# **CALIFORNIA COMMUNITY LIVING FUND PROGRAM**

## **Program Definitions**

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| **Aging & Disability Resource Connection (ADRC)** | ADRCs are intended to act as part of a "[No Wrong Door](https://nwd.acl.gov/index.html)" system which enables people of all ages, incomes, and disabilities to connect with any one ADRC partner organization for accessing a wide array of Long-Term Services and Support (LTSS) options in the community. ADRCs serve older adults, adults with disabilities, family caregivers, including individuals living in the community and residents in long-term care facilities, and respect the diversity of families and cultures that make up their local communities.  In California, ADRCs are a core partnership between Independent Living Centers (ILC) and Area Agencies on Aging (AAA) that work with other disability and aging organizations to streamline access to LTSS. |
| **Braiding Funding** | Braiding multiple funding streams is a process for using multiple funding sources to support the total costs of a common goal (for example, to expand access to institutional transition and diversion or LTSS).  When funds are braided, two or more funding sources are coordinated to support the total cost of a service. Revenues are allocated and expenditures tracked by different categories of funding sources.  Each individual funding stream maintains its specific program identity, meaning that funds from each specific funding source is tracked separately. This helps to ensure there is no duplicate funding.  Braiding for the CLF Program may include:   * Identifying funding streams. Identifying any local, state or federal funding streams that support institutional transition and diversion goals and outcomes. Identify gaps between existing funding streams and those that can be supported by the CLF Program. * Identifying eligible populations and compare requirements. Identifying individuals who need institutional transition and diversion services and their eligible for services funded through different funding streams. * Building a system to collaborate and coordinate. Develop methods to coordinate and collaborate with services and programs that can support institutional transition and diversion services or that provide LTSS to support on-going community needs. This might include a method to share confidential consumer information to determine eligibility. |
| **Community Living** | Community living provides individuals full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.  All people, regardless of age or disability, should have the right to make choices and to control the decisions in and about their lives. This right to self-determination includes decisions about their homes and work, as well as all daily choices.  A community living setting is selected by the individual from among various setting options, including non-disability-specific settings and an option for a private unit in a residential setting that also:   * Is based on the individual’s needs, preferences, and, for residential settings, ensures an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint. * Optimizes, but does regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, the physical environment, and with whom to interact.   Facilitates individual choice regarding services and supports, and who provides them. |
| **Community Living Funds** | The Community Living Fund Program advances the governor’s Master Plan for Aging (MPA) and the ADRC No Wrong Door model by expanding the capacity of disability and aging services and programs to provide person-centered transition and diversion services for people of all ages and with any type of disability who do not qualify for existing services. It is a $10 million State General Fund for DOR to expand related services over three years. |
| **Diversion** | Assisting individuals who are at risk of being institutionalized or entering an institutional setting by providing services, supports, and/or equipment that prevents them from going into a higher level of care, losing their housing, and/or formal or informal support systems. |
| **Full Time Equivalent (FTE)** | Full time equivalent (FTE) employee allocated to this program for institutional transition diversion services. One FTE is equivalent to 40 hours a week. |
| **Long-Term Services and Supports (LTSS)** | Long-term services and supports (LTSS) includes a broad range of services and supports delivered by paid providers and unpaid caregivers to people who have limitations in their ability to care for themselves. These limitations may be due to a physical, mental, cognitive, or chronic health condition that is expected to continue for an extended period. LTSS services can be provided in a variety of settings including at home, in the community, in residential care, or in institutional settings. |
| **No Wrong Door Model** | A No Wrong Door (NWD) System empowers individuals to make informed decisions, exercise control over their long-term care needs, and achieve their personal goals and preferences.  A NWD System expands access to services and supports, helping individuals and their caregivers navigate resources they need with a person-centered approach. This System streamlines access to LTSS options for older adults and individuals with disabilities and provides information and assistance to individuals needing public or private resources. |
| **Person-Centered Counseling (PCC)** | Person-centered counseling (PCC) allows individuals to be engaged in the decision-making process about their options, preferences, values, and financial resources. Individuals in need of services or who are planning to have access to one-on-one counseling in a variety of settings, including within the home, community residence, acute care hospital, school settings, or several other settings based on the individual's needs.  PCC is a valuable tool for the aging and disability networks that can improve access to care through streamlined partnerships, technology, and resources that put the focus on the needs of people and their caregivers.  A person-centered system recognizes that every individual is unique, and the system must be able to respond flexibly to each individual's situation, strengths, needs and preferences. PCC is centered on the individual and their personal goals and desires and is much broader in scope than any formal assessment or eligibility determination process tied to a public or private program. |
| **Person-Centered Services** | Person-centered services allow individuals to be engaged in the decision-making process about their options, preferences, values, and financial resources.  Person-centered services require person-centered planning, a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community. Most important, it is a process that is directed by the person who receives the support. |
| **Person with a Disability** | A person with a disability refers to an individual who has a physical, mental health, intellectual or developmental, hearing, vision, cognitive, chronic health condition, or other disability or impairment that limits one or more major life activity such as self-care, capacity for independent living and self-direction, and/or cognitive functioning and emotional adjustment.  People with disabilities can be of any age and have any type of disability. Disabilities can be apparent or hidden.  Individuals may be born with a disability or acquire the disability at some point in their life including as they age. |
| **Risk of Institutionalization** | Institutionalization is when a person is placed voluntarily or involuntarily in a hospital, medical treatment facility, nursing home, acute care facility, or mental health hospital, or when an individual is in a residential facility for an extended period, develops excessive dependency on the institution and its routines, and has a diminishing will or ability to function independently.  Risk of institutionalization means that the individual is in danger of residential facility placement due to their medical, functional, or cognitive status, but would be able to remain at home if community services and supports were provided.  The circumstances in which an individual is at-risk of no longer being able to live on their own and is eligible for placement in a licensed residential care facility. To be eligible for institutional level of care, an individual must have, at a minimum, one of the following:   * Functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transfer, bathing, toileting, and grooming; or * A medical condition to the extent requiring the level of care that would be provided in a nursing facility; or * Be unable to manage his/her own affairs due to emotional and/or cognitive impairment. |
| **Service Coordination** | Service coordination includes coordinating and facilitating access to a variety of services in a timely manner for people who need assistance in organizing and managing their care and/or supportive services. It includes consumer intake, assessment, person-centered planning and implementation, monitoring, reassessment, discharge services, and connecting individuals to find the supports and services to help with community living. It may require frequent visits and follow up depending on individual needs.  Service coordination is an integral component of long-term care service delivery and is central to accessing CLF Program services. |
| **Transition** | Assisting individuals to transition into the community from one of the following types of institutional facilities: licensed skilled nursing facility, intermediate care facility for the developmentally disabled, state hospital for the mentally ill, developmental center, rehabilitation hospital, and California Veterans home. Individuals in Acute Care Hospitals would be eligible when they are at risk of going into an institutional setting listed above. |