SAN FRANCISCO
HUMAN SERVICES AGENCY

Department of Benefits and Family Support

Department of Disability and Aging Services

P.O. Box 7988
San Francisco, CA
94120-7988
www.SFHSA.org

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

DATE: WEDNESDAY, JULY 19, 2023

DS

SUBJECT: NEW GRANT: **MULTIPLE VENDORS (NON-PROFIT)** TO PROVIDE CASE MANAGEMENT, CLINICAL COLLABORATIVE, AND VETERANS JUSTICE COURT SERVICES

GRANT TERM: 7/1/2023 - 6/30/2027

GRANT AMOUNT:	New	Contingency	Total
	$17,427,704	$1,742,772	$19,170,476

ANNUAL AMOUNT See Table below

	County	State	Federal	Contingency	Total
Funding Source					
FUNDING:	$ 17,427,704			$1,742,772	$19,170,476
PERCENTAGE:	100%				

The Department of Disability and Aging Services (DAS) requests authorization to enter into grants with multiple vendors for the period of July 1, 2023 through June 30, 2027, in an amount of $17,427,704, plus a 10% contingency for a total amount not to exceed $19,170,476. The purpose of the grant is to provide Case Management services, Clinical Collaborative services, and Veterans Justice Court Services.

	FY 23/24	FY 24/25	FY 25/26	FY 26/27	Total	Contingency	Not to Exceed
Case Management							
Bayview Hunter's Point Multipurpose Senior Services	$305,817	$305,817	$305,817	$305,817	$1,223,268	$122,327	$1,345,595
Catholic Charities	$314,195	$314,195	$314,195	$314,195	$1,256,780	$125,678	$1,382,458
Curry Senior Center	$467,880	$467,880	$467,880	$467,880	$1,871,520	$187,152	$2,058,672
Episcopal Community Services	$362,172	$362,172	$362,172	$362,172	$1,448,688	$144,869	$1,593,557
Felton Institute	$137,491	$137,491	$137,491	$137,491	$549,964	$54,996	$604,960
Homebridge	$129,164	$129,164	$129,164	$129,164	$516,656	$51,666	$568,322
Institute on Aging	$688,194	$688,194	$688,194	$688,194	$2,752,776	$275,278	$3,028,054
Kimochi Inc.	$175,394	$175,394	$175,394	$175,394	$701,576	$70,158	$771,734
On-Lok	$395,242	$395,242	$395,242	$395,242	$1,580,968	$158,097	$1,739,065
Openhouse	$166,980	$166,980	$166,980	$166,980	$667,920	$66,792	$734,712
Self-Help for the Elderly	$628,283	$628,283	$628,283	$628,283	$2,513,132	$251,313	$2,764,445
Clinical Collaborative							
Institute on Aging	$336,114	$336,114	$336,114	$336,114	$1,344,456	$134,446	$1,478,902
Veterans Justice Court							
San Francisco Pretrial Diversion	$250,000	$250,000	$250,000	$250,000	$1,000,000	$100,000	$1,100,000
Total (Case Management + Clinical Collaborative + Veterans Justice Court)	**$4,356,926**	**$4,356,926**	**$4,356,926**	**$4,356,926**	**$17,427,704**	**$1,742,772**	**$19,170,476**

Background

Case Management

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, coordination of service providers or stabilization of a living situation. All grantees are established providers of services to seniors and adults with disabilities. In addition, all Grantees are current providers of DAS funded case management services.

Clinical Collaborative

Recognizing the need for additional support to DAS funded case management staff, the Clinical Collaborative program was established to provide consultation and support in order to improve services delivered to the clients they serve and to promote professional growth opportunities

among the case managers. Case managers meet with Licensed Clinical Social Worker (LCSW) and Marriage and Family Therapist (MFT) clinicians for both individual and group supervision at various locations throughout San Francisco. Case management supervisors also have regularly scheduled opportunities to meet with the Clinical Collaborative to discuss issues and receive support.

Veterans Justice Court

The funding for the Veteran's Justice Court Case Management program will expand the services that DAS provides to a priority population, namely veterans, specifically those connected to the San Francisco Veterans Justice Court (VJC). In January 2015, VJC was established as a stand-alone collaborative court of the Superior Court of California, County of San Francisco. This newly DAS funded program is an exciting opportunity for the department and is aligned with the DAS mission and vision.

Services to be Provided

Case Management

The case management services contain core elements to ensure standardized and effective delivery of services. These core elements include a centralized waitlist 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 DAS 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

Clinical Collaborative

The program provides clinical support for all DAS funded case management agencies and their staff. Services provided by the Clinical

Collaborative include individual and group supervision, monthly meetings with agency managers and directors, and trainings on topics brought to the Clinical Collaborative by case managers or recognized as a need that would help to improve professional development.

Veterans Justice Court
Veterans Justice Court case management will be a newly DAS funded program. This program will provide intensive case management to a small caseload of veterans who are not eligible for full Veterans Affairs (VA) health care benefits and who are participating in the Veterans Justice Court (VJC), a collaborative program of the San Francisco Superior Court. VJC case management includes support services such as resource referrals, therapeutic, vocational, mental, and behavioral supports, meetings with judicial staff and participant drug testing. The primary goal of VJC is to reduce recidivism, increase public safety, and restore program participants to productive lives.

Selection
Grantees were selected through Request for Proposals #1086 which was competitively bid in March 2023.

Funding
Funding for this grant is provided through County General Funds.

ATTACHMENTS

Case Management
Bayview Hunter's Point Multipurpose Senior Services
Appendix A – SCOPE of Services
Appendix B – Budget

Catholic Charities
Appendix A – SCOPE of Services
Appendix B - Budget

Curry Senior Center
Appendix A – SCOPE of Services
Appendix B - Budget

Episcopal Community Services
Appendix A – SCOPE of Services

Appendix B - Budget

Felton Institute
Appendix A – SCOPE of Services
Appendix B - Budget

Homebridge
Appendix A – SCOPE of Services
Appendix B - Budget

Institute on Aging
Appendix A – SCOPE of Services
Appendix B - Budget

Kimochi Inc.
Appendix A – SCOPE of Services
Appendix B - Budget

On-Lok
Appendix A – SCOPE of Services
Appendix B - Budget

Openhouse
Appendix A – SCOPE of Services
Appendix B - Budget

Self-Help for the Elderly
Appendix A – SCOPE of Services
Appendix B - Budget

Clinical Collaborative
Institute on Aging
Appendix A – SCOPE of Services
Appendix B – Budget

Veterans Justice Court
San Francisco Pretrial Diversion
Appendix A – SCOPE of Services
Appendix B - Budget

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

BAYVIEW SENIOR SERVICES

Effective July 1, 2023 to June 30, 2027

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	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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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 Senior Service 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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 SF DAS 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 **Bayview Senior Services**					Term 7/1/23 - 6/30/27
(Check One) New _X___ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$221,512	$221,512	$221,512	$221,512	$886,048
Operating Expenses	$49,122	$49,122	$49,122	$49,122	$196,488
Subtotal	$270,634	$270,634	$270,634	$270,634	$1,082,536
Indirect Percentage (%)	13%	13%	13%	13%	13%
Indirect Cost	$35,183	$35,183	$35,183	$35,183	$140,732
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$305,817**	**$305,817**	**$305,817**	**$305,817**	**$1,223,268**
DAS Revenues					
General Funds	$305,817	$305,817	$305,817	$305,817	$1,223,268
Total DAS Revenue	**$305,817**	**$305,817**	**$305,817**	**$305,817**	**$1,223,268**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$305,817**	**$305,817**	**$305,817**	**$305,817**	**$1,223,268**
Full Time Equivalent (FTE)	4.00	4.00	4.00	4.00	16.00
Prepared by:					Date:
HSA-CO Review Signature: **HSA #1**					

Program: Case Management

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Case Manager	$68,640	1.00	100%	1.00	$68,640	$68,640	$68,640	$68,640	$274,560
Case Manager	$68,640	1.00	100%	1.00	$68,640	$68,640	$68,640	$68,640	$274,560
Case Mgt Supervisor	$81,120	1.00	30%	0.30	$24,336	$24,336	$24,336	$24,336	$97,344
Social Servicses Assistant	$45,760	1.00	25%	0.25	$11,440	$11,440	$11,440	$11,440	$45,760
Totals	$264,160	4.00	255.00%	2.55	$173,056	$173,056	$173,056	$173,056	$692,224
Fringe Benefits Rate	28.00%								
Employee Fringe Benefits	$73,965				$48,456	$48,456	$48,456	$48,456	$193,824
Total DAS Salaries and Benefits	$338,125				**$221,512**	**$221,512**	**$221,512**	**$221,512**	**$886,048**

HSA #2

Program: Case Management

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Scavenger)	$6,000	$6,000	$6,000	$6,000	$24,000
Office Supplies, Postage	$6,000	$6,000	$6,000	$6,000	$24,000
Building Maintenance Supplies and Repair					
Printing and Reproduction	$5,000	$5,000	$5,000	$5,000	$20,000
Insurance	$3,000	$3,000	$3,000	$3,000	$12,000
Staff Training	$5,000	$5,000	$5,000	$5,000	$20,000
Staff Travel	$1,200	$1,200	$1,200	$1,200	$4,800
Rental of Equipment	$5,000	$5,000	$5,000	$5,000	$20,000
Consultants/Subcontractors					
Other					
Technical Support	$4,800	$4,800	$4,800	$4,800	$19,200
Program Supplies	$13,122	$13,122	$13,122	$13,122	$52,488
Total DAS Operating Expenses	**$49,122**	**$49,122**	**$49,122**	**$49,122**	**$196,488**

HSA #3

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

CATHOLIC CHARITIES

Effective July 1, 2023 to June 30, 2027

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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
	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.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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.
- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **112** 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

Patrick Garcia
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 SF DAS 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					7/1/23 - 6/30/27
(Check One) New ☑ Renewal ☐ Modification ☐					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$251,757	$251,757	$251,757	$251,757	$1,007,028
Operating Expenses	$21,455	$21,455	$21,455	$21,455	$85,820
Subtotal	$273,212	$273,212	$273,212	$273,212	$1,092,848
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$40,983	$40,983	$40,983	$40,983	$163,932
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$314,195**	**$314,195**	**$314,195**	**$314,195**	**$1,256,780**
DAS Revenues					
General Funds	$314,195	$314,195	$314,195	$314,195	$1,256,780
Total DAS Revenue	**$314,195**	**$314,195**	**$314,195**	**$314,195**	**$1,256,780**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$314,195**	**$314,195**	**$314,195**	**$314,195**	**$1,256,780**
Full Time Equivalent (FTE)	2.99	2.99	2.99	2.99	11.96
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Program: Case Management

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Social Worker #1	$63,024	1.00	95%	0.95	$59,873	$59,873	$59,873	$59,873	$239,492
Social Worker #2	$63,024	1.00	95%	0.95	$59,873	$59,873	$59,873	$59,873	$239,492
Program Specialist (Supervisor)	$79,498	0.65	60%	0.39	$31,004	$31,004	$31,004	$31,004	$124,016
Assistant Deputy Director	$109,200	0.34	100%	0.34	$37,128	$37,128	$37,128	$37,128	$148,512
Totals	$314,746	2.99	350%	2.63	$187,878	$187,878	$187,878	$187,878	$751,512
Fringe Benefits Rate	34%								
Employee Fringe Benefits	$107,014				$63,879	$63,879	$63,879	$63,879	$255,516
Total DAS Salaries and Benefits	$421,760				**$251,757**	**$251,757**	**$251,757**	**$251,757**	**$1,007,028**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$4,675	$4,675	$4,675	$4,675	$18,700
Utilities(Elec, Water, Gas, Phone, Scavenger)	$3,800	$3,800	$3,800	$3,800	$15,200
Office Supplies, Postage	$450	$450	$450	$450	$1,800
Building Maintenance Supplies and Repair	$400	$400	$400	$400	$1,600
Printing and Reproduction	$350	$350	$350	$350	$1,400
Insurance	$5,380	$5,380	$5,380	$5,380	$21,520
Staff Training	$900	$900	$900	$900	$3,600
Staff Travel	$4,200	$4,200	$4,200	$4,200	$16,800
Rental of Equipment	$800	$800	$800	$800	$3,200
Consultants					
Other					
IT Support	$500	$500	$500	$500	$2,000
Total DAS Operating Expenses	**$21,455**	**$21,455**	**$21,455**	**$21,455**	**$85,820**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

CURRY SENIOR CENTER

Effective July 1, 2023 to June 30, 2027

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	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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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 from 8:00 a.m. to 4:30 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **148** 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

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 SF DAS 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	
Curry Senior Center				7/1/23 - 6/30/27	
(Check One) New __x__ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case management					
Budget Reference Page No.(s)					7/1/23 - 6/30/27
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	Total
Expenditures					
Salaries & Benefits	$368,252	$368,252	$368,252	$368,252	$1,473,008
Operating Expenses	$38,600	$38,600	$38,600	$38,600	$154,400
Subtotal	$406,852	$406,852	$406,852	$406,852	$1,627,408
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost (Line 16 X Line 15)	$61,028	$61,028	$61,028	$61,028	$244,112
Subcontractor/Capital Expenditures					
Total Expenditures	$467,880	$467,880	$467,880	$467,880	$1,871,520
HSA Revenues					
General Funds	$467,880	$467,880	$467,880	$467,880	$1,871,520
TOTAL HSA REVENUES	$467,880	$467,880	$467,880	$467,880	$1,871,520
Other Revenues					
Leverage- Medical supervisor	$194,545	$194,545	$194,545	$194,545	$778,180
Leverage- Translation	$7,500	$7,500	$7,500	$7,500	$30,000
Cash Match- Client Assistance Fund	$25,000	$25,000	$25,000	$25,000	$100,000
Total Revenues	$694,925	$694,925	$694,925	$694,925	$2,779,700
Full Time Equivalent (FTE)					
Prepared by:				Telephone No.:	
HSA-CO Review Signature:					
HSA #1					**6/20/2018**

Salaries & Benefits Detail

	Agency Totals		HSA Program		7/1/23 - 6/30/24 DAAS	7/1/24 - 6/30/25 DAAS	7/1/25 - 6/30/26 DAAS	7/1/26 - 6/30/27 DAAS	7/1/23 - 6/30/27 TOTAL
POSITION TITLE	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Case manager	$79,356	0.95	100%	0.95	$75,388	$75,388	$75,388	$75,388	$301,552
Case manager	$85,020	0.88	100%	0.88	$74,767	$74,767	$74,767	$74,767	$299,068
Case manager	$68,008	0.95	100%	0.95	$64,608	$64,608	$64,608	$64,608	$258,432
Direction of Clinical programs	$107,013	0.17	100%	0.17	$18,192	$18,192	$18,192	$18,192	$72,768
Program assistant- Chinese	$74,093	0.17	100%	0.17	$12,596	$12,596	$12,596	$12,596	$50,384
Program assistant- Lao	$51,719	0.17	100%	0.17	$8,792	$8,792	$8,792	$8,792	$35,168
Program assistant- Russian	$51,719	0.17	100%	0.17	$8,792	$8,792	$8,792	$8,792	$35,168
Program assistant- Vietnamese	$51,719	0.17	100%	0.17	$8,792	$8,792	$8,792	$8,792	$35,168
Data entry / QI analyst	$56,500	0.11	100%	0.11	$6,000	$6,000	$6,000	$6,000	$24,000
				-					
				-					
				-					
TOTALS	$625,147	0.96	600%	0.96	$277,927	$277,927	$277,927	$277,927	$1,111,708
FRINGE BENEFIT RATE	32.50%								
EMPLOYEE FRINGE BENEFITS	$203,170				$90,325	$90,325	$90,325	$90,325	$361,300
TOTAL SALARIES & BENEFITS	$828,317				$368,252	$368,252	$368,252	$368,252	$1,473,008

HSA #2 **6/20/2018**

Operating Expense Detail

Expenditure Category TERM	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	TOTAL 7/1/23 - 6/30/27
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Garbage)	$9,600	$9,600	$9,600	$9,600	$38,400
Office Supplies, Postage	$6,500	$6,500	$6,500	$6,500	$26,000
Building Maintenance Supplies and Repair	$7,000	$7,000	$7,000	$7,000	$28,000
Printing and Reproduction					
Insurance	$6,000	$6,000	$6,000	$6,000	$24,000
Staff Training	$500	$500	$500	$500	$2,000
Staff Travel-(Local & Out of Town)	$500	$500	$500	$500	$2,000
Rental of Equipment					
CONSULTANTS					
OTHER					
Program supplies	$500	$500	$500	$500	$2,000
Payroll fees	$1,000	$1,000	$1,000	$1,000	$4,000
Recruitment	$1,000	$1,000	$1,000	$1,000	$4,000
Computer support	$6,000	$6,000	$6,000	$6,000	$24,000
TOTAL OPERATING EXPENSES	$38,600	$38,600	$38,600	$38,600	$154,400

HSA #3 **6/20/2018**

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

EPISCOPAL COMMUNITY SERVICES

Effective July 1, 2023 to June 30, 2027

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	Episcopal Community 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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

Episcopal Community Services Case Management Services is housed at 705 Natoma St in San Francisco. The program provides services Monday through Friday from 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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 SF DAS 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
Episcopal Community Services					7/1/23 - 6/30/27
(Check One) New __X__ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$282,947	$282,947	$282,947	$282,947	$1,131,788
Operating Expenses	$31,985	$31,985	$31,985	$31,985	$127,940
Subtotal	$314,932	$314,932	$314,932	$314,932	$1,259,728
Indirect Percentage (15%)	15%	15%	15%	15%	15%
Indirect Cost	$47,240	$47,240	$47,240	$47,240	$188,959
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$362,172**	**$362,172**	**$362,172**	**$362,172**	**$1,448,688**
DAS Revenues					
General Funds	$362,172	$362,172	$362,172	$362,172	$1,448,688
Total DAS Revenue	**$362,172**	**$362,172**	**$362,172**	**$362,172**	**$1,448,688**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$362,172**	**$362,172**	**$362,172**	**$362,172**	**$1,448,688**
Full Time Equivalent (FTE)	4.00	4.00	4.00	4.00	16.00
Prepared by: Tiffany Luong					Date:
HSA-CO Review Signature:					
HSA #1					

Program: Case Management

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Director of Healthy Aging	$148,431	1.00	25%	0.25	$37,108	$37,108	$37,108	$37,108	$148,432
Program Manager	$101,891	1.00	50%	0.50	$50,946	$50,946	$50,946	$50,946	$203,784
Case Manager III - Bilingual	$66,011	1.00	100%	1.00	$66,011	$66,011	$66,011	$66,011	$264,044
Case Mananger II	$58,677	1.00	100%	1.00	$58,677	$58,677	$58,677	$58,677	$234,708
Totals	$375,010	4.00	275%	2.75	$212,742	$212,742	$212,742	$212,742	$850,968
Fringe Benefits Rate	33.00%								
Employee Fringe Benefits	$123,753				$70,205	$70,205	$70,205	$70,205	$280,820
Total DAS Salaries and Benefits	$498,763				**$282,947**	**$282,947**	**$282,947**	**$282,947**	**$1,131,788**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Scavenger)					
Office Supplies, Postage	$836	$836	$836	$836	$3,344
Building Maintenance Supplies and Repair	$21,519	$21,519	$21,519	$21,519	$86,076
Printing and Reproduction					
Insurance	$3,950	$3,950	$3,950	$3,950	$15,800
Staff Training	$450	$450	$450	$450	$1,800
Staff Travel	$150	$150	$150	$150	$600
IT Equipment					
Consultants/Subcontractors					
Other					
Telecommunications	$4,000	$4,000	$4,000	$4,000	$16,000
Recruitment	$80	$80	$80	$80	$320
Program Supplies	$1,000	$1,000	$1,000	$1,000	$4,000
Total DAS Operating Expenses	**$31,985**	**$31,985**	**$31,985**	**$31,985**	**$127,940**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

FELTON INSTITUTE

Effective July 1, 2023 to June 30, 2027

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	Felton Institute
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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

Felton Institute Case Management Services are provided at6221 Geary Boulevard, 3rd Floor, San Francisco, CA 94121. Hours of operation are Monday through Friday from 9:30 a.m. to 5:30 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **55** 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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 SF DAS 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
Felton Institute					7/1/23 - 6/30/27
(Check One) New __X__ Renewal ___ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$111,193	$111,193	$111,193	$111,193	$444,772
Operating Expenses	$8,365	$8,365	$8,365	$8,365	$33,460
Subtotal	$119,558	$119,558	$119,558	$119,558	$478,232
Indirect Percentage (%)	15.00%	15.00%	15.00%	15.00%	15.00%
Indirect Cost	$17,933	$17,933	$17,933	$17,933	$71,732
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$137,491**	**$137,491**	**$137,491**	**$137,491**	**$549,964**
DAS Revenues					
General Funds	$137,491	$137,491	$137,491	$137,491	$549,964
Total DAS Revenue	**$137,491**	**$137,491**	**$137,491**	**$137,491**	**$549,964**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$137,491**	**$137,491**	**$137,491**	**$137,491**	**$549,964**
Full Time Equivalent (FTE)	2.60	2.60	2.60	2.60	10.40
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Program Manager	$110,000	100%	11%	0.11	$12,100	$12,100	$12,100	$12,100	$48,400
Lead Case Manager	$73,750	100%	80%	0.80	$59,000	$59,000	$59,000	$59,000	$236,000
Case Manager	$60,000	60%	33%	0.20	$11,880	$11,880	$11,880	$11,880	$47,520
Totals	$243,750	2.60	124.00%	1.11	$82,980	$82,980	$82,980	$82,980	$331,920
Fringe Benefits Rate	34%								
Employee Fringe Benefits	$82,875				$28,213	$28,213	$28,213	$28,213	$112,852
Total DAS Salaries and Benefits	$326,625				**$111,193**	**$111,193**	**$111,193**	**$111,193**	**$444,772**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$4,000	$4,000	$4,000	$4,000	$16,000
Utilities(Elec, Water, Gas, Phone, Scavenger)	$950	$950	$950	$950	$3,800
Office Supplies, Postage					
Building Maintenance Supplies and Repair					
Printing and Reproduction	$100	$100	$100	$100	$400
Insurance	$940	$940	$940	$940	$3,760
Licenses and Fees					
Staff Training					
Staff Travel	$1,200	$1,200	$1,200	$1,200	$4,800
Rental of Equipment	$116	$116	$116	$116	$464
Consultants/Subcontractors					
Other					
Program related expenses	$1,059	$1,059	$1,059	$1,059	$4,236
Total DAS Operating Expenses	**$8,365**	**$8,365**	**$8,365**	**$8,365**	**$33,460**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

HOMEBRIDGE

Effective July 1, 2023 to June 30, 2027

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	Homebridge
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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

Homebridge Case Management services are based at their main office located at 1035 Market Street, Suite L-1, in San Francisco. Program hours are Monday through Friday from 8:00 a.m. to 5:15 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.
- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **55** 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

Tara Alvarez
Human Services Agency
PO Box 7988
San Francisco, CA 94120
Tara.Alvarez@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 SF DAS 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

	A	B	C	D	E	F
5	Name:					Term
6	**Homebridge**					7/1/23-6/30/27
7	(Check One) New ☑ Renewal ____ Modification ____					
8	If modification, Effective Date of Mod.	No. of Mod.				
9	**Program: Case Management**					
10	Budget Reference Page No.(s)					
11	Program Term	7/1/23-6/30/24	7/1/24-6/30/25	7/1/25-6/30/26	7/1/26-6/30/27	7/1/23-6/30/27
12	**Expenditures**					
13	Salaries & Benefits	$87,218	$86,465	$85,690	$84,891	$344,264
14	Operating Expenses	$25,100	$25,853	$26,629	$27,427	$105,009
15	**Subtotal**	$112,318	$112,318	$112,318	$112,318	$449,273
16	Indirect Percentage (%)	15%	15%	15%	15%	15%
17	Indirect Cost (Line 16 X Line 15)	$16,846	$16,846	$16,846	$16,846	$67,383
19	Total Expenditures	$129,164	$129,164	$129,164	$129,164	$516,656
20	**HSA Revenues**					
21	General Fund	$129,164	$129,164	$129,164	$129,164	$516,656
22						
23						
24						
25						
26						
27						
28						
29	TOTAL HSA REVENUES	$129,164	$129,164	$129,164	$129,164	$516,656
30	**Other Revenues**					
31						
32						
33						
34						
35						
36	Total Revenues	$129,164	$129,164	$129,164	$129,164	$516,656
37	Full Time Equivalent (FTE)	1.10				
39	Prepared by: Shantel Weingand	Telephone No.:				415-659-5345
40	HSA-CO Review Signature:					
41	**HSA #1**					

Homebridge

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	7/1/23-6/30/24 Budgeted Salary	7/1/24-6/30/25 Budgeted Salary	7/1/25-6/30/26 Budgeted Salary	7/1/26-6/30/27 Budgeted Salary	7/1/23-6/30/27 Budgeted Salary
Client Service Manager	$84,292	1.00	10%	0.10	$8,429	$7,851	$7,254	$6,841	$30,375
Case Manager	$65,026	1.00	100%	1.00	$64,863	$64,809	$64,754	$64,496	$258,923
TOTALS	$149,318	2.00	110%	1.10	$73,293	$72,660	$72,008	$71,337	$289,297
FRINGE BENEFIT RATE	19%								
EMPLOYEE FRINGE BENEFITS	$28,370				$13,926	$13,805	$13,682	$13,554	$54,967
TOTAL SALARIES & BENEFITS	$177,688				$87,218	$86,465	$85,690	$84,891	$344,264

HSA #2

Operating Expense Detail

Expenditure Category	TERM	7/1/23-6/30/24	7/1/24-6/30/25	7/1/25-6/30/26	7/1/26-6/30/27	7/1/23-6/30/27
Premsises Expenses/Rental of Property		$13,000	$13,390	$13,792	$14,205	$54,387
Utilities(Elec, Water, Gas, Phone, Garbage)		$2,000	$2,060	$2,122	$2,185	$8,367
Office Supplies, Postage		$1,000	$1,030	$1,061	$1,093	$4,184
Building Maintenance Supplies and Repair		$500	$515	$530	$546	$2,092
Printing and Reproduction		$400	$412	$424	$437	$1,673
Insurance		$2,200	$2,266	$2,334	$2,404	$9,204
Staff Training		$500	$515	$530	$546	$2,092
Staff Travel-(Local & Out of Town)						
Rental of Equipment						
CONSULTANTS						
OTHER						
Payroll		$1,500	$1,545	$1,591	$1,639	$6,275
Technology		$4,000	$4,120	$4,244	$4,371	$16,735
TOTAL OPERATING EXPENSE		**$25,100**	**$25,853**	**$26,629**	**$27,427**	**$105,009**
HSA #3						

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

INSTITUTE ON AGING (IOA)

Effective July 1, 2023 to June 30, 2027

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	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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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 (IOA) Case Management services are provided at 3575 Geary Boulevard in San Francisco. Hours of operation are 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

Patrick Garcia
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 SF DAS 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 Institute on Aging					Term 7/1/23 - 6/30/27
(Check One) New __X__ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$549,110	$549,110	$549,110	$549,110	$2,196,440
Operating Expenses	$50,794	$51,088	$51,442	$51,867	$205,191
Subtotal	$599,904	$600,198	$600,552	$600,977	$2,401,631
Indirect Percentage (15%)	15%	15%	15%	15%	15%
Indirect Cost	$88,290	$87,996	$87,642	$87,217	$351,145
Total DAS Expenditures	**$688,194**	**$688,194**	**$688,194**	**$688,194**	$2,752,776
DAS Revenues					
General Funds	$688,194	$688,194	$688,194	$688,194	$2,752,776
Total DAS Revenue	**$688,194**	**$688,194**	**$688,194**	**$688,194**	**$2,752,776**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$688,194**	**$688,194**	**$688,194**	**$688,194**	**$2,752,776**
Full Time Equivalent (FTE)	7.50	7.50	7.50	7.50	30.00
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Care Manager #1	$84,054	1.00	100%	1.00	$84,054	$84,054	$84,054	$84,054	$336,216
Care Manager #2	$74,337	1.00	100%	1.00	$74,337	$74,337	$74,337	$74,337	$297,348
Care Manager #3	$76,781	1.00	100%	1.00	$76,781	$76,781	$76,781	$76,781	$307,124
Care Manager #4	$81,506	1.00	100%	1.00	$81,506	$81,506	$81,506	$81,506	$326,024
Clinical Supervisor	$107,182	0.50	100%	0.50	$53,591	$53,591	$53,591	$53,591	$214,364
Manager, LTCM Nor Cal	$115,710	1.00	20%	0.20	$23,142	$23,142	$23,142	$23,142	$92,568
Sr. Program Coordinator	$61,994	1.00	50%	0.50	$30,997	$30,997	$30,997	$30,997	$123,988
Sr. Director, Care Management Programs	$148,799	1.00	10%	0.10	$14,880	$14,880	$14,880	$14,880	$59,520
Totals	$750,363	7.50	580%	5.30	$439,288	$439,288	$439,288	$439,288	$1,757,152
Fringe Benefits Rate	25%								
Employee Fringe Benefits	$187,591				$109,822	$109,822	$109,822	$109,822	$439,288
Total DAS Salaries and Benefits	$937,954				**$549,110**	**$549,110**	**$549,110**	**$549,110**	**$2,196,440**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$5,359	$5,359	$5,359	$5,359	$21,436
Utilities(Elec, Water, Gas, Phone, Scavenger)	$1,553	$1,637	$1,637	$1,637	$6,464
Office Supplies, Postage	$2,374	$3,374	$4,124	$4,324	$14,196
Building Maintenance Supplies and Repair					
Printing and Reproduction					
Insurance	$2,167	$2,167	$2,167	$2,167	$8,668
Licenses and Fees	$5,260	$5,260	$5,260	$5,260	$21,040
Staff Training, Meetings	$8,554	$11,004	$11,196	$9,304	$40,058
Staff Travel	$1,500	$3,000	$3,200	$2,062	$9,762
Rental of Equipment					
Consultants/Subcontractors					
Other					
Wireless Fees	$2,194	$2,194	$2,194	$2,194	$8,776
Small Equipment (Technology	$10,500	$3,500			$14,000
Recruitment Fee	$32	$32	$32	$32	$128
Purchase of Service	$7,800	$9,361	$11,233	$13,478	$41,872
Respite Fund	$3,501	$4,200	$5,040	$6,050	$18,791
Total DAS Operating Expenses	**$50,794**	**$51,088**	**$51,442**	**$51,867**	**$205,191**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

KIMOCHI INC.

Effective July 1, 2023 to June 30, 2027

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	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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

Kimochi Inc. Case Management services are provided at 1715 Buchanan Street in San Francisco. Hours of operation are 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

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 SF DAS 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.				7/1/23 - 6/30/27	
(Check One) New __x__ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case management					
Budget Reference Page No.(s)					7/1/23 - 6/30/27
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	Total
Expenditures					
Salaries & Benefits	$133,788	$133,788	$133,788	$133,788	$535,152
Operating Expenses	$19,093	$19,093	$19,093	$19,093	$76,372
Subtotal	$152,881	$152,881	$152,881	$152,881	$611,524
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost (Line 16 X Line 15)	$22,513	$22,513	$22,513	$22,513	$90,052
Subcontractor/Capital Expenditures					
Total Expenditures	$175,394	$175,394	$175,394	$175,394	$701,576
HSA Revenues					
General Funds	$175,394	$175,394	$175,394	$175,394	$701,576
TOTAL HSA REVENUES	$175,394	$175,394	$175,394	$175,394	$701,576
Other Revenues					
Total Revenues					
Full Time Equivalent (FTE)					
Prepared by:				Telephone No.:	
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

	Agency Totals		HSA Program		7/1/23 - 6/30/24 DAAS	7/1/24 - 6/30/25 DAAS	7/1/25 - 6/30/26 DAAS	7/1/26 - 6/30/27 DAAS	7/1/23 - 6/30/27 TOTAL
POSITION TITLE	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Social services program coordinator	$66,560	0.40	100%	0.40	$26,624	$26,624	$26,624	$26,624	$106,496
Case manager, Japanese speaking	$58,240	0.60	100%	0.60	$34,944	$34,944	$34,944	$34,944	$139,776
Case manager, Korean speaking	$54,080	0.75	100%	0.75	$40,560	$40,560	$40,560	$40,560	$162,240
				-					
				-					
				-					
				-					
				-					
TOTALS	$178,880			-	$102,128	$102,128	$102,128	$102,128	$408,512
FRINGE BENEFIT RATE	31%								
EMPLOYEE FRINGE BENEFITS	$55,453				$31,660	$31,660	$31,660	$31,660	$126,640
TOTAL SALARIES & BENEFITS	$234,333				$133,788	$133,788	$133,788	$133,788	$535,152

HSA #2

Operating Expense Detail

Expenditure Category TERM	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	TOTAL 7/1/23 - 6/30/27
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Garbage)	$2,900	$2,900	$2,900	$2,900	$11,600
Office Supplies, Postage					
Building Maintenance Supplies and Repair					
Printing and Reproduction	$2,793	$2,793	$2,793	$2,793	$11,172
Insurance	$4,900	$4,900	$4,900	$4,900	$19,600
Staff Training	$1,000	$1,000	$1,000	$1,000	$4,000
Staff Travel-(Local & Out of Town)					
Rental of Equipment					
CONSULTANTS					
OTHER					
Computer / IT / Website	$2,750	$2,750	$2,750	$2,750	$11,000
Telephone	$3,750	$3,750	$3,750	$3,750	$15,000
Dues / Subscriptions	$1,000	$1,000	$1,000	$1,000	$4,000
TOTAL OPERATING EXPENSES	$19,093	$19,093	$19,093	$19,093	$76,372
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

ON-LOK/ 30th STREET SENIOR CENTER

Effective July 1, 2023 to June 30, 2027

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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

On-Lok/ 30th Street Senior Center Case Management services are provided at 225 30th Streer 3rd floorv in San Francisco. Hours of operation are Monday through Friday from 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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

Patrick Garcia
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 SF DAS 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.

Document Date: July 1, 2023

HUMAN SERVICES AGENCY BUDGET SUMMARY
BY PROGRAM

Name					Term
On-Lok					7/1/23 - 6/30/27
(Check One) New ☑ Renewal ☐ Modification ☐					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$305,600	$305,600	$305,600	$305,600	$1,222,400
Operating Expenses	$38,089	$38,089	$38,089	$38,089	$152,356
Subtotal	$343,689	$343,689	$343,689	$343,689	$1,374,756
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$51,553	$51,553	$51,553	$51,553	$206,212
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$395,242**	**$395,242**	**$395,242**	**$395,242**	**$1,580,968**
DAS Revenues					
General Funds	$395,242	$395,242	$395,242	$395,242	$1,580,968
Total DAS Revenue	**$395,242**	**$395,242**	**$395,242**	**$395,242**	**$1,580,968**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$395,242**	**$395,242**	**$395,242**	**$395,242**	**$1,580,968**
Full Time Equivalent (FTE)	4.00	4.00	4.00	4.00	16.00
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Senior Center Program Manager	$102,709	0.75	55%	0.41	$42,367	$42,367	$42,367	$42,367	$169,468
Case Manager #1	$76,902	1.00	100%	1.00	$76,902	$76,902	$76,902	$76,902	$307,608
Case Manager #2	$78,394	1.00	100%	1.00	$78,394	$78,394	$78,394	$78,394	$313,576
Case Manager #3	$75,366	0.50	50%	0.25	$18,842	$18,842	$18,842	$18,842	$75,368
Senior Center Operations Manager	$85,317	0.10	55%	0.06	$4,692	$4,692	$4,692	$4,692	$18,768
Administrative Assistant	$70,412	0.20	55%	0.11	$7,745	$7,745	$7,745	$7,745	$30,980
Assistant Director	$114,022	0.20	20%	0.04	$4,561	$4,561	$4,561	$4,561	$18,244
Director	$142,533	0.25	20%	0.05	$7,127	$7,127	$7,127	$7,127	$28,508
Totals	$745,655	4.00	455%	2.92	$240,630	$240,630	$240,630	$240,630	$962,520
Fringe Benefits Rate	27%								
Employee Fringe Benefits	$201,327				$64,970	$64,970	$64,970	$64,970	$259,880
Total DAS Salaries and Benefits	$946,982				**$305,600**	**$305,600**	**$305,600**	**$305,600**	**$1,222,400**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property					
Utilities(Elec, Water, Gas, Phone, Scavenger)	$3,490	$3,490	$3,490	$3,490	$13,960
Office Supplies, Postage	$724	$724	$724	$724	$2,896
Building Maintenance Supplies and Repair	$5,815	$5,815	$5,815	$5,815	$23,260
Printing and Reproduction	$725	$725	$725	$725	$2,900
Insurance	$1,455	$1,455	$1,455	$1,455	$5,820
Licenses and Fees					
Staff Training	$1,000	$1,000	$1,000	$1,000	$4,000
Staff Travel	$10,000	$10,000	$10,000	$10,000	$40,000
Rental of Equipment	$400	$400	$400	$400	$1,600
Consultants					
Other					
Payroll Processing	$300	$300	$300	$300	$1,200
Data Plan	$2,180	$2,180	$2,180	$2,180	$8,720
PPE Supplies	$1,500	$1,500	$1,500	$1,500	$6,000
Social Worker Intern stipend	$3,500	$3,500	$3,500	$3,500	$14,000
Recruiting Fee	$1,000	$1,000	$1,000	$1,000	$4,000
Purchased Services (Client Assistance)	$6,000	$6,000	$6,000	$6,000	$24,000
Total DAS Operating Expenses	**$38,089**	**$38,089**	**$38,089**	**$38,089**	**$152,356**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

OPENHOUSE

Effective July 1, 2023 to June 30, 2027

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	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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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 provided at the Bob Ross LGBT Senior Center, 65 Laguna Street in San Francisco. Hours of operation are Monday through Friday from 9:30 a.m. to 5:30 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.
- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **55** 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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 SF DAS 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
Openhouse					7/1/23 - 6/30/27
(Check One) New __X__ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$145,200	$145,200	$145,200	$145,200	$580,800
Operating Expenses					
Subtotal	$145,200	$145,200	$145,200	$145,200	$580,800
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$21,780	$21,780	$21,780	$21,780	$87,120
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$166,980**	**$166,980**	**$166,980**	**$166,980**	**$667,920**
DAS Revenues					
General Funds	$166,980	$166,980	$166,980	$166,980	$667,920
Total DAS Revenue	**$166,980**	**$166,980**	**$166,980**	**$166,980**	**$667,920**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$166,980**	**$166,980**	**$166,980**	**$166,980**	**$667,920**
Full Time Equivalent (FTE)	3.00	3.00	3.00	3.00	12.00
Prepared by: Matthew Cimino					Date: 06/15/23
HSA-CO Review Signature:					
HSA #1					

Openhouse

Program: Case Management

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Case Manager	$64,000	100%	100%	1.00	$64,000	$64,000	$64,000	$64,000	$256,000
CSS Manager	$80,000	100%	35%	0.35	$28,000	$28,000	$28,000	$28,000	$112,000
Director of CSS	$100,744	100%	29%	0.29	$29,000	$29,000	$29,000	$29,000	$116,000
Totals	$244,744	3.00	163.79%	1.64	$121,000	$121,000	$121,000	$121,000	$484,000
Fringe Benefits Rate	20.00%								
Employee Fringe Benefits	$48,949				$24,200	$24,200	$24,200	$24,200	$96,800
Total DAS Salaries and Benefits	$293,693				**$145,200**	**$145,200**	**$145,200**	**$145,200**	**$580,800**

HSA #2

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

SELF-HELP FOR THE ELDERY

Effective July 1, 2023 to June 30, 2027

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	Self-Help for the Elderly
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
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
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
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older

SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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:

Self-Help for the Elderly Case Management services are provided at 601 Jackson in San Francisco. Hours of operation are 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 SF DAS GetCare database which all OCP 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 case management providers will access the Centralized Intake and Waitlist system which serves as the starting point for clients needing case management services. All clients seeking to enroll in case management services must go through the Centralized Intake and Waitlist (CIW) process. Referrals for OCP 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. 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 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.

- DAS funded case managers and case management supervisors will attend case management provider's meetings as scheduled.
- DAS funded 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 **100**% of comprehensive assessments due each contract year.*
- Grantee will complete **100**% of service plans due each contact year.*
- Grantee will complete **90**% of monthly contacts during each contract year.*
- Grantee will complete **90**% of face-to-face contacts each contract year.*

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- **70%** of identified service goals will be met.*

- In collaboration with DAS, annually administer a client/participant satisfaction survey with a minimum return rate of **35%.**

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database: *(https://sfdas.getcare.com/paceseam/login.seam),* 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 SF DAS 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 SF DAS 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
SELF-HELP FOR THE ELDERLY					7/1/23 - 6/30/27
(Check One) New _X___ Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Case Management					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$488,448	$488,448	$488,448	$488,448	$1,953,792
Operating Expenses	$57,885	$57,885	$57,885	$57,885	$231,540
Subtotal	$546,333	$546,333	$546,333	$546,333	$2,185,332
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$81,950	$81,950	$81,950	$81,950	$327,800
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$628,283**	**$628,283**	**$628,283**	**$628,283**	**$2,513,132**
DAS Revenues					
General Funds	$628,283	$628,283	$628,283	$628,283	$2,513,132
Total DAS Revenue	**$628,283**	**$628,283**	**$628,283**	**$628,283**	**$2,513,132**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$628,283**	**$628,283**	**$628,283**	**$628,283**	**$2,513,132**
Full Time Equivalent (FTE)	8.00	8.00	8.00	8.00	32.00
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		DAS Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Case Management Supervisor	$75,000	100%	100%	1.00	$75,000	$75,000	$75,000	$75,000	$300,000
Case Manager	$66,560	100%	100%	1.00	$66,560	$66,560	$66,560	$66,560	$266,240
Case Manager	$62,400	100%	100%	1.00	$62,400	$62,400	$62,400	$62,400	$249,600
Case Manager	$66,560	100%	100%	1.00	$66,560	$66,560	$66,560	$66,560	$266,240
Case Manager	$62,400	100%	100%	1.00	$62,400	$62,400	$62,400	$62,400	$249,600
Case Manager	$58,240	100%	80%	0.80	$46,592	$46,592	$46,592	$46,592	$186,368
Director of Social Service	$120,000	100%	8%	0.08	$9,600	$9,600	$9,600	$9,600	$38,400
Program Manager	$100,000	100%	8%	0.08	$8,000	$8,000	$8,000	$8,000	$32,000
Totals	$611,160	8.00	596.00%	5.96	$397,112	$397,112	$397,112	$397,112	$1,588,448
Fringe Benefits Rate	23%								
Employee Fringe Benefits	$140,567				$91,336	$91,336	$91,336	$91,336	$365,344
Total DAS Salaries and Benefits	$751,727				**$488,448**	**$488,448**	**$488,448**	**$488,448**	**$1,953,792**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$22,200	$22,200	$22,200	$22,200	$88,800
Utilities(Elec, Water, Gas, Phone, Scavenger)	$15,000	$15,000	$15,000	$15,000	$60,000
Office Supplies, Postage	$2,550	$2,550	$2,550	$2,550	$10,200
Building Maintenance Supplies and Repair	$8,000	$8,000	$8,000	$8,000	$32,000
Printing and Reproduction	$135	$135	$135	$135	$540
Insurance	$4,500	$4,500	$4,500	$4,500	$18,000
Staff Training	$200	$200	$200	$200	$800
Staff Travel	$3,000	$3,000	$3,000	$3,000	$12,000
Rental of Equipment	$2,000	$2,000	$2,000	$2,000	$8,000
Consultants/Subcontractors					
Other					
Recruitment	$300	$300	$300	$300	$1,200
Total DAS Operating Expenses	**$57,885**	**$57,885**	**$57,885**	**$57,885**	**$231,540**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE

INSTITUTE ON AGING

Case Management: Clinical Collaborative Services

JULY 1, 2023 TO JUNE 30, 2027

I. Purpose:

The purpose of this grant is to improve the knowledge, skills, and performance of DAS/OCP funded case managers working with older adults and adults with disabilities and to more broadly maintain agency level excellence in the provision of services.

Clinical supervision is an important component of the services offered. It provides clinical support for individual case managers to improve the services delivered to their clients, to provide professional growth for the individual case manager, and to help deter staff burnout. The clinical supervisor/consultant will provide such resources by bringing together community case managers from OCP-funded case management agencies, for group and individual supervision meetings, clinical oversight, and consultation. The case management clinical supervision as part of the collaborative is guided by Department of Disability and Aging Services Program Memorandum #39 – "Case Management Program Standards."

In addition to working with community-based organizations and their case management staff, Clinical Collaborative services' staff is asked to work with DAS/OCP staff around program and project improvements as needed.

II. Definitions:

Adult with a Disability	A person, 18 years of age or older living with one or more disabilities
Case Management Module	An on-line case management module, which includes comprehensive assessment, service plan, progress notes and other tools. It is part of the SF DAS GetCare web-based application.
DAS	Department of Disability and Aging Services
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
HSA	Human Services Agency of the City and County of San Francisco.
Older Adult	Person who is 60 years of age or older, used interchangeably with Senior.
OCP	Office of Community Partnerships
SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to perform consumer intake/assessment/enrollment, record service units, run reports, etc.

III. Eligibility for Clinical Collaborative Services:

The intended recipients of the services provided by the Clinical Collaborative are OCP funded case management programs, their case managers and supervisors.

IV. Location and Time of Services:

Clinical Collaborative services are based at IOA's offices at 3575 Geary Blvd in San Francisco. The group and individual supervision, clinical oversight, and consultation are delivered at a variety of locations including participating agency sites, IOA offices, City offices, and other locations as agreed upon including virtual options.

V. Description of Services

The goals of the Clinical Collaborative are:

- Improve case managers' knowledge, skills, and abilities.
- Emphasize core elements of case management – intake/enrollment, comprehensive assessment, service planning/implementation, monitoring, progress notes, re-assessment, discharge/disenrollment.

To meet these goals, the Grantee shall provide individual and group clinical consultation, clinical oversight, chart, and documentation review (via the online Case Management Module), and an opportunity for professional networking/resource sharing.

Clinical Collaborative services includes at a minimum the following:

- **Monthly group supervision meetings for the Clinical Collaborative.** Group meetings provide case consultation, topic specific training, and review of core tasks and standards of case management. For group meetings, the Clinical Collaborative staff may also bring in outside experts and trainers to expand knowledge of resources, geriatric-related topics, behavioral health related issues, clinical skills and case management strategies with a focus on assessment, developing service plans, client relationship building, and managing challenging client issues. The Clinical Collaborative staff will encourage or enable participants' sharing of community resources, cross-agency referrals, peer review and guidance.

- **Bi-Weekly individual clinical consultation to members of the Collaborative.** Individual sessions emphasize specific case manager issues, challenging client issues, and offers guidance for maintaining quality services. In addition, individual consultation provides a forum to address and improve charting and documentation issues.

- **Monthly meetings with OCP case management supervisors and directors.** On a monthly basis, the Clinical Collaborative staff will meet with the agency supervisors and/or directors to ensure coordination between the Collaborative and the day to day case management supervisors, to improve program effectiveness and avoid any problems of "dual supervision."

- **Routine review of assessments and service plans developed by case managers.** Reviews will look for thoroughness, relevance and client engagement upon admission or enrollment to the program**.**

- The Collaborative's staff will advise OCP staff on program improvements and projects as needed.

VI. Objectives:

Service Objectives

Grantee will be required to follow specific service objectives that measure the quantity of services provided:

- Grantee will provide a minimum of **44** case management clinical group consultation meetings per year.
- Grantee will provide a minimum of **550** individual consultation sessions to the case managers annually.
- Grantee will provide a total of **12** meetings with participating case management agency supervisors or directors.

Outcome Objectives

Grantee will meet the following outcome objectives on an annual basis:

- At least eighty-five percent (85%) of case managers receiving services through the Collaborative and responding to an annual satisfaction survey will state the services were beneficial to them.
- At least eighty-five percent (85%) of case managers receiving services through the Collaborative and responding to an annual satisfaction survey will state the services helped improve their skill level and performance.
- At least eighty-five percent (85%) of case managers receiving services through the Collaborative and responding to an annual satisfaction survey will report that when they brought specific issues to the Collaborative, they were able to get training on that issue.
- At least eighty-five percent (85%) of case management supervisors and directors receiving services through the Collaborative and responding to a satisfaction survey will state that the services were beneficial to their case manager staff.
- At least eighty-five percent (85%) of case management supervisors and directors receiving services through the Collaborative and responding to an annual satisfaction survey will report that Collaborative services helped improve their case managers' skill levels and performance.
- At least eighty-five percent (85%) of case management supervisors and directors receiving services through the Collaborative and responding to an annual satisfaction survey will report that if they brought an issue facing their case managers to the Collaborative, the Collaborative would be able to provide consultation or training to help the case managers.

VII. REPORTING REQUIREMENTS:

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

A. The grantee will enter into the SF DAS GetCare Service Unit section all the units of service by the 5th working day of the month for the preceding month.
B. Monthly reports must be entered into the Contracts Administration, Reporting, and Billing Online (CARBON) system.
C. Grantee will provide an annual report summarizing the contract activities, referencing the tasks as described in Service and Outcome Objectives.
D. Grantee will participate in annual Consumer Satisfaction Survey in cooperation with Office of Community Partnerships (OCP) with a minimum return rate of 85% of case managers and 85% of supervisors and directors participating in Collaborative services. Grantee will also survey attendees at the end of each community training provided.
E. Grantee shall develop and deliver ad hoc reports as requested by HSA.
F. Grantee is required to attend all mandatory Case Management Provider's meetings and other meetings as needed.
G. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules as applicable.
H. Apart from reports requested to be sent via e-mail to the Program Analyst and/or Contract Manager, all other reports should be sent to the following addresses:

Erica Maybaum
Program Support Analyst
DAS, Office of Community Partnerships
Erica.Maybaum@SFgov.org

Tara Alvarez
Senior Contract Manager
HSA, Office of Contract Management
Tara.Alvarez@SFgov.org

VIII. MONITORING ACTIVITIES:

A. Program Monitoring: Program monitoring will include review of compliance to 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 SF DAS 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 director 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
Institute On Aging					7/1/23 - 6/30/27
(Check One) New _X___ Renewal ___ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Clinical Collaborative					
Budget Reference Page No.(s)					(Total)
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$271,529	$271,529	$271,529	$271,529	$1,086,116
Operating Expenses	$20,744	$20,744	$20,744	$20,744	$82,976
Subtotal	$292,273	$292,273	$292,273	$292,273	$1,169,092
Indirect Percentage (%)	15%	15%	15%	15%	15%
Indirect Cost	$43,841	$43,841	$43,841	$43,841	$175,364
Total DAS Expenditures	**$336,114**	**$336,114**	**$336,114**	**$336,114**	**$1,344,456**
DAS Revenues					
General Funds	$336,114	$336,114	$336,114	$336,114	$1,344,456
Total DAS Revenue	**$336,114**	**$336,114**	**$336,114**	**$336,114**	**$1,344,456**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$336,114**	**$336,114**	**$336,114**	**$336,114**	**$1,344,456**
Full Time Equivalent (FTE)	2.50	2.50	2.50	2.50	10.00
Prepared by:					Date:
HSA-CO Review Signature:					
HSA #1					

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Supervisor, Clinical Collaborative	$93,575	1.00	100%	1.00	$93,575	$93,575	$93,575	$93,575	$374,300
Citywide Clinical Trainer #1	$81,911	1.00	100%	1.00	$81,911	$81,911	$81,911	$81,911	$327,644
Citywide Clinical Trainer #2	$83,474	0.50	100%	0.50	$41,737	$41,737	$41,737	$41,737	$166,948
Totals	$258,960	2.50	300.00%	2.50	$217,223	$217,223	$217,223	$217,223	$868,892
Fringe Benefits Rate	25.00%								
Employee Fringe Benefits	$64,740				$54,306	$54,306	$54,306	$54,306	$217,224
Total DAS Salaries and Benefits	$323,700				**$271,529**	**$271,529**	**$271,529**	**$271,529**	**$1,086,116**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	(Total) 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$4,060	$4,060	$4,060	$4,060	$16,240
Utilities(Elec, Water, Gas, Phone, Scavenger)					
Office Supplies, Postage	$1,097	$1,097	$1,600	$1,722	$5,516
Building Maintenance Supplies and Repair					
Printing and Reproduction					
Insurance	$1,243	$1,243	$1,243	$1,243	$4,972
Licenses and Fees	$6,161	$6,161	$6,161	$6,161	$24,644
Staff Training/Retreat	$2,750	$2,750	$5,122	$5,000	$15,622
Staff Travel	$375	$375	$1,000	$1,000	$2,750
Rental of Equipment					
Consultants/Subcontractors					
Other					
Equipment Data Plan	$1,558	$1,558	$1,558	$1,558	$6,232
Small Equipment (Technology	$3,500	$3,500			$7,000
Recruitment Fee					
Total DAS Operating Expenses	**$20,744**	**$20,744**	**$20,744**	**$20,744**	**$82,976**
HSA #3					

APPENDIX A: SERVICES TO BE PROVIDED BY GRANTEE
San Francisco Pretrial Diversion Project
Effective July 1, 2023 to June 30, 2027

VETERANS JUSTICE COURT CASE MANAGEMENT

I. Purpose:

Office of Community Partnerships funds a veteran-focused case management program to support the specialized needs of veterans facing criminal charges by providing the social service, education and support they need to lead productive and independent lives. Activities include comprehensive assessment, case management, court appearances, with services including re-entry plans, therapeutic groups, and resource and referrals.

II. Definitions

Adult with a Disability	Person 18-59 years of age or older living with a disability
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	San Francisco Pretrial Diversion Project
HSA	San Francisco Human Services Agency
OCP	Office of Community Partnerships
Older Adult	Person who is 60 years or older
Socially Isolated	Having few social relationships and few people to interact with regularly
SF DAS GetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
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)
Veterans Administration (VA)	A government organization that provides assistance to people who have served in the armed forces.
Veterans Justice Court (VJC)	The Grantee shall provide case management services to eligible clients consistent with the Veterans Treatment Courts (VTC) requirements. The eligibility requirements for VTC are found here: https://www.courts.ca.gov/11181.htm. In San Francisco, the VTC court is known as the Veterans Justice Court (VJC).
Veterans Treatment Courts (VTC)	Veterans treatment courts are currently located in 28 California counties and target the root causes of veterans' criminal behavior. The goal of these courts is to resolve criminal cases through treatment and support. In San Francisco the VTC is referred to as the Veterans Justice Court.

III. Eligibility for Services

To be eligible for services, clients must be:

- Veterans from any military branch with criminal cases in San Francisco, regardless of residence location and veteran status.

- Veterans with criminal cases in San Francisco, regardless of residence location, and court ordered from the judge in the case, and
- Attend court as ordered, and
- Meet with clinical staff regularly as ordered, and
- Follow the treatment plan recommendation, and
- Willing to participate in the program

IV. Location and Time of Services:

San Francisco Pretrial Diversion Project I located at 236 8th Street, San Francisco, CA 94103. Services will be offered throughout the city including the San Francisco Superior Court and the San Francisco County jail.

VI. Description of Services

1. The Grantee shall provide case management services to eligible clients consistent with the Veterans Treatment Courts (VTC) requirements.

2. All Veterans Justice Court Case Management staff have the following qualifications:
   a) Minimum 1.0 FTE VJC case manager(s)
   b) Staff holding a Master's Degree in Social Work or Psychology, Licensed Clinical Social Worker or Marriage and Family Therapist preferred, or Bachelor of Arts level with extensive experience working with criminal justice, homeless, and substance use populations with mental health issues.
   c) Staff must meet all San Francisco Sheriff Department jail clearance requirements

3. Performance of core elements are recorded in the SF DAS GetCare database.

1) The case management process includes at a minimum the following:

a. Comprehensive Assessment
   Conduct thorough clinical needs assessments both in and out of custody including designing service plans with clients to address needs and gaps and to adhere to all court orders. Assessment should be completed within 30 days of enrollment in the program or as proposed by applicant

b. Case Management Services
   Provide intensive case management to a caseload of veterans who do not qualify for VA Health Care Benefits. Case management includes, but is not limited to monitoring and supervising clients to ensure compliance with court requirements as well as client individual re-entry plans. Counsel clients on a regular basis regarding conditions of release and design individual treatment

plans with clients.

c. Court Appearance and Case Conferences
Attend court and case conferencing weekly to update the judge and team on client progress.

d. Therapeutic Groups
Assist in conducting Cognitive Behavioral Therapy and/or Dialectical Behavior Therapy groups with clinical supervision for VJC clients utilizing evidence-based curriculum such as Thinking for a Change.

e. Referrals
Refer client to appropriate service agencies, including Department of Public Health Treatment Access Program, Veterans Service Office, Veterans Administration, substance abuse treatment, mental health care provider, veteran mentors and report on progress.

f. Progress Notes
Accurately document client attendance and progress into database. Progress notes should include referrals given, any follow-up needed, client updates, requests, etc.

g. Other Services Provided by VJC as Appropriate
Meet clients as they are released from jail and escort them to treatment and services.

VII. Objectives:

Service Objectives
For each Fiscal Year:

- Grantee will complete 100% of comprehensive assessments due each contract year.
- 100% of eligible participants connected to support services such as substance use and mental health treatment, medical assistance, education or training for employment, support for legal issues or other meaningful activities.
- Grantee will attend **48** court appearances and case conferences.
- Grantee will assist in conducting **48** therapeutic groups with the support of clinical supervision.

* Tracked via documentation in the SF DAS GetCare database

Outcome Objectives
The outcome objectives to be measured annually are:

- Grantee ill annually provide VJC Case Management services to a total of 40 eligible participants.
- 75% of participants will have completed the 15–18-month VJC program annually.
- Grantee will implement a participant satisfaction survey with a minimum return rate of 35%

* Tracked via documentation in the SF DAS 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 SF DAS GetCare database, 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 SF DAS 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. The Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules when applicable.

J. All staff are required to complete the Less-Than-Full Access CLETS examination and become trained on Criminal Offender Record Information (CORI) requirements, which explicate standards of data privacy and information security within the context of the criminal legal system

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

Erica Maybaum	Steve Kim
Program Support Analyst	Contract Manager
DAS, Office of Community Partnerships	HSA, Office of Contract Management
Erica.Maybaum@SFgov.org	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 SF DAS 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
San Francisco Pretrial Diversion Project					7/1/23 - 6/30/27
(Check One) New **X** Renewal ____ Modification ____					
If modification, Effective Date of Mod. No. of Mod.					
Program: Veterans Justice Court Case Management					
Budget Reference Page No.(s)					Total
Program Term	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	7/1/23 - 6/30/27
DAS Expenditures					
Salaries & Benefits	$172,500	$172,500	$172,500	$172,500	$690,000
Operating Expenses	$44,015	$41,346	$43,401	$44,942	$173,703
Subtotal	$216,515	$213,846	$215,901	$217,442	$863,703
Indirect Percentage (15%)	15%	15%	15%	15%	15%
Indirect Cost	$33,485	$36,154	$34,099	$32,558	$136,297
Capital/Subcontractor Expenditures					
Total DAS Expenditures	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$1,000,000**
DAS Revenues					
General Funds	$250,000	$250,000	$250,000	$250,000	$1,000,000
Total DAS Revenue	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$1,000,000**
Non DAS Revenues					
Total Non DAS Revenue					
TOTAL DAS AND NON DAS REVENUE	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$1,000,000**
Full Time Equivalent (FTE)	1.70	1.70	1.70	1.70	6.80
Prepared by: Tom Iacobucci, Dir. of Finance					Date: 4/20/23
HSA #1					

San Francisco Pretrial Diversion Project

Program: Veterans Justice Court Case Management

Salaries & Benefits Detail

DAS Salaries & Benefits	Agency Totals		HSA Program		7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	Total 7/1/23 - 6/30/27
Position Title	Annual Full Time Salary for FTE	Total FTE	% FTE funded by HSA (Max 100%)	Adjusted FTE	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary	Budgeted Salary
Veteran's Court Case Manager	$69,000	1	100%	1.00	$69,000	$69,000	$69,000	$69,000	$276,000
Veteran's Court Clinician	$102,000	0.5	100%	0.50	$51,000	$51,000	$51,000	$51,000	$204,000
Manager of Diversion	$90,000	0.2	100%	0.20	$18,000	$18,000	$18,000	$18,000	$72,000
Totals	$261,000	1.70	300%	1.70	$138,000	$138,000	$138,000	$138,000	$552,000
Fringe Benefits Rate	25%								
Employee Fringe Benefits	$65,250				$34,500	$34,500	$34,500	$34,500	$138,000
Total DAS Salaries and Benefits	$326,250				**$172,500**	**$172,500**	**$172,500**	**$172,500**	**$690,000**

HSA #2

Operating Expense Detail

	7/1/23 - 6/30/24	7/1/24 - 6/30/25	7/1/25 - 6/30/26	7/1/26 - 6/30/27	Total 7/1/23 - 6/30/27
DAS Operating Expenses					
Expenditure Category					
Rental of Property	$19,450	$20,228	$21,239	$22,514	$83,430
Utilities(Elec, Water, Gas, Phone, Scavenger, Internet)	$4,677	$4,864	$5,107	$4,254	$18,903
Office Supplies, Postage	$813	$845	$888	$941	$3,486
Building Maintenance Supplies and Repair	$186	$194	$204	$1,779	$2,363
Printing and Reproduction	$1,537	$1,598	$1,678	$3,996	$8,810
Insurance	$3,452	$3,591	$3,770	$449	$11,262
Licenses and Fees	$388	$404	$424	$465	$1,681
Staff Training	$256	$267	$280	$317	$1,121
Staff Travel	$751	$782	$821	$711	$3,065
Staff Computer	$4,500	$250	$250	$250	$5,250
Consultants/Subcontractors					
Jones IT	$5,223	$5,432	$5,703	$6,045	$22,403
Other					
Client and Staff Transportation	$1,236	$1,285	$1,350	$1,431	$5,302
Client Supplies	$1,545	$1,607	$1,687	$1,788	$6,627
Total DAS Operating Expenses	**$44,015**	**$41,346**	**$43,401**	**$44,942**	**$173,703**
HSA #3					