**Section 230.630 Service Activities**

Case Management service activities minimally include the following components:

a) Case Finding Activities: The identification of individuals for intake.

b) Intake: Through the administration of a defined intake process developed or approved by the Area Agency on Aging, an individual with potential case management needs, as defined below, shall be identified.

1) An individual must be age 60 or older; and

2) An individual must demonstrate a need which requires development of a coordinated case plan, follow-up, and/or advocacy; and/or

3) An individual has multiple or complex problems which are often chronic in nature and which may affect the ability of that individual to live independently; and/or

4) An individual has potential need for multiple services; and/or

5) An individual has presented problems which are vague or ill-defined; and/or

6) An individual has insufficient informal supports to care for his/her needs.

c) Needs Assessment: A face-to-face comprehensive assessment, preferably conducted in the home or place of residence of the client, must be conducted for each case management client utilizing a standardized tool, developed or approved by the Area Agency on Aging, to evaluate the conditions of the client and to identify goal oriented needs for services and/or problems needing resolution.

d) Case Plan Development: A written plan of care shall be prepared for each client utilizing appropriate and available formal and informal resources, using a standardized form developed or approved by the Area Agency on Aging. The case plan shall identify available services and problem solving efforts to meet the client's determined needs and to enable the client to live with maximum possible independence. A copy of the case plan shall be given to the client and/or client's family and/or significant individual, and so documented in the client's file.

e) Case Plan Implementation: A referral of the applicant/client to an appropriate resource for service provision and/or problem resolution shall be made and documented in the applicant's/client's file. If the referral is made to an informal network (family, friends, etc.), the service and/or problem-solving arrangement agreed to regarding duties and responsibilities shall be documented in the client's case plan. The following activities shall be performed for each client, as appropriate and needed:

1) Active intervention and advocacy on behalf of the client to access necessary services from community organizations and to resolve problems experienced by the client;

2) Establishment of linkages with service providers for the prompt and effective delivery of services needed by the client, including submission of instructions for service delivery to the appropriate service providers;

3) Encouragement of informal care given by individuals, family, friends, neighbors, and community organizations, so that publicly supported services supplement rather than supplant the roles and responsibilities of these natural support systems.

f) Review and Evaluation of Client Status:

1) Follow-up: Periodic monitoring shall be conducted through telephone or face-to-face contact to ensure prompt and effective service delivery and response to changes in the client's needs and status. All follow-up shall be documented in the client's file.

2) Reassessment: A face-to-face reassessment of the client's condition and needs must be conducted, preferably in the home of the client, no later than the 12th month from the last completed (re)assessment, or more frequently as directed by change in the client's circumstance.

g) Case Closure: Case closure shall occur in the following instances.

1) Death of the client;

2) Relocation out of the CCU's geographic service area;

3) Client cannot be located;

4) Client is hospitalized, enters a group care facility, is institutionalized or is not available for services for more than ninety consecutive calendar days;

5) Client is no longer in need of case management services because of changes in the client's condition or circumstances;

6) Client refuses services;

7) Client requests termination;

8) Client refuses to cooperate in the provision of case management services.

h) Transfer: When a client moves from the CCU's geographic service area, the CCU shall, with the client's and/or client's family and/or significant individual's documented consent, refer the client to the CCU serving the area to which the client has moved.

(Source: Added at 15 Ill. Reg. 18642, effective December 13, 1991)