SAN FRANCISCO
HUMAN SERVICES AGENCY

Department of Benefits and Family Support

Department of Disability and Aging Services

Office of Early Care and Education

P.O. Box 7988
San Francisco, CA
94120-7988
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London Breed
Mayor

Trent Rhorer
Executive Director

MEMORANDUM

TO: DISABILITY AND AGING SERVICES COMMISSION

THROUGH: KELLY DEARMAN, EXECUTIVE DIRECTOR

FROM: CINDY KAUFFMAN, DEPUTY DIRECTOR
ESPERANZA ZAPIEN, DIRECTOR OF CONTRACTS

DS

DATE: FEBRUARY 1, 2023

SUBJECT: GRANT MODIFICATION: MULTIPLE GRANTEES (NON-PROFITS) FOR PROVISION OF CASE MANAGEMENT

	Current	Modification	Revised Total		
GRANT TERM:	07/01/21 – 06/30/23	01/01/23 – 06/30/23	07/01/21 – 06/30/23		
	Current	Modification	Revised	Contingency	Total
GRANT AMOUNT:	$6,114,832	$486,879	$6,601,711	$660,172	$7,261,883
Funding Source	County	State	Federal	Contingency	Total
FUNDING:	$6,601,711			$660,172	$7,261,883
PERCENTAGE:	100%				100%

The Department of Disability and Aging Services (DAS) requests authorization to modify the existing grants with multiple providers for the provision of Case Management for the period of January 1, 2023 through June 30, 2023 in the additional amount of $486,879 plus a 10% contingency for a revised total amount not to exceed $7,261,883. The specific breakdown of funding per grantee is summarized in the following table.

Location	Current Amount 1/1/2021 - 6/30/2023	Modification	Revised FY22/23 Budget	Revised Total 1/1/2021 - 6/30/2023	10% Contingency	Total Not to Exceed
Bayview Senior Services	$532,110	$39,762	$305,817	$571,872	$57,187	$629,059
Catholic Charities	$523,308	$52,541	$314,195	$575,849	$57,585	$633,434
Curry Senior Center	$743,542	$73,164	$444,935	$816,706	$81,671	$898,377
Episcopal Community Services	$637,676	$41,874	$360,712	$679,550	$67,955	$747,505
Institute On Aging	$1,127,832	$68,317	$632,233	$1,196,149	$119,615	$1,315,764
Jewish Family & Children's Services	$218,546	$12,691	$121,964	$231,237	$23,124	$254,361
Kimochi	$281,296	$34,746	$175,394	$316,042	$31,604	$347,646
On Lok Day Services	$716,080	$37,202	$395,242	$753,282	$75,328	$828,610
Openhouse	$241,014	$46,473	$166,980	$287,487	$28,749	$316,236
Self Help for the Elderly	$1,093,428	$80,109	$546,714	$1,173,537	$117,354	$1,290,891
Total	**$6,114,832**	**$486,879**	**$3,464,186**	**$6,601,711**	**$660,172**	**$7,261,883**

Background

Case management facilitates service connections for older adults and adults with disabilities. These services promote and maintain the optimum level of functioning in the most independent setting possible. Examples of service connections in which a case manager might assist include: connection to health services, money management, or stabilization of a living situation.

Case management supervisors and agency leadership have shared the challenges of retaining and hiring qualified case managers. To support the agencies, DAS has identified funds for salary increases for case management programs. In addition, the case management contracts received cost of doing business allocations. Curry and Openhouse also

received addback funding from the Board of Supervisors to support LBGTQ+ serving case managers.

Services to be Provided
The case management services contain core elements to ensure standardized and effective delivery of services. These core elements include a centralized waitlist, introduced in May of 2017, and an on-line module that allows case managers to document and track client progress. Upon completion of service plan goals, clients can be re-assessed, and if it is determined that case management services are no longer required, then clients are dis-enrolled and referred to other community-based services as needed. Depending on the client's needs, case managers meet with clients at least monthly to ensure consistent delivery of services. Services provided under OCP funded case management include:

1. Intake/Enrollment
2. Comprehensive Assessment
3. Service Planning
4. Service Plan Implementation
5. Monitoring
6. Progress Notes
7. Reassessment
8. Discharge/Disenrollment

Modification
There are no deliverable changes to the Appendix A-1.

Selection
Grantees were selected through Request for Proposals #780 which was competitively bid in March 2018.

Funding
These grants will be funded through Dignity Funds.

ATTACHMENTS

- **Bayview Senior Services**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Catholic Charities**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Curry Senior Center**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Episcopal Community Services**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Institute On Aging**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Jewish Family & Children's Services**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Kimochi**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **On Lok Day Services**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Openhouse**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

- **Self Help for the Elderly**

  Appendix A-1 – Services to be provided
  Appendix B-1 – Budget

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

Bayview Hunters Point Multipurpose Senior Services, Inc.

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of

	services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Bayview Hunters Point Multipurpose Senior Services, Inc. (Bayview Senior Services)
HSA	San Francisco Human Services Agency
Limited English-Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior

Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Bayview Case Management services are located at 1390 ½ Turk St., 1753 Carroll St. and 1111 Buchannan St in San Francisco. Services are available Monday through Friday from 9:00 a.m. to 4:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.

- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will provide case management services to at least **_110_** unduplicated consumers.

  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

- Grantee will complete **__90___**% of comprehensive assessments due each contract year.*
- Grantee will complete **__90___**% of service plans due each contact year.*
- Grantee will complete **__100__**% of monthly contacts during each contract year.*
- Grantee will complete **__100__**% of face-to-face contacts each contract year.*

* Tracked via documentation in the CA GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: (*https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

Steve Kim
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Steve.Kim@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

HUMAN SERVICES AGENCY BUDGET SUMMARY

Name	Term
Bayview Senior Services	7/1/21-6/30/23

(Check One) New ☐ Renewal ____ Modification ____

If modification, Effective Date of Mod. 1/1/2023 No. of Mod.# 1

Program: Case Management

Budget Reference Page No.(s)	Actual	Current	Modification	Revised	Total
Program Term	7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
Expenditures					
Salaries & Benefits	$183,091	$183,091	$13,631	$196,722	$379,813
Operating Expenses	$54,457	$54,457	$21,870	$76,327	$130,784
Subtotal	$237,548	$237,548	$35,501	$273,049	$510,597
Indirect Percentage (%)	12%	12%	12%	12%	12%
Indirect Cost (Line 16 X Line 15)	$28,507	$28,507	$4,260	$32,768	$61,275
Subcontractor/Capital Expenditures					$0
Total Expenditures	$266,055	$266,055	$39,761	$305,817	$571,872
HSA Revenues					
General Fund	$234,128	$234,129		$269,119	$503,247
CFDA 93.778 (12%)	$31,927	$31,927		$36,698	$68,625
FY22/23 OTO			$29,120		
FY22/23 CODB			$10,642		
TOTAL HSA REVENUES	$266,055	$266,055	$39,762	$305,817	$571,872
Other Revenues					
Total Revenues	$266,055	$266,055	$39,762	$305,817	$571,872
Full Time Equivalent (FTE)					

Prepared by:

HSA-CO Review Signature: _____

Bayview Senior Services
Program: Case Management
(Same as Line 9 on HSA #1)

Salaries & Benefits Detail

	A	B	C	D	E	H	I	J	M	N
10						7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
11		Agency Totals		HSA Program		Actual	Current	Modification	Revised	TOTAL
12	POSITION TITLE	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
13	Case Manager	$58,240	100%	100%	100%	$61,200	$61,200	$4,831	$66,031	$127,231
14	Case Manager	$58,240	100%	100%	100%	$60,000	$60,000	$4,833	$64,833	$124,833
15	Case Management Supervisor	$72,800	100%	30%	30%	$21,840	$21,840	$985	$22,825	$44,665
16										
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29										
30	TOTALS		3.00	230%	2.30	$143,040	$143,040	$10,649	$153,689	$296,729
31										
32	FRINGE BENEFIT RATE	28%								
33	EMPLOYEE FRINGE BENEFITS	$0				$40,051	$40,051	$2,982	$43,033	$83,084
34										
35										
36	TOTAL SALARIES & BENEFITS	$0				$183,091	$183,091	$13,631	$196,722	$379,813

Bayview Senior Services
Program: Case Management
(Same as Line 9 on HSA #1)

Operating Expense Detail

Expenditure Category	TERM	Actual 7/1/21-6/30/22	Current 7/1/22-6/30/23	Modification 7/1/22-6/30/23	Revised 7/1/22-6/30/23	TOTAL 7/1/21-6/30/23
Rental of Property						
Utilities(Elec, Water, Gas, Phone, Garbage)		$ 6,500	$ 6,500		$ 6,500	$ 13,000
Office Supplies, Postage		$ 5,000	$ 5,000		$ 5,000	$ 10,000
Building Maintenance Supplies and Repair						
Printing and Reproduction		$ 5,000	$ 5,000		$ 5,000	$ 10,000
Insurance		$ 6,030	$ 6,030		$ 6,030	$ 12,060
Staff Training		$ 5,000	$ 5,000		$ 5,000	$ 10,000
Staff Travel-(Local & Out of Town)		$ 1,200	$ 1,200		$ 1,200	$ 2,400
Rental of Equipment		$ 4,500	$ 4,500		$ 4,500	$ 9,000
CONSULTANTS						
Computer/phone/interrnet technical assistance		$ 4,400	$ 4,400		$ 4,400	$ 8,800
OTHER						
Cllient support supplies		$ 16,827	$ 16,827	$ 21,870	$ 38,697	$ 55,524
TOTAL OPERATING EXPENSE		**$ 54,457**	**$ 54,457**	**$ 21,870**	**$ 76,327**	**$ 130,784**

HSA #3 **1/4/2023**

APPENDIX A-1: SERVICES TO BE PROVIDED

CATHOLIC CHARITIES

Effective July 1, 2021 to June 30, 2023

CASE MANAGEMENT

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18- 59 years of age or older living with a disability
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates

	services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation.
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Catholic Charities
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult

Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only 'case monitoring' (i.e., no active service plan needs) or 'finding housing' are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Catholic Charities' Case Management services are housed at 65 Beverly St. and available from 9:00 a.m. to 5:00 p.m. Monday through Friday.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives

For each Fiscal Year:

- Grantee will provide case management services to at least **132** unduplicated consumers.
  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)
- Grantee will complete **90**% of comprehensive assessments due each contract year.*
- Grantee will complete **90**% of service plans due each contact year.*
- Grantee will complete **100**% of monthly contacts during each contract year.*
- Grantee will complete **100**% of face-to-face contacts each contract year.*

  * Tracked via documentation in the CA GetCare database

Outcome Objectives

The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
Program Analyst
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@SFgov.org

Patrick Garcia
Contract Manager
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Patrick.Garcia@SFgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name					Term
Catholic Charities					7/1/21-6/30/23
(Check One) New: Renewal: Modification: X					
If modification, Effective Date of Mod. 1/1/23 No. of Mod. 1					
Program: Case Management					
Budget Reference Page No.(s)			(Modification)		(Total)
Program Term	7/1/21-6/30/22	7/1/22-6/30/23	1/1/23-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
Expenditures					
Salaries & Benefits	$212,998	$212,998	$48,805	$261,803	$474,801
Operating Expenses	$14,527	$14,527	($3,117)	$11,410	$25,937
Subtotal	$227,525	$227,525	$45,688	$273,213	$500,738
Indirect Percentage (%)	15%	15%		15%	15%
Indirect Cost (Line 16 X Line 15)	$34,129	$34,129	$6,853	$40,982	$75,111
Subcontractor/Capital Expenditures					
Total Expenditures	**$261,654**	**$261,654**	**$52,541**	**$314,195**	**$575,849**
HSA Revenues					
General Fund	$212,109	$212,109		$212,109	$424,218
Federal Funds (CFDA 93.778)	$34,529	$34,529		$34,529	$69,058
CODB	$15,016	$15,016	$8,861	$23,877	$38,893
Wage Increase (OTO 22/23)			$43,680	$43,680	$43,680
TOTAL HSA REVENUES	**$261,654**	**$261,654**	**$52,541**	**$314,195**	**$575,849**
Other Revenues					
Total Revenues	**$261,654**	**$261,654**	**$52,541**	**$314,195**	**$575,849**
Full Time Equivalent (FTE)					

Prepared by:

HSA-CO Review Signature: _____

HSA #1

Salaries & Benefits Detail

					7/1/21-6/30/22					7/1/22-6/30/23	(Modification) 1/1/23-6/30/23	7/1/22-6/30/23	(Total) 7/1/21-6/30/23
	Agency Totals		HSA Program		DAS	Agency Totals		HSA Program		DAS	DAS	DAS	DAS
POSITION TITLE	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Program Director	$80,759	1.00	31%	0.31	$24,732	$98,729	1.00	33%	0.33	$24,732	$7,849	$32,581	$57,313
Social Worker #1	$57,714	1.00	75%	0.75	$43,286	$62,587	1.00	88%	0.88	$43,286	$11,478	$54,764	$98,050
Social Worker #2	$57,714	1.00	75%	0.75	$43,286	$62,587	1.00	88%	0.88	$43,286	$11,478	$54,764	$98,050
Social Worker #3	$57,714	0.50	100%	0.50	$28,857	$62,587	0.50	90%	0.45	$28,857	-$693	$28,164	$57,021
Director of Client Services	$134,985	1.00	6%	0.06	$8,437	$134,985	1.00		-	$8,437	-$8,437		$8,437
Program Specialist	$72,800	0.25	80%	0.20	$14,560	$76,440	0.60	66%	0.40	$14,560	$15,710	$30,270	$44,830
TOTALS	$461,686	4.75	367%	2.57	$163,158	$497,915	5.10	364%	2.93	$163,158	$37,385	$200,543	$363,701
FRINGE BENEFIT RATE	31%					31%				31%			
EMPLOYEE FRINGE BENEFITS	$141,031				$49,840	$152,098				$49,840	$11,420	$61,260	$111,100
TOTAL SALARIES & BENEFITS	**$602,717**				**$212,998**	**$650,013**				**$212,998**	**$48,805**	**$261,803**	**$474,801**

HSA #2

Operating Expense Detail

Expenditure Category	7/1/21-6/30/22	7/1/22-6/30/23	(Modification) 1/1/23-6/30/23	7/1/22-6/30/23	(Total) 7/1/21-6/30/23
Rental of Property	$4,266	$4,266	-$341	$3,925	$8,191
Utilities(Elec, Water, Gas, Phone, Garbage)	$4,073	$4,073	-$3,000	$1,073	$5,146
Office Supplies, Postage	$300	$300		$300	$600
Building Maintenance Supplies and Repair	$150	$150		$150	$300
Printing and Reproduction	$100	$100		$100	$200
Insurance	$4,256	$4,256	-$476	$3,780	$8,036
Staff Training	$165	$165		$165	$330
Staff Travel-(Local & Out of Town)	$867	$867	$700	$1,567	$2,434
Rental of Equipment	$150	$150		$150	$300
CONSULTANTS					
Computer related	$200	$200		$200	$400
OTHER					
TOTAL OPERATING EXPENSE	**$14,527**	**$14,527**	**-$3,117**	**$11,410**	**$25,937**
HSA #3					

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

CURRY SENIOR CENTER

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered.

	Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation.
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Curry Senior Center
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services.
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships

Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Curry Senior Center Case Management services are provided at 333 Turk Street, San Francisco, CA, 94102. Hours of operation are Monday through Friday, 8:00am to 4:30pm.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #38 "OCP Case Management Program Standards" (as revised March 2, 2022). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

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b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The

case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

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The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

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- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and

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- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will provide case management services to at least **180** unduplicated consumers.

  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

- Grantee will complete **__90___**% of comprehensive assessments due each contract year.*
- Grantee will complete **__90___**% of service plans due each contact year.*
- Grantee will complete **__100__**% of monthly contacts during each contract year.*
- Grantee will complete **__100__**% of face-to-face contacts each contract year.*

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Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

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Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

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F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

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I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

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PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

Ella Lee
Human Services Agency
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San Francisco, CA 94120
Ella.Lee@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

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HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name				Term	
Curry Senior Center				FY 21/22 - FY 22/23	
(Check One) New ____ Renewal ____ Modification __x__					
If modification, Effective Date of Mod.	No. of Mod.				
Program: Case Management					
Budget Reference Page No.(s)					
Program Term	FY 21/22	FY 22/23			Total
Expenditures	Revised	Budget	Modification	Revised	
Salaries & Benefits	$293,396	$293,979	$55,706	$349,685	$643,081
Operating Expense	$29,883	$29,300	$7,915	$37,215	$67,098
Subtotal	$323,279	$323,279	$63,621	$386,900	$710,179
Indirect Percentage (%)	15%	15%		15%	
Indirect Cost (Line 16 X Line 15)	$48,492	$48,492	$9,543	$58,035	$106,527
Capital Expenditure					
Total Expenditures	$371,771	$371,771	$73,164	$444,935	$816,706
HSA Revenues					
General Fund	$301,370	$301,370		$301,370	$602,740
CFDA #93.778 (14%)	$49,060	$49,060		$49,060	$98,120
CODB	$21,341	$21,341	$14,871	$36,212	$57,553
LGBTQ+ case manager			$33,333	$33,333	$33,333
Case manager wage increase			$24,960	$24,960	$24,960
TOTAL HSA REVENUES	$371,771	$371,771	$73,164	$444,935	$816,706
Other Revenues					
Leverage-Medical Supervisor	$194,545	$194,545		$194,545	$389,090
Leverage-Translation	$7,500	$7,500		$7,500	$15,000
Cash Match-Client Assistance Fund	$25,000	$25,000		$25,000	$50,000
Total Revenues	$227,045	$227,045		$227,045	$454,090
Full Time Equivalent (FTE)	3.40			3.56	
Prepared by:				Telephone No.:	Date
HSA-CO Review Signature:					
HSA #1					**10/25/2016**

Salaries & Benefits Detail

	FY 21/22								FY 22/23			Total
	Agency Totals		HSA Program		HSA Program	Agency Totals		HSA Program		HSA Program				
POSITION TITLE	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Revised Salary	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Modification	Revised Salary	HSA Program
Case Manager	$68,250	1.00	100.00%	1.00	$68,250	$77,221	1.00	100.00%	1.00	$68,250	$8,971	$77,221	$145,471
Case Manager	$73,125	1.00	89.93%	0.90	$65,761	$82,349	1.00	100.00%	1.00	$64,674	$17,675	$82,349	$148,110
Case Manager	$68,250	1.00	54.25%	0.54	$37,026	$73,808	1.00	72.29%	0.72	$44,888	$8,468	$53,356	$90,382
Director of Clinical Programs	$98,943	0.85	20.00%	0.17	$16,880	$103,896	1.00	17.00%	0.17	$16,880	$782	$17,662	$34,542
Program Assistant-Chinese	$63,375	1.00	16.35%	0.16	$10,362	$71,936	1.00	17.00%	0.17	$7,136	$5,093	$12,229	$22,591
Program Assistant-Lao	$41,315	0.53	29.95%	0.16	$6,600	$50,213	0.67	18.75%	0.13	$6,000	$308	$6,308	$12,908
Program Assistant-Russian	$41,315	0.67	23.96%	0.16	$6,600	$50,213	0.67	18.75%	0.13	$6,000	$308	$6,308	$12,908
Program Assistant-Vietnamese	$40,170	0.93	21.07%	0.20	$7,900	$50,213	1.00	14.92%	0.15	$6,000	$1,492	$7,492	$15,392
Eligibility Clerk	$59,753	1.00	0.52%	0.01	$310		-		-	$310	($310)		$310
Receptionist	$57,744	1.00	10.39%	0.10	$6,000	$60,645	1.00	10.00%	0.10	$6,000	$65	$6,065	$12,065
				-					-				
				-					-				
				-					-				
TOTALS	$543,990	8.99	366.42%	3.40	$225,689	$543,273	8.34	368.71%	3.56	$226,138	$42,852	$268,990	$494,679
FRINGE BENEFIT RATE	30%					30%				30%			
EMPLOYEE FRINGE BENEFITS	$163,197				$67,707	$162,982				$67,841	$12,854	$80,695	$148,402
TOTAL SALARIES & BENEFITS	$707,187				$293,396	$706,255				$293,979	$55,706	$349,685	$643,081

HSA #2 **10/25/2016**

Operating Expense Detail

TERM	FY 21/22	FY 22/23			Total
	Revised	Budget	Modification	Revised	
EXPENDITURE CATEGORY					
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Garbage)	$7,000	$7,000	$1,500	$8,500	$15,500
Office Supplies, Postage	$5,000	$5,000	$500	$5,500	$10,500
Building Maintenance Supplies and Repair	$5,500	$6,000	$500	$6,500	$12,000
Printing and Reproduction					
Insurance	$5,000	$5,500	$500	$6,000	$11,000
Staff Training	$500	$500		$500	$1,000
Staff Travel-(Local & Out of Town)	$300	$300		$300	$600
Rental of Equipment					
CONSULTANT/SUBCONTRACTOR DESCRIPTIVE TITLE					
OTHER					
Program supplies	$500	$500		$500	$1,000
Payroll fees	$513	$500	$200	$700	$1,213
Recruitment	$4,000	$4,000		$4,000	$8,000
Computer Support	$1,570		$4,715	$4,715	$6,285
TOTAL OPERATING EXPENSE	$29,883	$29,300	$7,915	$37,215	$67,098

HSA #3 **10/25/2016**

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

EPISCOPAL COMMUNITY SERVICES

CASE MANAGEMENT
Effective July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among

	providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation
CARBON	Contracts Administration, Reporting, and Billing On Line System
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Episcopal Community Services (ECS)
HSA	San Francisco Human Services Agency
Limited English-Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult

Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

The Episcopal Community Services Case Management program is housed at 705 Natoma St. The program provides services Monday through Friday 8:30 a.m. to 5:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need

for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.

- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will provide case management services to at least **_125_** unduplicated consumers.

  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

- Grantee will complete **__90___**% of comprehensive assessments due each contract year.*
- Grantee will complete **__90___**% of service plans due each contact year.*
- Grantee will complete **__100__**% of monthly contacts during each contract year.*
- Grantee will complete **__100__**% of face-to-face contacts each contract year.*

* Tracked via documentation in the CA GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

Rocio Duenas
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Rocio.Duenas@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name: **EPISCOPAL COMMUNITY SERVICES OF SAN FRANCISCO** | Term: 7/1/2021-6/30/2023

(Check One) New ____ Renewal ____ Modification __X__

If modification, Effective Date of Mod. 1/1/23 No. of Mod. 1

Program: **CASE MANAGEMENT**

Budget Reference Page No.(s)

Program Term	Revised 7/1/21-6/30/22	7/1/22-6/30/23	Modification 7/1/22-6/30/23	Revised 7/1/22-6/30/23	Total
Expenditures					
Salaries & Benefits	$242,803	$242,803	$26,669	$269,472	$512,275
Operating Expenses	$34,447	$34,447	$9,744	$44,191	$78,638
Subtotal	$277,250	$277,250	$36,413	$313,663	$590,913
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$41,588	$41,588	$5,461	$47,049	$88,637
Subcontractor/Capital Expenditure					
Total Expenditures	$318,838	$318,838	$41,874	$360,712	$679,550
HSA Revenues					
General Fund	$267,476	$267,476		$267,476	$534,952
CFDA #93.778	$42,075	$42,075		$42,075	$84,150
CODB	$9,287	$9,287		$9,287	$18,574
FY22-23 CODB			$12,754	$12,754	$12,754
FY22-23 OTO			$29,120	$29,120	$29,120
Total HSA Revenue	$318,838	$318,838	$41,874	$360,712	$679,550
Other Revenues					
TOTAL DAS AND NON DAS REVENUE	$318,838	$318,838	$41,874	$360,712	$679,550
Full Time Equivalent (FTE)		2.75			

Prepared by: Lisa Liu Date: 4/14/2021

HSA-CO Review Signature: _____

HSA #1 **11/4/2021**

Program: CASE MANAGEMENT

(Same as Line 11 on HSA #1)

Salaries & Benefits Detail

	Agency Totals		HSA Program		DAS budgeted salary				
Position	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Revised 7/1/21-6/30/22	7/1/22-6/30/23	Modification	Revised 7/1/22-6/30/23	Total
Director of Healthy Aging	$146,496	1.00	25.00%	0.25	$32,130	$32,130	$4,494	$36,624	$66,260
CKSC Program Manager	$100,543	1.00	50.00%	0.50	$45,422	$45,422	$4,850	$50,272	$104,844
CKSC Case Manager III - Bilingual	$65,158	1.00	100.00%	1.00	$58,240	$58,240	$6,918	$65,158	$119,980
CKSC Case Manager III - Homeless/Non Homeless	$50,447	1.00	100.00%	1.00	$47,840	$47,840	$2,607	$50,447	$95,680
Totals	$362,644	4.00	275.00%	2.75	$183,632	$183,632	$18,869	$202,501	$386,764
Fringe Benefits Rate	31.49%								
Employee Fringe Benefits	$114,207				$59,171	$59,171	$7,800	$66,971	$126,142
Total Salaries and Benefits	$476,851				$242,803	$242,803	$26,669	$269,472	$512,906

HSA #2 **11/4/2021**

Program: CASE MANAGEMENT
(Same as Line 11 on HSA #1)

Operating Expense Detail

Expenditure Category	Revised 7/1/21-6/30/22	7/1/22-6/30/23	Modification	Revised 7/1/22-6/30/23	Total
Rental of Property					
Utilities (Elec, Water, Gas, Phone, Garbage)					
Program:					
Building Maintenance Supplies and Repair	$21,867	$21,867	$3,944	$25,811	$47,678
Office Supplies			$1,000	$1,000	$1,000
Printing and Reproduction	$1,100	$1,100		$1,100	$2,200
Insurance	$2,850	$2,850	$2,000	$4,850	$7,700
Staff Training	$530	$530	$500	$1,030	$1,560
Staff Travel-(Local & Out of Town)	$1,000	$1,000		$1,000	$2,000
Equipment					
Consultant					
Other					
Staff Recruitment	$200	$200	$300	$500	$700
Program/Client Supplies	$1,400	$1,400	$1,000	$2,400	$3,800
Telecommunications	$5,500	$5,500	$1,000	$6,500	$12,000
Total Operating Expenses	$34,447	$34,447	$9,744	$44,191	$78,638

HSA #3 **11/4/2021**

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

INSTITUTE ON AGING

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional

	teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation
CARBON	Contracts Administration, Reporting, and Billing On Line System
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Institute on Aging (IOA)
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services.
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult

Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Institute on Aging Case Management services are located at 3575 Geary Boulevard in San Francisco. Services are available Monday through Friday from 9:00 a.m. to 5:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need

for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.

- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will provide case management services to at least **_220_** unduplicated consumers.

  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

- Grantee will complete **__90___**% of comprehensive assessments due each contract year.*
- Grantee will complete **__90___**% of service plans due each contact year.*
- Grantee will complete **__100__**% of monthly contacts during each contract year.*
- Grantee will complete **__100__**% of face-to-face contacts each contract year.*

* Tracked via documentation in the CA GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

Tim Vo
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Tim.Vo@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units

of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

	A	B	C	D	E	F
1						Appendix B-1, Page 1
2						
3	**HUMAN SERVICES AGENCY BUDGET SUMMARY**					
4	**BY PROGRAM**					
5	Name					Term
6	**Institute on Aging**					7/1/21-6/30/23
7	(Check One) New Renewal ☐ Modification X					
8	If modification, Effective Date of Mod. No. of Mod.					
9	**Program: Case Management**					
10	Budget Reference Page No.(s)			(Modification)		(Total)
11	Program Term	7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
12	**Expenditures**					
13	Salaries & Benefits	$433,034	$432,874	$53,717	$486,591	$919,625
14	Operating Expenses	$57,329	$57,489	$5,689	$63,178	$120,507
15	**Subtotal**	$490,363	$490,363	$59,406	$549,769	$1,040,132
16	Indirect Percentage (%)	15%	15%		15%	15%
17	Indirect Cost (Line 16 X Line 15)	$73,553	$73,553	$8,911	$82,464	$156,017
18	Subcontractor/Capital Expenditures					
19	**Total Expenditures**	**$563,916**	**$563,916**	**$68,317**	**$632,233**	**$1,196,149**
20	**HSA Revenues**					
21	General Fund	$489,501	$489,501		$489,501	$979,002
22	Federal Funds (CFDA 93.778)	$74,415	$74,415		$74,415	$148,830
23	CODB			$22,557	$22,557	$22,557
24	CM Wage Funding			$45,760	$45,760	$45,760
25						
26	**TOTAL HSA REVENUES**	**$563,916**	**$563,916**	**$68,317**	**$632,233**	**$1,196,149**
27	**Other Revenues**					
28						
29						
30						
31						
32						
33	**Total Revenues**	**$563,916**	**$563,916**	**$68,317**	**$632,233**	**$1,196,149**
34	Full Time Equivalent (FTE)					
36	Prepared by:					
37	HSA-CO Review Signature: _____					
38	**HSA #1**					

Institute on Aging

Program: Case Management

Salaries & Benefits Detail

POSITION TITLE	Agency Totals: Annual Full TimeSalary for FTE	Agency Totals: Total FTE	HSA Program: % FTE funded by HSA (Max 100%)	HSA Program: Adjusted FTE	7/1/21-6/30/22 DAS Budgeted Salary	Agency Totals: Annual Full TimeSalary for FTE	Agency Totals: Total FTE	HSA Program: % FTE funded by HSA (Max 100%)	HSA Program: Adjusted FTE	7/1/22-6/30/23 DAS Budgeted Salary	(Modification) 7/1/22-6/30/23 DAS Budgeted Salary	7/1/22-6/30/23 DAS Budgeted Salary	(Total) 7/1/21-6/30/23 DAS Budgeted Salary
Care Manager #1	68,598	1.00	100%	100%	$ 57,098	74,118	1.00	100%	1	$ 59,598	$ 14,520	$ 74,118	$ 131,216
Care Manager #2	57,420	1.00	100%	100%	$ 60,920	70,977	1.00	100%	1	$ 60,920	$ 10,057	$ 70,977	$ 131,897
Care Manager #3 (Bilingual C/M)	56,294	1.00	100%	100%	$ 71,494	77,590	1.00	100%	1	$ 69,994	$ 7,596	$ 77,590	$ 149,084
Care Manager #4 (Bilingual S)	74,887	1.00	100%	100%	$ 74,887	78,693	1.00	100%	1	$ 74,887	$ 3,806	$ 78,693	$ 153,580
Project Manager	$118,000	1.00	10%	0.10	$ 17,000	$119,770	1.00	10%	0.1	$ 8,350	$ 3,627	$ 11,977	$ 28,977
Manager, NorCal CM	110,700	1.00	0%	0%	$ 128								$ 128
Clinical Supervisor	$95,000	1.00	45%	45%	$ 37,100	$95,000	1.00	55%	0.55	$ 42,750	$ 9,500	$ 52,250	$ 89,350
Snr. Mngr Community Programs	$117,000	1.00	10%	10%	$ 9,700	$122,815	1.00	5%	0.05	$ 11,700	$ (5,559)	$ 6,141	$ 15,841
Senior Program Coordinator	$60,000	1.00	5%	5%	$ 3,000	$60,000	1.00	10%		$ 3,000	$ (3,000)	$ -	$ 3,000
VP, CLS	$190,000	1.00	5%	5%	$ 9,500	$192,850	1.00			$ 9,500	$ (9,500)	$ -	$ 9,500
CLS Business Manager	$112,000	1.00	5%	5%	$ 5,600	$117,233	1.00	5%	0.05	$ 5,600	$ 262	$ 5,862	$ 11,462
Manager LTCM						$112,000	1.00	10%	0.1	$ -	$ 6,892	$ 6,892	$ 6,892
Senior Director Care Management						$146,000	1.00	5%	0.05	$ -	$ 4,773	$ 4,773	$ 4,773
TOTALS	$ 580,899	11.00	480%	4.80	$346,427	$ 516,148	12.00	500%	4.90	$346,299	$42,974	$389,273	$735,700
FRINGE BENEFIT RATE	25%					25%				25%			
EMPLOYEE FRINGE BENEFITS	$145,225				$86,607	$129,037				$86,575	$10,743	$97,318	$ 183,925
TOTAL SALARIES & BENEFITS	$726,124				$433,034	$645,185				$432,874	$53,717	$486,591	$919,625

HSA #2

Institute on Aging
Program: Case Management

Operating Expense Detail

Expenditure Category	7/1/22-6/30/23	(Modification) 7/1/22-6/30/23	7/1/22-6/30/23	(Total) 7/1/21-6/30/23
Rental of Property	$14,200	($1,612)	$12,588	$ 22,588
Utilities (Elec, Water, Gas, Scavenger)	$4,500		$4,500	$ 9,000
Office Supplies, Postage	$3,200		$3,200	$ 7,400
Building Maintenance Supplies and Repair				
Printing and Reproduction				
Insurance	$2,000	$400	$2,400	$ 4,400
Staff Training/retreat	$2,785		$2,785	$ 9,410
Staff Travel (Local & Out of Town)	$2,700		$2,700	$ 5,400
Consultants/Subcontractors				
Translation	$300		$300	$ 600
Other				
Wireless fees	$4,154		$4,154	$ 8,308
Small Equipiment (Technology)	$8,400	$2,851	$11,251	$ 19,651
Liscenses and Fees	$3,800	$1,800	$5,600	$ 9,600
Recruitment fee	$750	$250	$1,000	$ 1,750
Purchase of Service	$7,200	$1,000	$8,200	$ 15,400
Respite Fund	$3,500	$1,000	$4,500	$ 7,000
TOTAL OPERATING EXPENSE	**$ 57,489**	**$ 5,689**	**$ 63,178**	**$ 120,507**

HSA #3

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

Jewish Family and Children Services

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur

	within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Jewish Family and Children's Services
HSA	San Francisco Human Services Agency
Limited English-Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services.
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary

OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.).

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation

- Needs limited to only 'case monitoring' (i.e., no active service plan needs) or 'finding housing' are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Jewish Family and Children's Services Case Management services are offered out of the JFCS offices at 2534 Judah Street, San Francisco, CA, 94122, Monday through Friday, 8:30am to 5:00pm.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment
All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment
Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning
The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation
The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring
Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

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Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

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The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

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- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
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procedures to operationalize the standards within their own agency to best meet client needs.

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Service Objectives

For each Fiscal Year:

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  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)
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- Grantee will complete **90**% of service plans due each contact year.*
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The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
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Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/)*, and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

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D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

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H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

and

Tim Vo
Human Services Agency
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San Francisco, CA 94120
Tim.Vo@sfgov.org

IX. MONITORING ACTIVITIES:

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organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

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HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name					Term
Jewish Family and Children's Services					FY 22/23
(Check One) New ____ Renewal ____ Modification __x__					
If modification, Effective Date of Mod.	No. of Mod.				
Program: Case Management					
Budget Reference Page No.(s)					
Program Term	FY 21/22	FY 22/23			Total
Expenditures	Revised	Budget	Modification	Revised	
Salaries & Benefits	$100,090	$100,090	$11,504	$111,594	$211,684
Operating Expense	$3,041	$3,041	$475	$3,516	$6,557
Subtotal	$103,131	$103,131	$11,978	$115,109	$218,240
Indirect Percentage (%)	6%	6%	6%	6%	
Indirect Cost (Line 16 X Line 15)	$6,142	$6,142	$713	$6,855	$12,997
Capital Expenditure					
Total Expenditures	$109,273	$109,273	$12,691	$121,964	$231,237
HSA Revenues					
General Fund	$88,580	$88,580		$88,580	$177,160
CFDA #93.778 (14%)	$14,420	$20,693		$14,420	$28,840
CODB FY21-22	$6,273			$6,273	$12,546
CODB FY22-23				$4,371	$4,371
OTO				$8,320	$8,320
TOTAL HSA REVENUES	$109,273	$109,273	$12,691	$121,964	$231,237
Other Revenues					
Total Revenues	$109,273	$109,273	$12,691	$121,964	$231,237
Full Time Equivalent (FTE)					
Prepared by: Norman Santos				415-449-1274	12/14/2022
HSA-CO Review Signature:					
HSA #1					**11/11/2022**

Salaries & Benefits Detail

	Agency Totals		HSA Program		FY 21/22	FY 22/23			Total
					DAS Program	DAS Program	DAS Program	DAS Program	DAS Program
POSITION TITLE	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE		Budgeted Salary	Modification	Revised Salary	Budgeted Salary
Bi-Lingual Care Manager	*$69,362*	*1.00*	*100%*	1.00	$69,362	$69,362		$69,362	$138,724
Program Supervision	*$132,928*	*1.00*	*11%*	0.11	$14,179	$14,179	($10,634)	$3,545	$17,724
Program Supervision	$123,024	1.00	19%	0.19			$20,236	$20,236	$20,236
				-					
				-					
TOTALS	$571,363	3.00	130%	1.30	$83,541	$83,541	$9,602	$93,143	$176,684
FRINGE BENEFIT RATE	20%					20%			
EMPLOYEE FRINGE BENEFIT	$113,184				$16,549	$16,549	$1,902	$18,451	$35,000
TOTAL SALARIES & BENEFIT	$684,547				$100,090	$100,090	$11,504	$111,594	$211,684

HSA #2 **11/11/2022**

Program: Case Management
(Same as Line 9 on HSA #1)

Operating Expense Detail

	TERM	FY 21/22	FY 22/23			Total
EXPENDITURE CATEGORY			Budget	Modification	Revised	
Rental of Property		$750	$750	$254	$1,004	$1,754
Utilities(Elec, Water, Gas, Phone, Garbage)		$63	$63	($9)	$54	$117
Office Supplies, Postage		$272	$272		$272	$544
Building Maintenance Supplies and Repair		$1,310	$1,310	$175	$1,485	$2,795
Printing and Reproduction		$135	$135		$135	$270
Insurance		$393	$393	$55	$448	$841
Staff Training						
Staff Travel-(Local & Out of Town)		$118	$118		$118	$236
Rental of Equipment						
CONSULTANT/SUBCONTRACTOR DESCRIPTIVE TITLE						
OTHER						
TOTAL OPERATING EXPENSE		$3,041	$3,041	$475	$3,516	$6,557

HSA #3 **11/11/2022**

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

Kimochi Inc.

CASE MANAGEMENT

July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems

	arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation.
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Kimochi Inc.
HSA	San Francisco Human Services Agency
Limited English-Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary

OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.).

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.

- Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
- Needs limited to only 'case monitoring' (i.e., no active service plan needs) or 'finding housing' are not a demonstrable need for OCP case management services

V. Location and Time of Services:

The Kimochi Inc, Case Management program is housed at 1715 Buchanan Street in San Francisco. The hours of operation are Monday through Friday 9:00 a.m. to 5:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment
All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment
Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning
The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation
The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring
Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes
Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment
Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment
Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives

For each Fiscal Year:

- Grantee will provide case management services to at least **68** unduplicated consumers.
  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)
- Grantee will complete **90** % of comprehensive assessments due each contract year.*
- Grantee will complete **90** % of service plans due each contact year.*
- Grantee will complete **100** % of monthly contacts during each contract year.*
- Grantee will complete **100** % of face-to-face contacts each contract year.*

* Tracked via documentation in the CA GetCare database

Outcome Objectives

The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25%** of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case

Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

and

Ella Lee
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Ella.Lee@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name					Term
Kimochi, Inc.					FY 21/22 - FY 22/23
(Check One) New ____ Renewal ____ Modification __x__					
If modification, Effective Date of Mod.		No. of Mod.			
Program: Case Management					
Budget Reference Page No.(s)					
Program Term	FY 21/22	FY 22/23			Total
Expenditures	Revised	Budget	Modification	Revised	
Salaries & Benefits	$103,800	$103,800	$29,120	$132,920	$236,720
Operating Expense	$21,043	$21,043	$2,400	$23,443	$44,486
Subtotal	$124,843	$124,843	$31,520	$156,363	$281,206
Indirect Percentage (%)	10%	10%		10%	
Indirect Cost (Line 16 X Line 15)	$12,484	$12,484	$3,226	$15,710	$28,194
Capital Expenditure	$3,321	$3,321		$3,321	$6,642
Total Expenditures	$140,648	$140,648	$34,746	$175,394	$316,042
HSA Revenues					
General Fund	$132,574	$132,574		$132,574	$265,148
CODB	$8,074	$8,074	$5,626	$13,700	$21,774
Case manager wage increase			$29,120	$29,120	$29,120
TOTAL HSA REVENUES	$140,648	$140,648	$34,746	$175,394	$316,042
Other Revenues					
Total Revenues	$140,648	$140,648	$34,746	$175,394	$316,042
Full Time Equivalent (FTE)					
Prepared by: Shawne O'Connell				Telephone No.: 415-931-2294	
HSA-CO Review Signature:					
HSA #1					**12/17/2021**

Program: Case Management
(Same as Line 9 on HSA #1)

Salaries & Benefits Detail

	Agency Totals		HSA Program		FY 21/22 DAS Program	Agency Totals		HSA Program		FY 22/23 DAS Program	FY 22/23 DAS Program	FY 22/23 DAS Program	Total DAS Program
POSITION TITLE	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Revised Salary	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Modification	Revised Salary	
Social Services Coordinator	$62,400	1.00	35%	0.35	$21,840	$70,720	1.00	51%	0.51	$21,840	$14,163	$36,003	$57,843
Case Manager, Japanese	$51,000	1.00	60%	0.60	$30,600	$58,240	1.00	48%	0.48	$30,600	($2,454)	$28,146	$58,746
Case Manager, Korean	$51,000	1.00	60%	0.60	$30,600	$58,240	0.74	86%	0.64	$30,600	$6,510	$37,110	$67,710
				-					-				
				-					-				
				-					-				
				-					-				
				-					-				
TOTALS	$102,000	3.00	155%	1.55	$83,040	$116,480	2.74	185%	1.63	$83,040	$18,219	$101,259	$184,299
FRINGE BENEFIT RATE	25%					31%				25%			
EMPLOYEE FRINGE BENEFITS	$25,500				$20,760	$29,120				$20,760	$10,901	$31,661	$52,421
TOTAL SALARIES & BENEFITS	$127,500				$103,800	$145,600				$103,800	$29,120	$132,920	$236,720

HSA #2 **12/17/2021**

Operating Expense Detail

TERM	FY 21/22	FY 22/23			Total
	Revised	Budget	Modification	Revised	
EXPENDITURE CATEGORY					
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Garbage)	$4,500	$4,500		$4,500	$9,000
Office Supplies, Postage					
Building Maintenance Supplies and Repair					
Printing and Reproduction					
Insurance D&O	$1,500	$1,500		$1,500	$3,000
Insurance General	$4,643	$4,643		$4,643	$9,286
Staff Traing					
Staff Travel-(Local & Out of Town)					
Rental of Equipment					
CONSULTANT/SUBCONTRACTOR DESCRIPTIVE TITLE					
OTHER					
Computer/IT/Website	$3,900	$3,900		$3,900	$7,800
Prof Services - Accounting	$2,000	$2,000	$1,900	$3,900	$5,900
Telephone	$4,500	$4,500	$500	$5,000	$9,500
TOTAL OPERATING EXPENSE	$21,043	$21,043	$2,400	$23,443	$44,486

HSA #3 **12/17/2021**

Program: Case Management
(Same as Line 9 on HSA #1)

Program Expenditure Detail

EQUIPMENT		FY 21/22	FY 22/23			Total
No.	ITEM/DESCRIPTION	Revised	Budget	Modification	Revised	
2	Desktop Computers	$3,321	$3,321		$3,321	$6,642
2	Desktop Computers					
TOTAL EQUIPMENT COST		$3,321	$3,321		$3,321	$6,642
REMODELING						
Description						
TOTAL REMODELING COST						
TOTAL CAPITAL EXPENDITURE (Equipment and Remodeling Cost)		$3,321	$3,321		$3,321	$6,642

HSA #4 **12/17/2021**

APPENDIX A-1: SERVICES TO BE PROVIDED

ON-LOK / 30TH STREET SENIOR CENTER

Effective July 1, 2021 to June 30, 2023

CASE MANAGEMENT

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates

	services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation.
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	On-Lok/ 30th Street Senior Center
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services.
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult

Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.).

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
  - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
  - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

30th Street Senior Center Case Management services are located at 225 30th Street 3rd floor in San Francisco. Services are available Monday through Friday 8:30 a.m. to 5:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 “OCP Case Management Program Standards” (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

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- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives

For each Fiscal Year:

- Grantee will provide case management services to at least **132** unduplicated consumers.
  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)
- Grantee will complete **90**% of comprehensive assessments due each contract year.*
- Grantee will complete **90**% of service plans due each contact year.*
- Grantee will complete **100**% of monthly contacts during each contract year.*
- Grantee will complete **100**% of face-to-face contacts each contract year.*

  * Tracked via documentation in the CA GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*
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VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

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G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

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K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
Program Analyst
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@SFgov.org

Patrick Garcia
Contract Manager
Human Services Agency
PO Box 7988
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Patrick.Garcia@SFgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name					Term
On-Lok Day Services					7/1/21-6/30/23
(Check One) New: Renewal: Modification: X					
If modification, Effective Date of Mod. 07/01/22 No. of Mod. 2					
Program: Case Management					
Budget Reference Page No.(s)			(Modification)		(Total)
Program Term	7/1/21-6/30/22	7/1/22-6/30/23	1/1/23-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
Expenditures					
Salaries & Benefits	$274,753	$275,781	$27,978	$303,759	$578,512
Operating Expenses	$36,586	$35,558	$4,372	$39,930	$76,516
Subtotal	$311,339	$311,339	$32,350	$343,689	$655,028
Indirect Percentage (%)	15%	15%		15%	15%
Indirect Cost (Line 16 X Line 15)	$46,701	$46,701	$4,852	$51,553	$98,254
Subcontractor/Capital Expenditures					
Total Expenditures	**$358,040**	**$358,040**	**$37,202**	**$395,242**	**$753,282**
HSA Revenues					
General Fund	$290,239	$290,239		$290,239	$580,478
Federal Funds (CFDA 93.778)	$47,248	$47,248		$47,248	$94,496
CODB	$20,553	$20,553	$14,322	$34,875	$55,428
Wage Increase (OTO 22/23)			$22,880	$22,880	$22,880
TOTAL HSA REVENUES	**$358,040**	**$358,040**	**$37,202**	**$395,242**	**$753,282**
Other Revenues					
Agency Cash - Fundraising	$22,937	$22,937		$22,937	$45,875
Total Revenues	**$380,977**	**$380,977**	**$37,202**	**$418,179**	**$799,157**
Full Time Equivalent (FTE)	2.96	3.07	0.28	3.35	6.31
Prepared by: Meko Ma					
HSA-CO Review Signature: _____					
HSA #1					

Salaries & Benefits Detail

H.S.A-DAS	Agency Totals		HSA Program		7/1/21-6/30/22 **DAS**	Agency Totals		HSA Program		7/1/22-6/30/23 **DAS**	(Modification) 1/1/23-6/30/23 **DAS**	7/1/22-6/30/23 **DAS**	(Total) 7/1/21-6/30/23 **DAS**
POSITION TITLE	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Geriatrics Support Services Manager	$84,843	0.70	75%	0.53	$44,543	$96,345	1.00	75%	0.75	$63,632	$8,627	$72,259	$116,802
Case Manager #1	$70,900	1.00	100%	1.00	$70,900	$72,135	1.00	100%	1.00	$63,231	$8,904	$72,135	$143,035
Case Manager #2	$76,500	1.00	100%	1.00	$76,500	$76,500	1.00	78%	0.78	$55,171	$4,499	$59,670	$136,170
Hospitality Coordinator	$49,878	1.00	7%	0.07	$3,491	$49,878	1.00	7%	0.07	$3,491		$3,491	$6,982
Administrative Secretary	$60,778	0.54	20%	0.11	$6,564	$60,778	1.00	20%	0.20	$12,156		$12,156	$18,720
Assistant Director	$96,907	0.74	20%	0.15	$14,343	$96,907	1.00	20%	0.20	$19,469		$19,469	$33,812
TOTALS	$439,806	4.98	322%	2.85	$216,341	$452,543	6.00	300%	3.00	$217,150	$22,030	$239,180	$455,521
FRINGE BENEFIT RATE	27%					27%				27%			
EMPLOYEE FRINGE BENEFITS	$118,748				$58,412	$122,187				$58,631	$5,948	$64,579	$122,991
TOTAL DAS SALARIES & BENEFITS	**$558,554**				**$274,753**	**$574,730**				**$275,781**	**$27,978**	**$303,759**	**$578,512**

Non-DAS	Agency Totals		HSA Program		7/1/21-6/30/22 **Non-DAS**	Agency Totals		HSA Program		7/1/22-6/30/23 **Non-DAS**	(Modification) 1/1/23-6/30/23 **Non-DAS**	7/1/22-6/30/23 **Non-DAS**	(Total) 7/1/21-6/30/23 **Non-DAS**
POSITION TITLE	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by CBO (Max 100%)	Adjusted FTE	Budgeted Salary	Annual Full TimeSalary for FTE	Total FTE	% FTE funded by CBO (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Geriatrics Support Services Manager	$84,843	0.70				$96,345	1.00						
Case Manager #1	$70,900	1.00				$72,135	1.00			$7,669	-$7,669		
Case Manager #2	$76,500	1.00				$76,500	1.00	22%	0.22	$21,329	-$4,499	$16,830	$16,830
Hospitality Coordinator	$49,878	1.00	3%	0.03	$1,496	$49,878	1.00	3%	0.03	$1,497		$1,497	$2,993
Administrative Secretary	$60,778	0.54				$60,778	1.00						
Assistant Director	$96,907	0.74	10%	0.07	$7,170	$96,907	1.00	10%	0.10	$9,603		$9,603	$16,773
TOTALS	$439,806	4.98	13%	0.10	$8,666	$452,543	6.00	35%	0.35	$40,098	-$12,168	$27,930	$36,596
FRINGE BENEFIT RATE	27%					27%				13%			
EMPLOYEE FRINGE BENEFITS	$118,748				$2,340	$122,187				$5,034	$2,507	$7,541	$9,752
TOTAL NON-DAS SALARIES & BENEFITS	**$558,554**				**$11,006**	**$574,730**				**$45,132**	**-$9,661**	**$35,471**	**$46,348**
TOTAL DAS & NON-DAS SALARIES & BENEFITS	**$558,554**				**$285,759**	**$574,730**				**$320,913**	**$18,317**	**$339,230**	**$624,860**

HSA #2

Operating Expense Detail

Expenditure Category	7/1/21-6/30/22	7/1/22-6/30/23	(Modification) 1/1/23-6/30/23	7/1/22-6/30/23	(Total) 7/1/21-6/30/23
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Garbage)	$2,608	$3,308		$3,308	$5,916
Office Supplies, Postage	$1,100	$500		$500	$1,600
Building Maintenance Supplies and Repair	$8,500	$8,500		$8,500	$17,000
Printing and Reproduction	$1,100	$1,900		$1,900	$3,000
Insurance	$2,000	$1,650		$1,650	$3,650
Staff Training		$750		$750	$750
Staff Travel-(Local & Out of Town)	$8,000	$8,000	$4,372	$12,372	$20,372
Rental of Equipment	$450	$450		$450	$900
Consultants/Subcontractors					
Other					
Payroll Processing	$400	$400		$400	$800
Data Plan	$2,750	$2,000		$2,000	$4,750
Purchased Services - client assistance	$5,578	$3,400	$3,200	$6,600	$12,178
Social Worker Intern stipend		$3,200	($3,200)		
PPE Supplies	$1,500	$1,500		$1,500	$3,000
Recruiting Fee	$2,600				$2,600
TOTAL OPERATING EXPENSE	**$36,586**	**$35,558**	**$4,372**	**$39,930**	**$76,516**

HSA #3

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

OPENHOUSE

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional

	teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation
CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Openhouse
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships

Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.).

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only ‘case monitoring’ (i.e., no active service plan needs) or ‘finding housing’ are not a demonstrable need for OCP case management services

V. Location and Time of Services:

Openhouse Case Management services are offered out of the Bob Ross LGBT Senior Center, 65 Laguna Street, San Francisco, CA, 94102. Hours of operation are Monday through Friday, 9:30am to 5:30pm.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

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- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

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  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

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A. The grantee will enroll the clients into the CA GetCare database: *(https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered online to this website link: *https://calmaa.hfa3.org/signin*

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Steve.Kim@sfgov.org

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HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name			Term		
Openhouse			Jul 2021 - Jun 2023		
(Check One) New ____ Renewal ____ **Modification __x__**					
If modification, Effective Date of Mod. 1/1/2023	No. of Mod.# 1				
Program: Case Management					
Budget Reference Page No.(s)	Actual	Current	Modification	Revised	
Program Term	FY21/22	FY 22/23	FY 22/23	FY 22/23	Total
Expenditures					
Salaries & Benefits	$104,789	$104,789	$40,411	$145,200	$249,989
Operating Expenses					
Subtotal	$104,789	$104,789	$40,411	$145,200	$249,989
Indirect Percentage (%)	15%	15%	15%	15%	15.00%
Indirect Cost	$15,718	$15,718	$6,062	$21,780	$37,498
Subcontractor/Capital Expenditure					
Total Expenditures	$120,507	$120,507	$46,473	$166,980	$287,487
HSA Revenues					
General Fund	$120,507	$120,507		$120,507	$241,014
OTO			$33,333	$33,333	$33,333
CODB			$4,820	$4,820	$4,820
Additional OTO			$8,320	$8,320	$8,320
Total HSA Revenue	$120,507	$120,507	$46,473	$166,980	$287,487
Other Revenues					
TOTAL DAS AND NON DAS REVENUE	$120,507	$120,507	$46,473	$166,980	$287,487
Full Time Equivalent (FTE)					
Prepared by: Matthew Cimino	Telephone No.: 415-530-2783				
HSA-CO Review Signature:					

HSA #1 **1/4/2023**

Program: Case Management
(Same as Line 11 on HSA #1)

Salaries & Benefits Detail

	Agency Totals		HSA Program		DAS budgeted salary				
Position	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Actual FY21/22	Current FY 22/23	Modification FY 22/23	Revised FY 22/23	Total
Case Manager-I	$64,305	1.00	87.69%	0.88	$37,118	$44,233	$12,158	$56,391	$93,509
Mgr of CSS	$71,000	1.00	49.95%	0.50	$3,911	$20,230	$15,234	$35,464	$39,375
Director of CSS	$95,000	1.00	30.68%	0.31	$11,923	$22,861	$6,284	$29,145	$41,068
Case Manager-II	$54,995	1.00			$34,372				$34,372
Totals	$285,300	4.00	168.32%	1.68	$87,324	$87,324	$33,676	$121,000	$208,324
Fringe Benefits Rate	20.00%								
Employee Fringe Benefits	$57,060				$17,465	$17,465	$6,735	$24,200	$41,665
Total Salaries and Benefits	$342,360				$104,789	$104,789	$40,411	$145,200	$249,989

HSA #2 **1/4/2023**

APPENDIX A-1: SERVICES TO BE PROVIDED BY GRANTEE

SELF-HELP FOR THE ELDERLY

CASE MANAGEMENT
July 1, 2021 to June 30, 2023

Modified: January 4, 2023

I. Purpose:

Office of Community Partnerships funds case management programs to help facilitate connections for older adults and adults with disabilities to services that promote and maintain the optimum level of functioning in the most independent setting. Activities of case management services include intake/enrollment, assessment, service planning and implementation, monitoring, reassessment, and ultimately discharge/disenrollment from services.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability.
At risk of institutionalization	To be considered at risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transferring, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone
Case Management	Case management is a process to plan, seek, advocate for, and monitor services from different social service or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
City	City and County of San Francisco, a municipal corporation

CARBON	Contracts Administration, Reporting, and Billing On Line System
Communities of Color	An inclusive term and unifying term for persons who do not identify as White, who have been historically and systemically disadvantaged by institutionalized and interpersonal racism
DAS	Department of Disability and Aging Servicers
Disability	A condition or combination of conditions that is attributable to a mental, cognitive or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
Grantee	Self-Help for the Elderly (SHE)
HSA	San Francisco Human Services Agency
Limited English- Speaking Proficiency	Any person who does not speak English well or is otherwise unable to communicate effectively in English because English is not the person's primary language
Low Income	Having income at or below 300% of the federal poverty line defined by the federal Bureau of the Census and published annually by the U.S. Department of Health and Human Services
LGBTQ+	An acronym/term used to refer to persons who self-identify as non-heterosexual and/or whose gender identity does not correspond to their birth sex. This includes, but is not limited to, lesbian, gay, bisexual, transgender, genderqueer, and gender non-binary
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older, used interchangeably with senior
Senior	Person who is 60 years or older, used interchangeably with older adult
Socially Isolated	Having few social relationships and few people to interact with regularly
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9.)

III. Target Population

This program is designed to serve all ethnicities and populations, with focused expertise to

promote the unique cultural needs which have been identified as demonstrating the greatest economic and social need:

- Persons with low income
- Persons who are socially isolated
- Persons with limited English-speaking proficiency
- Persons from communities of color
- Persons who identify as LGBTQ+
- Persons at risk of institutionalization

IV. Eligibility for Services

To be eligible for services, clients must be:

- An older adult aged 60 years or older, or
- An adult with a disability aged 18-59
- A resident of San Francisco
- At an income level of 400% of federal poverty or less
- Not currently receiving duplicative case management services
- Has a demonstrable need for case management and is willing to participate in the program.
    - Demonstrable need includes: inability to coordinate needed services, identifiable service needs such as connection to health services, money management, or stabilization of living situation
    - Needs limited to only 'case monitoring' (i.e., no active service plan needs) or 'finding housing' are not a demonstrable need for OCP case management services

V. Location and Time of Services:

The Self-Help for the Elderly Case Management program is housed at 601 Jackson Street in San Francisco. It is open Monday through Friday from 9:00 a.m. to 5:00 p.m.

VI. Description of Services

Grantee shall provide case management services to eligible clients consistent with OCP Policy Memorandum #39 "OCP Case Management Program Standards" (as revised March 5, 2018). The OCP Case Management Program Standards include core elements described below. Performance of core elements are recorded in the CA GetCare database which all OCP funded case management providers are required to utilize.

***Grantee shall continue to follow guidance in or instructions from health care providers, the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH), and local health departments relating to COVID-19. If there are contradictory requirements between the most current CDC, CDPH, and local health department guidance or health orders, providers should follow the strictest requirements. These requirements shall be followed with the intent to maximize the health and safety of Grantee staff and clients receiving services.

1) The Case Management process includes at a minimum the following:

a. Intake/Enrollment

All clients seeking to newly enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP funded case management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The CIW process helps determine presumptive eligibility of the potential client, track unmet need, and streamline the referral process. OCP funded case management providers will select clients from the CIW for enrollment in services.

b. Comprehensive Assessment

Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems to be addressed in a service plan to coordinate services.

c. Service Planning

The information collected through the comprehensive assessment will allow a case manager to identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment.

d. Service Plan Implementation

The implementation of the service plan is the process of putting the plan into action. The case manager acts as a link between the client and the needed services, helping to assure the most appropriate, timely, and cost effective delivery of service to the client.

e. Monitoring

Regular monitoring activities are conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved and to assess ongoing need for case management services. Monitoring is necessary as the client's health or personal situation may change, which would require an alteration to the care plan. At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

f. Progress Notes

Progress notes are the ongoing chronology of the client's record and case management activities. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Progress notes also indicate changes in client situation such as health, living situation, and functional ability.

g. Reassessment

Case management requires a comprehensive reassessment of each client on an annual basis and upon significant changes.

h. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends case management services to the client. case management services will be ended when the client: (1) moves out of San Francisco, (2) no longer wishes to use case management, (3) improves or stabilizes to the point that services are no longer necessary, (4) dies, (5) exhibits threatening or dangerous behavior toward case management staff, or (6) is receiving duplicative services.

2) Client Caseload

The Grantee shall ensure that one full time equivalent case manager should handle a monthly caseload of 40 clients. For case managers serving a caseload that requires frequent or urgent service needs, the monthly caseload requirement may be reduced to 32 active cases but this requires notification and approval from the assigned OCP program analyst at the time of caseload reduction. This notification must include documentation to justify the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

3) Additional Requirements

- Grantee will participate in the DAS funded Case Management City Wide Clinical Collaborative program.
- OCP Case Management Program Standards provide the framework for case management services, however the Grantee must establish its own policies and procedures to operationalize the standards within their own agency to best meet client needs.
- Case managers and case management supervisors will attend case management provider's meetings as scheduled.
- Case managers will be provided with adequate case management training as-needed. DAS/OCP funded case management training purchased or provided by Grantee must be approved by DAS/OCP staff.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will provide case management services to at least **_280_** unduplicated consumers.

  (Note: Unduplicated consumers to be served on an annual basis shall be at a minimum 55 unduplicated consumers per 1.0 FTE Case Manager staff.)

- Grantee will complete **__90___**% of comprehensive assessments due each contract year.*
- Grantee will complete **__90___**% of service plans due each contact year.*
- Grantee will complete **__100__**% of monthly contacts during each contract year.*
- Grantee will complete **__100__**% of face-to-face contacts each contract year.*

* Tracked via documentation in the CA GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.
- **25**% of cases closed with status of "improved" or "no longer needed services."*

* Tracked via documentation in the CA GetCare database

VIII. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement.

A. The grantee will enroll the clients into the CA GetCare database: (*https://ca.getcare.com/caprovider/),* and enter all the required data in the Case Management Module, including medication list, assessment, progress notes, service plan etc.

B. The grantee will enter into the CA GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.

C. Monthly, quarterly, and annual reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system as required by DAS and contracts department staff.

D. Grantee shall submit Community Services Block Grant (CSBG) time study to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered on line to this website link: *https://calmaa.hfa3.org/signin*

E. Grantee shall issue a Fiscal Closeout Report at the end of the fiscal year. The report is due to HSA no later than July 31 each grant year. This report must be submitted to the CARBON system.

F. Grantee will participate in an annual consumer survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 35% of contracted annual unduplicated consumers to be served.

G. Grantee shall develop and deliver a bi-annual summary report of SOGI data collected as requested by DAS/HSA. The due dates for submitting the summary reports are January 10 (for July 1 – December 31 data) and July 10 (for January 1 – June 30 data).

H. Grantee shall develop and deliver ad hoc reports as requested by DAS/HSA.

I. Grantee is required to attend all mandatory case management trainings, Quarterly Provider's Meetings, or other meetings as scheduled by DAS.

J. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules.

K. Apart from reports with specific instructions above, all other reports and communications should be sent to the following addresses:

Erica Maybaum
DAS, Office of Community Partnerships
PO Box 7988
San Francisco, CA 94120
Erica.Maybaum@sfgov.org

Tahir Shaikh
Human Services Agency
PO Box 7988

San Francisco, CA 94120
Tahir.Shaikh@sfgov.org

IX. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of the participants' record entered into the Case Management Module, compliance with specific program standards or requirements as stated in the OCP Policy Memorandum #39, Case Management Standards; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports on CA GetCare, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of provision of training to staff regarding the elder abuse reporting; evidence that program staff have completed the California Department of Aging (CDA) Security Awareness Training program operation, which includes a review of a written policies and procedures manual of all OCP-funded programs, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of directors list and whether services are provided appropriately according to Sections VI and VII.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, the current board roster and selected board minutes for compliance with the Sunshine Ordinance, and HIPAA compliance.

	A	F	I	J	K	L
1					Appendix B1, Page 1	
2					Document Date: 12/12/2022	
3	**HUMAN SERVICES AGENCY BUDGET SUMMARY**					
4						
5	Name					7/1/21-6/30/23
6	SELF-HELP FOR THE ELDERLY					
7	(Check One) New Renew☐l ____ Modification _X___					
8	If modification, Effective Date of Mod. No. of Mod. 3					
9	Program: Case Management					
10	Budget Reference Page No.(s)	Budget	Budget	Modifications	Revised Budget	Total
11	Program Term	7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
12	**Expenditures**					
13	Salaries & Benefits	$375,164	$419,917	$51,879	$471,796	$846,960
14	Operating Expense	$76,827	$55,486	$10,881	$66,367	$143,194
15	**Subtotal**	$451,991	$475,403	$62,760	$538,163	$990,154
16	Indirect Percentage (%)	15%	15%		15%	15%
17	Indirect Cost (Line 16 X Line 15)	$67,923	$71,311	$10,449	$81,760	$149,683
18	Capital Expenditure	$26,800		$6,900	$6,900	$33,700
19	Total Expenditures	$546,714	$546,714	$80,109	$626,823	$1,173,537
20	**HSA Revenues**					
21	General Fund (86%)	$443,184	$443,184		$443,184	$886,368
22	CFDA #93.778(14%)	$72,146	$72,146		$72,146	$144,292
23	CODB	$31,384	$31,384		$31,384	$62,768
24	CODB FY 22/23 4%			$21,869	$21,869	$21,869
25	Add-Back			$58,240	$58,240	$58,240
26						
27						
28						
29	TOTAL HSA REVENUES	$546,714	$546,714	$80,109	$626,823	$1,173,537
30	**Other Revenues**					
31						
32						
33						
34						
35						
36	Total Revenues	$546,714	$546,714	$80,109	$626,823	**$1,173,537**
37	Full Time Equivalent (FTE)					
39	Prepared by: Leny Nair					Date 11/17/2022
40	HSA-CO Review Signature: _____					
41	**HSA #1**					**11/15/2007**

SELF-HELP FOR THE ELDERLY
Program: Case Management
(Same as Line 9 on HSA #1)

Salaries & Benefits Detail

	A	B	C	D	E	J	M	N	O	P
10						7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	7/1/21-6/30/23
11		Agency Totals		For HSA Program		For DAS Program				
12	POSITION TITLE	Annual Full TimeSalary for FTE	Total % FTE	% FTE	Adjusted FTE	Modified Salary Budget	Revised Budgeted Salary	Modifications	Revised Budgeted Salary	TOTAL
13	Case Management Supervisor-TBH	$75,000	50%	100%	50%	$51,769	$64,480	($26,980)	$37,500	$89,269
14	*Case Manager, Henry*	$68,500	100%	97%	97%	$59,126	$58,490	$8,235	$66,725	$125,851
15	*Case Manager, Weng*	$60,650	100%	97%	97%	$51,890	$48,853	$10,221	$59,074	$110,964
16	*Case Manager, Violetta*	$69,600	100%	97%	97%	$60,984	$59,613	$8,230	$67,843	$128,827
17	Case Manager, Sarah	$56,160	75%	82%	62%	$27,030	$54,080	($8,180)	$45,900	$72,930
18	Director of Social Service, Emily	$105,000	100%	21%	21%	$22,560	$22,560		$22,560	$45,120
19	Program Manager-Sao Leng	$95,400	100%	34%	34%	$22,500	$22,500	$10,353	$32,853	$55,353
20	CM Assistant - Huan, Yin Yin	$50,000	100%	100%	100%			$50,000	$50,000	$50,000
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	TOTALS	$580,310	7.25	6.28	5.58	$295,859	$330,576	$51,879	$382,455	$678,314
31										
32	FRINGE BENEFIT RATE	23%					27%		23%	
33	EMPLOYEE FRINGE BENEFITS	$133,471				$79,305	$89,341		$89,341	$168,646
34										
35										
36	TOTAL SALARIES & BENEFITS	$713,781				$375,164	$419,917	$51,879	$471,796	$846,960
37	**HSA #2**									**11/15/2007**

SELF-HELP FOR THE ELDERLY

Program: Case Management
(Same as Line 9 on HSA #1)

Operating Expense Detail

Expenditure Category	TERM	7/1/21-6/30/22	7/1/22-6/30/23	7/1/22-6/30/23	7/1/22-6/30/23	TOTAL 7/1/21-6/30/23
Rental of Property		$22,264	$26,707	$381	$27,088	$49,352
Utilities(Elec, Water, Gas, Phone, Scavenger)		$19,000	$12,000	$4,000	$16,000	$35,000
Office Supplies, Postage		$6,600	$2,000		$2,000	$8,600
Building Maintenance Supplies and Repair		$17,963	$8,779	$2,000	$10,779	$28,742
Printing and Reproduction			$0		$0	$0
Insurance		$5,500	$2,500	$2,000	$4,500	$10,000
Staff Training		$200	$200		$200	$400
Staff Travel-(Local & Out of Town)		$4,000	$3,000	$500	$3,500	$7,500
Rental of Equipment						
CONSULTANT/SUBCONTRACTOR DESCRIPTIVE TITLE						
OTHER						
Recruitment Expenses		$300	$300	$1,000	$1,300	$1,600
PPE(Personal protective equipment such as mask, gloves, hand sanitizers, wipes)		$1,000		$1,000	$1,000	$2,000
TOTAL OPERATING EXPENSE		$76,827	$55,486	$10,881	$66,367	$143,194

SELF-HELP FOR THE ELDERLY
Program: Case Management
(Same as Line 9 on HSA #1)

Capital Expenditure Detail
(Equipment and Remodeling Cost)

	A	B	C	D	E	F
9						TOTAL
10	E Q U I P M E N T	TERM	7/1/21-6/30/22	7/1/22-6/30/23	#REF!	
11	No.	ITEM/DESCRIPTION				
12	7	Desktops & Monitors	10,500	4,500		15,000
13	5	Ipads	3,000			3,000
14	5	Printer with toner	2,500			2,500
15	5	Portable Scanner	1,500			1,500
16	3	Paper Shredder	1,500			1,500
17	5	Wireless Talker	1,300			1,300
18	5	Sit & Stand Desk Converter	3,000			
19	3	Laptops	3,500	2,400		5,900
20						
21	TOTAL EQUIPMENT COST		26,800	6,900	0	33,700
22						
23	R E M O D E L I N G					
24	Description:					0
25						0
26						0
27						0
28						0
29						0
30	TOTAL REMODELING COST		0	0	0	0
31						
32	TOTAL CAPITAL EXPENDITURE		26,800	6,900	0	33,700
33	(Equipment and Remodeling Cost)					
34	**HSA #4**					**11/15/2007**