SHARED AIDE PLAN
COMPOSITE PLAN
PART A

I. IDENTIFYING INFORMATION

Social Services District: ____

Name and Address of Delegee ____
Agency/Entity (if applicable) ____

Name and Title of Person ____
Completing Plan: ____

Telephone: (_ _ _) _ _ _ - _ _ _ _ , extension _ _ _ _
Fax: (_ _ _) _ _ _ - _ _ _ _

Date of Plan Completion: _ _ /_ _ /_ _ _ _

II. IMPLEMENTATION PLAN

A. Briefly describe the efficiencies you expect to accomplish by implementation of a shared aide program (for example: improved utilization of home care workers, more responsive care, cost savings).

B. Complete the chart on the next page to project your long range, district-wide plan for implementation of shared aide services.

C. For each shared aide site expected to be operational by June 30, 1992, complete a Part B, Site Profile.

D. Are you considering integration of clients receiving a different type of home care service or home care services under other reimbursement mechanisms into your shared aide program at initial implementation or at some time in the future? For example: clients receiving home health aide services from a CHHA under Medicare or Homemaker services under EISEP?

_____Yes _____No _______Unknown

If yes, indicate the services(s) or reimbursement source(s), the projected number of clients, and the projected integration date.

Service or Reimbursement Source	Number of Clients	Projected Integration Date Month	Year

III.STAFFING

Identify the number of case managers, nurse supervisors, and provider agency coordinators who will be responsible for your shared aide program across all sites expected to be implemented by June 30, 1992. Indicate whether these are existing staff and estimate the percentage of time each of these persons allocates to the program. For example: 2 case managers, existing staff, 50% of time to plan. If your shared aide plan involves other staff in your district or in the participating provider agency(ies), list the positions involved and complete the remaining information for each position.

Position	Number	Existing Staff? Yes	Existing Staff? No	Time to Shared Aide Plan (%)
Case Manager				
Nurse Supervisor				
Provider Agency Coordinator				
Other (Specify Position)				

IV. EDUCATION/SELECTION OF CLIENTS, PROVIDER AGENCIES, AND HOME CARE WORKERS

Briefly describe the process(es)/methods that will be used to

A. educate clients about the shared aide program.

B. inform/educate provider agencies, physicians, housing authorities, and governmental and community agencies/officials,etc. about the shared aide program.

C. select the provider agency(cies) to participate in the shared aide program.

D. select the home care workers who will be involved in shared aide services delivery.

V. OPERATIONAL DIFFERENCES BETWEEN NON-SHARED AIDE AND SHARED AIDE PROGRAMS

Indicate whether differences exist between your non-shared aide personal care services program and your shared aide program for each of the following components and areas. If differences exist, briefly describe the nature of each difference.

Component	Area	Difference? Yes	Difference? No	Nature of Difference
Nursing assessments	agency responsible			
	manner in which done			
Case management	responsibilities			
	manner in which done			
	frequency of client contact			
Nursing supervision	agency responsible			
	supervisor/home care worker ratio			
	manner in which done			
	frequency of visits			

- Briefly describe <u>any other</u> differences between your non-shared aide program and your shared aide program for nursing assessments, case management, nursing supervision, or for any other component of services delivery such as authorization of services.

VI. MONITORING/EVALUATING SHARED AIDE PLAN OUTCOMES

Briefly describe the methods and frequencies (e.g., annually, monthly) which will be used to monitor/evaluate each of the following outcomes:

Outcome	Monitoring/Evaluation Method(s)	Frequency
Hours of services actually provided against services authorized		
Client satisfaction with shared aide program		
Home care worker satisfaction with shared aide program		
Home care worker turnover/ stability of employment		
Costs of providing services/ cost savings		

VII. FORMS CHECKLIST

If you have developed any of the following documents or materials for your shared aide program, check and attach labeled copies of the document or material.

_____ client brochures, letters, etc. explaining the shared aide program
_____ public relations materials for community agencies, housing authorities, client advocates, legislators, etc.
_____ policy or procedural handbooks, manuals, instructions, etc.
_____ monitoring and evaluation instruments

END OF PART A

COMPLETE A PART B FOR EACH SHARED AIDE SITE EXPECTED TO BE OPERATIONAL BY JUNE 30, 1992

SHARED AIDE PLAN
SITE PROFILE
PART B

1. Social Services District: _____

2. Name and Address of Delegee _____
   Agency/Entity (if applicable): _____

3. Site Name and Address or Description of Geographical Area:

3. Actual/Projected Start-up Date: _____ Month _____ Year

4. Client Profile

   a. Volume (Actual or Projected)

   Identify the number of clients who are receiving/will receive personal care services under the non-shared aide program at this site and the number of these clients who are receiving/will receive personal care services under the shared aide program.

	Clients Receiving Services Under Non-Shared Aide Program (#)	Clients Receiving Services Under Shared Aide Program (#)
Personal Care, Level I		
Personal Care, Level II		

   b. Characteristics

   Describe the characteristics of clients in your shared aide program at this site by checking yes or no in response to each of the following questions. Briefly describe any limitation(s) you may have imposed/expect to impose.

Do you/will you include	Yes	No	Limitation
clients of all ages?			
non-self directing clients who have informal supports?			

(OVER)

4.b. Characteristics (cont.)

Do you/will you include	Yes	No	Limitation
clients requiring multiple shift or continuous twenty-four hour care?			

- Briefly describe any other client characteristics which are significantly different from characteristics of clients in your non-shared aide program. For example: you exclude/plan to exclude clients from the shared aide program who require assistance with certain personal care functions, e.g. toileting.

5. Availability of Shared Aide Services

During what days and hours of the week are shared aide services available/will be available at this site? _____

_____

6. Provider Agency(cies)/Home Care Workers

a. Identify the name and address of the provider agency(cies) and the number of full and part-time home care workers involved/expected to be involved in delivery of shared aide services <u>at this site.</u>

Agency Name and Address	Home Care Workers Full-Time (#)	Part-Time (#)

b. Does/will the home care worker in the shared aide program receive a higher hourly wage than the worker in the non-shared aide program?
_____ No _____ Yes

c. Does/will the home care worker in the shared aide program receive different or additional fringe benefits than the worker in the non-shared aide program? <u>For example:</u> more vacation days.
_____ No _____ Yes; describe differences:

END OF PART B
END OF SHARED AIDE PLAN

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
SHARED AIDE PLAN

NOTICE OF APPROVAL/DISAPPROVAL

To:_____ Initial Plan:____
Amended Plan:____

Date Received by Department: _ _ /_ _ /_ _
Date of this Notice: _ _ /_ _ /_ _

DISPOSITION:

____Delegation approved.

____Plan approved; no recommendations; first Quarterly Shared Aide Report due _____ for the period _____, 199_.

____Plan approved; recommendations below: first Quarterly Shared Aide Report due _____ for the period _____, 199_.

Recommendations:

____Plan disapproved; deficiencies as follows:

____Incomplete or inconsistent information;

____Inadequate documentation;

____Non-compliance with program standards/policies;

____Unclear organizational structure; unclear responsibilities or roles of staff and/or agencies involved;

____Unrealistic/inappropriate time frame for achieving full district-wide implementation;

____No or unexplained efficiencies;

____Other;

(OVER)

ACTION NEEDED TO AMEND PLAN:

Name:_____
Title:_____
Signature:_____
Telephone Number:_____
Fax Number: (518) 473-4232

Submit amended plan within thirty business days of receipt of this notice to:

New York State Department of Social Services
DMA-LTC
Home Care Unit
P.O. Box 1935
Albany, New York 12201-1935