the office.

- Backup and print key files. Staff should identify their own critical files and back them up on the H drive, a flash drive, and/or print out key documents on a regular basis. ***Files that have been printed out or saved on flash drives should be taken with you to make sure they are safe.***

- Logout. Follow normal logoff/signoff procedures for computer systems.
- Power Down. Properly power down all computer related equipment including workstations, monitors and printers.
- Unplug Equipment. Unplug power cords of computers, monitors and printers from the wall. ***Don't unplug telephone or data network cables unless equipment must be moved (see below).*** If these cables must be disconnected, unplug the "equipment end" rather than the "wall-jack end" of the cable.
- Move Equipment. Move equipment away from windows and off the floor to avoid possible water damage.
- Cover Equipment. Cover computer equipment securely with plastic sheeting after power-down. Plastic trash bags can be used as an option.
- Create and distribute staff emergency contact lists including cell numbers.
- Lock up confidential files. (In case of looting).
- Put up hurricane shutters/plywood if possible. If time, manpower, and resources allow, put up plywood or other protective materials over windows and glass doors.
- Lock up confidential files, pack up paper files, and store files high above the floor.

734 RESPONSIBILITIES OF APS COUNTY STAFF

A. The Placement Screen in CAPSS must be completed on all clients in placement prior to an emergency, severe weather or natural disaster.
B. Each case manager will provide the names and contact information of the APS client to their supervisor along with a brief explanation for designating the client as "high risk." When a client is in DSS custody, an emergency contact information plan should be completed.
C. The supervisor and/or county director are responsible for developing and maintaining a master list of high risk clients within their given area.
D. As new cases are acquired by the case manager, they should immediately be added to the master list for that area. The case manager should consider removal of obese clients and discuss plans for evacuation and make it a part of planning for services.
E. Custody cases should be included even though these clients are considered to be in protective environments. The South Carolina Department of Health and Environmental Control (DHEC) has an Emergency Evacuation Plan Component for Nursing Homes, Hospitals and Community Residential Facilities.

735 ACTIONS TO TAKE ON "HIGH RISK CLIENTS" DURING SEVERE WEATHER OR NATURAL DISASTER WATCH

A. APS staff will make contact (by phone or home visit) and assess safety and well-being of each high risk client. Resident administrators should be contacted to make sure the emergency plan contact information (including alternate contact) in the event of any medical emergency

or relocation of client is correct. Case managers should make sure arrangements for medication refills and other special needs like oxygen are in place for the client.
B. The APS staff will attempt to ensure that each high risk client is aware of evacuation procedures for his/her county and the location of local shelters. Facility administrators should be reminded of DHEC's emergency evacuation plan.
C. The APS staff will attempt to ensure that high risk clients have access to emergency supplies (first aid kits, flashlights, radios, batteries, etc.). The local Red Cross should be contacted regarding availability of emergency kits. If there are no kits available, the Red Cross should be asked to provide information to the county director/supervisor as to how to obtain these supplies in advance so that they are readily available to the client.
D. The APS staff will ensure each high risk client has telephone numbers for police, hospitals, neighbors, friends, family or any other resources that are able and willing to assist in meeting needs during times of severe weather or natural disaster.
E. After other resources (law enforcement, etc) have been explored, APS staff may be required to provide and/or arrange transportation for high risk clients to shelters. This will need to be done during the early stages of a severe weather watch as it is not expected that staff put themselves or others in danger while severe weather is occurring.
F. Following the end of severe weather/natural disaster, APS staff will follow up with the high risk client and/or facilities to assess the client's safety and see if there are any immediate needs that should be addressed.

736 ESTABLISHING COMMUNICATION FOR SEVERE WEATHER

A. Establish a chain of command for each county and ensure each staff member has an understanding of his/her role.
There must be a clear line of authority so that communications run smoothly during events of severe weather. Once the county director becomes aware of the threat or disaster then he/she should contact appropriate staff to inform them that the local disaster preparedness plan is in effect. The chain of command should be as follows:
1. State Director;
2. Deputy State Director;
3.County Director;
4. Program Supervisor;
5. APS Case Managers;
B. Attach a list of team members with both work and after-hour phone numbers (cells, pagers, home, etc.) to the Disaster Preparedness Plan.

737 RESOURCES

Each county office will develop and maintain a list of resources readily available to assist in meeting client needs in preparation for or after severe weather or natural or other disaster. Resources should include the following:
A. Access to local area council/agency on aging
1. Coordinate services and resources which will be available for APS clients during times of disaster
2. Update service information and contacts periodically to ensure accuracy and availability

B. Memorandum of Understanding
1. The MOU should be developed with local community representatives to clarify roles and responsibilities of participating agencies
2. The MOU should address evacuation routes and the destination points of the routes.

738 STATE EMERGENCY MANAGEMENT TEAM

1. The county staff should be familiar with the State Emergency Management Team
2. The county staff should review the information from the State Management Team periodically to ensure accuracy and familiarity with the county's role and responsibilities during a state of emergency.

739 SAFFIR-SIMPSON HURRICANE SCALE

RATING DESCRIPTION
Winds 74 to 95 miles per hour (mph)
CATEGORY 1 Minimal structural damage
Manufactured housing at risk
Power lines, signs and tree branches blown down

Winds 96 to 110 mph
CATEGORY 2 Moderate structural damage to walls, roofs, and windows
Manufactured housing at greater risk
Large signs and tree branches blown down
Storm surge 6 to 8 feet

Winds 111 to 130 mph
CATEGORY 3* Extensive structural damage to walls, roofs and windows
Trees blown down
Storm surge 9 to 12 feet

Winds 131 to 155 mph
CATEGORY 4* Extreme damage to structure and roofs
Trees uprooted
Storm surge 13 to 18 feet

Winds in excess of 155 mph
CATEGORY 5* Catastrophic damage
Structures destroyed
Storm surge 18 feet or higher
NOTE: Flying debris or projectiles such as signs, trees, glass, roof, shingles, lawn furniture and toys can cause severe property damage as well as major injuries or even death.

*Category 3 or higher is defined as a “Major Hurricane.”

740 FUJITA-PEARSON TORNADO SCALE

F0 – Gale Tornado (40-72 mph)
Light damage, some damage to chimneys: branches broken off trees; shallow-rooted trees pushed over: sign boards
damaged.
F1 - Moderate Tornado (73-112 mph)
Moderate damage; The lower limit is the beginning of Hurricane wind speed; peels surface off roofs; mobile homes pushed off foundations or overturned; moving autos pushed off the road; attached garages may be destroyed.
F2 – Significant Tornado (113-157)
Considerable damage; entire roofs torn from frame houses; mobile homes demolished; boxcars pushed over; large trees snapped or uprooted; light-object missiles generated.
F3 – Severe Tornado (158 – 206)
Severe damage; walls torn from well-constructed houses; trains overturned; most trees in forests uprooted; heavy cars lifted off ground and thrown.
F4 – Devastating Tornado (207 – 260)
Well-constructed houses leveled; structures with weak foundations blown off some distance; cars thrown and large missiles generated.
F5 – Incredible Tornado (261-318)
Strong frame houses lifted off foundations and carried considerable distances to disintegrate; automobile-sized missiles fly through the air 100 yards or more; trees debarked; steel reinforced concrete structures badly damaged.

741 SOUTH CAROLINA DEPT. OF SOCIAL SERVICES, MEMORANDUM OF UNDERSTANDING, EMERGENCY PREPARDNESS PLAN

This MEMORANDUM OF UNDERSTANDING is entered into by and between the South Carolina Department of Social Services (SCDSS),
the South Carolina Emergency Management Agency (SCEMA), the (local) Law Enforcement (LE), the South Carolina Department of Mental Health (DMH)
and South Carolina Department of Disabilities and Special Needs (DDSN), the American Red Cross (ARC) and the South Carolina Department of Health and Environmental Control (DHEC) for the purpose of establishing the responsibilities of each agency in the operation of Medical Needs Shelters within the State of South Carolina.
WHEREAS, during emergency events, citizens of South Carolina with certain medical conditions may need assistance in maintaining pre-event levels of health; and
WHEREAS, the signatory agencies of this agreement have designated responsibilities under the State Emergency Operations Plan (EOP) and obligations to the citizens of the state:
NOW THEREFORE, the below signed parties hereto covenant as follows:
SCDHEC will assure the provision of medical care and equipment including, but not limited to, medical staff, emergency medical services, medical supplies, medical records and archiving of records, cots/beds for medical patients, linens for medical beds, safety staff, cleaning of medical care areas and disposal of medical waste.

SCDSS will assure participation in the operation of emergency shelters, but not limited to, arranging MOU's with agencies providing emergency shelter, arranging for opening and closing of shelter facilities and general food service for shelter staff patients and families.
SCEMA will assure: final site selection after coordination with shelter security, backup power, cots for staff, families of patients and communication equipment.
SCDMH will assume care for or make arrangements for the provision of care for patients with serious mental illnesses and significant emotional disorders.
The patients' care or arrangements for care may include but is not limited to the provision of staff, equipment and supplies as needed including but not limited to the
provision of staff, equipment and supplies as needed.
SCDDSN will assume care or will make arrangements for the provision of care for patients with issues pertaining to mental retardation and related disabilities, autism, traumatic brain injury and spinal cord injury and conditions. The patient s' care or arrangements for care may include but is not limited to the provision of staff, equipment and supplies as needed. Local units of ARC, at the request of the proper local DSS office, may provide limited feeding support, provided resources are available for such support without interfering with other service delivery. This feeding support will be the same as other recipients of American Red Cross feeding operations. American Red Cross workers cannot deliver food when weather conditions make travel dangerous.
LE will state its plan for the specific county _____

Entered into by signature below:

_____ Date _____
Director or Designee
South Carolina Department of Health
and Environmental Control

_____ Date _____
Director or Designee
Department of Social Services

_____ Date _____
Director or Designee Emergency Management Agency

_____ Date _____
Director or Designee
South Carolina Department of Mental Health

_____ Date _____
Director or Designee
South Carolina Department of Disabilities
and Special Needs

_____ Date _____
Director of Preparedness and Response
American Red Cross Southeast Service Area

_____ Date _____
Law Enforcement Agency

Referenced Documents:
Adult Services Policy and Procedure Manual (11/18/2002)
APS Emergency Preparedness Plan (2017)
SCDSS APS Emergency Preparedness- APS Staff, Offices and Equipment (2017)
DHEC's Special Needs Shelter brochure