

COMMUNITY VISION INC DISABILITY SERVICES

POLICIES & PROCEDURES UNDER REVIEW October 2007 – March 2008

Related Programs

- **Kinship**

- Adult mentorship and Respite
- Child and Youth Respite
- Create

- **My Vision**

- Intensive Family Support Options
- Alternatives to Employment
- Post School Options

Service purchasing

SECTION 1 – SERVICE ACCESS

THESE POLICIES WILL BE
ACCESSIBLE FOR COMMENT
UNTIL 17th November 2007

REFERRALS & ACCESS (ENTRY)

Policy: To ensure that services are provided to Carers who meet the eligibility criteria and have high priority needs.

Procedures:

- I. Access to services will be decided on a non-discriminatory basis
- II. Referrals will be received from carers of an individual with a disability or an agency acting on their behalf.
- III. An initial application & assessment will be undertaken to determine eligibility for service. This may be undertaken by a referring agency or the 'Link Coordinator'.
- IV. When a carer/ participant is deemed to be eligible for service, the Link Coordinator will undertake a further detailed assessment to determine their level of need relative to other demands upon the service.
- V. The following Priority of Access procedures will apply to services received through Kinship and Child and Youth Respite
- VI. When a Carer is not offered a service, they may be referred to an agency/s where an appropriate service may be forthcoming

Services will be allocated in the following priority order

1. Participants / families at risk of abuse or neglect or family breakdown
 2. Illness of a family member
 3. Families who are isolated and have limited extended family support or agency support
 4. Other
- In addition to these Guidelines, preference will be given to new participants.
 - Services will continue to be provided on a 'First come First served' basis where each family / participant may receive services once during a 2 month period to a maximum of 4 services per year. However special provision will be made to ensure services are available to those families / participants that meet the Priority of Access Guidelines.

- Community Vision will develop a system of allocating its direct service budget to accommodate the proposed practices.

VII. Eligibility will be as follows:

- **CHILD & YOUTH RESPITE**

- I. For a carer to be eligible for service the individual with a disability must meet the following criteria:
- II. Be under 18 years of age
- III. Eligible for Level 2 or 3 services from the Disability Services Commission
- IV. Living at home in the care of their family
- V. When a carer/ participant is deemed to be eligible for service, the Link Coordinator will undertake a further detailed assessment to determine their level of need relative to other demands upon the service.

- **KINSHIP.**

- I. Kinship participants can live anywhere in the Perth Metro area, however priority is given to those people living in the Northern suburbs.
- II. Kinship participants must be living with a disability (intellectual, physical, neurological, cognitive, sensory or autism).
- III. Be aged over 18 years (people become eligible on Jan 01 of the year they are due to turn 18).
- IV. When eligibility for either mentorship or respite is confirmed, the Link Coordinator will undertake a further detailed assessment to determine level of need relative to other demands upon Kinship
- V. When a carer/ participant is deemed to be eligible for service, the Link Coordinator will undertake a further detailed assessment to determine their level of need relative to other demands upon the service.

VIII. **MY VISION**

- I. Participants are referred from the Disability Services Commission
- II. The Commission will advise CVI of the participants funding
- III. Following receipt of an Individual Needs Assessment from The Disability Services Commission, the Team Leader will

make contact with the family to assess any additional needs prior to CVI accepting the offer for the participant to join the service.

- IV. the Team Leader will meet with the individual to determine a starting date for service commencement
- V. CVI will inform the commission of acceptance / decline of the participant into the service based on the organisations capacity to provide a holistic service to the participant
- VI. If the participant is accepted into the program, the Team Leader will write to the family advising them of the hours available to the family as well as the agreed days of service delivery
- VII. A service delivery budget will be designed for the individual. This will be done by the Manager in consultation with the Team Leader
- VIII. The program Link Coordinator will meet with the family to develop a preliminary program and to arrange a link with a CSP prior to commencement

IX. INTENSIVE FAMILY SUPPORT SERVICES

- I. Participants are self referred or access can be initiated from the Disability Services Commission
- II. the Team Leader will meet with the individual to:
 1. Discuss options of service delivery, which will include
 - i. Nature of support services required
 - ii. Options of management (shared or organisation managed)
 - iii. Funding requisition plans
 - iv. Determine a starting date for service commencement
 2. An Intensive Family Support funding plan will be submitted to DSC along with the agreed starting date. This will be done by the Manager – Community Family Care Services, in consultation with the Team Leader
- III. Upon final approval from the Commission, the program Link Coordinator will meet with the family to develop a preliminary program and to arrange a link with a CSP prior to commencement

CESSATION OF SERVICES (EXIT)

Policy: Community Vision will ensure that the rationale for cessation of services is fair and understood by the carer.

Procedures:

- I. The start and finish date for services to be provided will be recorded on the care plan.
- II. If a participant/ carer's circumstances change or the capacity of the service to provide services changes, the finish date may be varied accordingly.
- III. In the event of such a change in finish date, the service will attempt to maximise as far as possible the period of notice provided to the carer.
- IV. Where community Vision initiates cessation of services, full reasons will be provided to the participant/ carer.
- V. The following timelines to particular services apply:

CHILD & YOUTH RESPITE

- VI. All services will be provided on a 'one-off', time limited basis to assist a carer to meet the demands of a particular set of circumstances.

KINSHIP

- VII. All services will be provided on a 'one-off', time limited basis to provide respite to a participant or to assist a participant to achieve a particular goal over an agreed period of time.

MY VISION & INTENSIVE FAMILY SUPPORT OPTIONS

- VIII. Services are ongoing and recurrent, however, the family and or the service provider may choose to cease service provision based on any of the following reasons which are not exhaustive:
 - i. The agencies inability to meet the care needs of the individual participant
 - ii. The individual participant and or their families inability to meet the service provision obligations of the agency
 - iii. The agency and the individuals values conflicting
- IX. Service funding for this programs are portable and so the family / individual may arrange for another agency to manage or share the management of their funding with them.

When a Carer chooses to leave the service assistance will be offered to find other potential services of benefit.

SECTION 2 – INDIVIDUAL NEEDS

INDIVIDUAL CARE

Policy : All clients and their families are to be incorporated in the opportunities to foster empowerment & individual choice by enabling greater input into decisions on their priority of needs and personal goals within the scope of the service to be provided.

Procedures:

- I. In consultation with the carer and individual with a disability, the Link Coordinator will develop a care plan that documents the nature and timing of the services to be provided.
- II. The individual plan must :
 - Be multi-dimensional and look at the whole person in the context of their community and the range of formal and informal supports required to maintain and promote their overall quality of life;
 - involve the individual, their family and significant others in the process of assessment of needs, personal goals, planning of services and regular review;
 - be carried out by an informed, experienced staff member with good knowledge of the organisation and local services;
 - be flexible and responsive to meet changing needs;
 - promote valued roles for the individual;
 - have adequate safeguards and grievance procedures; and
 - planning must be focussed around the goals of the individual
 - Have agreed strategies to achieve these goals
 - Be dated,
 - include a review date and be regularly reviewed

THE AIM OF THE CARE PLAN IS:

A) FOR THE INDIVIDUAL:

- to provide an overview of the person's goals to be met by Community Vision

- to provide opportunity for the person and the most significant people in the persons life to participate in planning the direction of the person's service;
- to provide a guide (via objectives) for staff about what their role, tasks and responsibilities are for the agreed period with respect to improving the quality of service for the individual;
- to provide a method to systematically monitor how appropriately a person's identified goals are being met, and
- to Identify any critical areas that may require more detailed assessment.

B) FOR COMMUNITY VISION

- to provide a system that ensures all consumers are regularly reviewed and that their needs are met appropriately;
- to provide a system that helps measure how well Community Vision adheres to the Disability Service Standards, and
- to provide a system that collects individual consumer information that can be used to shape organisation and individual plans.

III. Before service may commence, the carer must complete and sign the following documents:

- Client Service Agreement
- Client/Carer Consent & Authorisation Form
- Profile and Care Requirements – Individual with a Disability

IV. Changes to the care plan may only be authorised by the Link Coordinator. These will be undertaken in consultation with the carer and individual with a disability.

V. Staff will be given a copy of the care plan and instructed to abide by its details as they undertake their duties.

VI. If a staff arrives to commence their work with the individual with a disability – and for some reason it is not possible to meet the requirements of the care plan – the staff carer will:

- Contact the Link Coordinator to seek direction. In the absence of the Consultant, direction will be sought from the Team Leader.

- If neither of these staff are available, the Client Support staff will terminate the work and inform the service at the earliest opportunity.