



SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
Adult Services

South Carolina Department of Social Services

Adult Protective Services Policy Manual

Protective Services

**South Carolina Department of Social Services
Adult Protective Services Policy and Procedure Manual**

APS Program Policy – Protective Services

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100 PURPOSE AND SCOPE OF PROGRAM:

PURPOSE. Protective Services (Treatment Services) promotes the intervention and protection of Vulnerable Adults from abuse, neglect, self-neglect, and exploitation. The mission of the Adult Protective Services Program is to protect Vulnerable Adults from abuse, neglect and exploitation by investigating and providing temporary assistance until long term community services can be secured.

INTENT. Protective Services ordered pursuant to S.C. Code of Laws, SECTION 43-35-45 (F), must be provided in the least restrictive setting available and appropriate for the Vulnerable Adult and non-institutional placement must be used whenever possible. It is the intent of the Adult Protective Services Program to provide respectable assistance that minimizes or eliminates risk while supporting the Vulnerable Adult's self-worth and dignity.

SCOPE OF TREATMENT SERVICES. The scope of APS Treatment Services includes assessment of the Vulnerable Adult's needs and services through the completion of a Needs Assessment and Service Plan. Treatment Services entails service coordination including county level multi-agency inter-disciplinary Adult Protective Services Coordination Team meetings with community partners who provide long term services to Vulnerable Adults. Emphasis is placed on the delivery of services to the Vulnerable Adult in which review and monitoring are essential components.

The mission of the Adult Protective Services program is to protect Vulnerable Adults from abuse, neglect, self-neglect and exploitation by investigating and providing temporary assistance until long term community services can be secured. When a thorough APS Investigation does not reveal a need for adult protection, the Investigative case will be closed. However, when the APS Investigation reveals that the client is a Vulnerable Adult who has been abused, neglected, or exploited or the Vulnerable Adult is at substantial risk of being abused, neglected, or exploited and the Vulnerable Adult is unable to protect herself or himself, Adult Protective Services are provided and a Treatment Services case is opened.

110 CASE MANAGEMENT COMPONENTS

Documentation in CAPSS must be completed in a specified manner once a Treatment Services line has been opened. When the APS Treatment Services Case Manager enters a narrative in CAPSS, he/she will begin by labeling the narrative with a Case Management Component. These four (4) components categorize the subject that the narrative discusses. The following terms define the content and activity that is associated with each component:

Assessment - This component includes activities completed while performing a thorough assessment of an individual to determine service needs including activities that focus on needs identification to determine the need for any medical, educational, social or other services. Such assessment activities include the following:

1. Gathering individual history;
2. Identifying the needs of the client and completing related documentation;
3. Gathering information from other sources such as family members, medical providers, social workers, service providers and educators, other knowledgeable individuals in the community such as an unrelated caregiver, minister or others who have information about the Vulnerable Adult.

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The Assessment component should be labeled at the top of the narrative in CAPSS when describing the above activities. The case management component “**Assessment**” is used when the Case Manager is gathering information to complete the Needs Assessment in CAPSS.

Case Planning - This component is used when the Case Manager is documenting the activities in CAPSS after following up with the provider(s) who are actually providing the service(s) to the client. This component involves the development (and periodic revision) of a specific Service Plan based on the information collected through the assessment, which specifies the goals and actions to address the medical, social, educational and other services needed by the Vulnerable Adult. This component includes activities such as ensuring the *active* participation of the Vulnerable Adult and working with the representative or the authorized health care decision maker and others to develop goals. The Case Manager also identifies a course of action to respond to the assessed needs of the Vulnerable Adult. This component is also used to gather all service contracts and address service activities which are to be added into the Vulnerable Adult’s Service Plan. The “**Case Planning**” component should be used prior to the completion of the Service Plan.

Referral/Linkage - Referral and related activities, such as scheduling appointments for the Vulnerable Adult, helps the client obtain needed services. This includes activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve objectives specified in the case plan. The “**Referral & Linkage**” component denotes all referrals made by the agency on behalf of the client. A CAPSS narrative entry may state that “*The Case Manager made referral to CLTC for Mr. Lawton to receive assistance with his ADLs.*”

Monitoring/Follow-up - This component is used to indicate contact with the client *after* the Needs Assessment and Service Plan are completed in CAPSS. This component is guided by the tasks on the client’s most recent Service Plan. This component includes activities and contacts that are necessary to ensure the Service Plan is implemented effectively and the needs of the Vulnerable Adult are being addressed. “**Monitoring/Follow-up**” may include activities with the Vulnerable Adult, family members, service providers or other entities/individuals. These activities will assist the Case Manager in determining if the services outlined in the Service Plan are meeting the needs of the Vulnerable Adult.

111 ASSESSING THE NEEDS OF A VULNERABLE ADULT FOR TREATMENT SERVICES

When a thorough APS Investigation determines that the alleged victim is a Vulnerable Adult who is in need of Protective Services due to abuse, neglect, self-neglect or exploitation or there is a substantial risk of abuse, neglect, self-neglect or exploitation, a Treatment Services case is opened to assess the needs of the client and to identify the services that will reduce risk factors and establish safety and stability for the Vulnerable Adult.

APS Supervisor Responsibilities

1. Close Assessment line.
2. Open Treatment Services line on same day Assessment line is closed.
3. If there is court involvement, a new referral to the Legal Case Management System (LCMS) must be made in the Treatment Services line.
4. Assign Treatment Services case to APS Case Manager.
5. Complete Transfer Staffing and note in CAPSS. Upload completed **Case Transfer and/or Case Staffing** (DSS Form 3062) in CAPSS.

APS Case Manager Responsibilities

1. Make face to face contact with the Vulnerable Adult at least once a month.

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2. Case Manager will make semi-monthly contact with the provider and/or family member who is providing services to the client.
3. Complete Needs Assessment in Treatment Services line in CAPSS within ten (10) **business** days of the Case Decision.
4. Complete Service Plan ten (10) business days after completion of the Needs Assessment.
5. Complete Summary to court every six months.

120 THE LEGAL CASE MANAGEMENT SYSTEM

In order to initiate a legal action, a referral must be made by the Case Manager. It is the responsibility for the local legal staff to update LCMS. In order to make a referral of an APS case to LCMS, the APS Case Manager/Supervisor or designee should follow this procedure:

1. Open the client's case in CAPSS.
2. Select the program service line to be referred (Assessment or Treatment).
3. Click on "Legal."
4. Click on "Update."
5. Select the LCMS Referral Type (Urgent or Non-Urgent).
6. Click "Commit."

The Case Manager will know that the referral was successful, if the LCMS Referral Sent Date appears in CAPSS within thirty (30) minutes of entry. This action is a one-time referral needed by the Case Manager. If the initial referral is made in the Assessment Service line, another referral must be made in the Treatment Service line after closing the Assessment Service line. No other action is needed by the Case Manager. Any time court action is initiated, a referral to LCMS must be made immediately by following the above steps. LCMS must be informed as to which service line the court data is forwarded, i.e. Assessment or Treatment Services line.

130 THE APS NEEDS ASSESSMENT

The APS Needs Assessment must be completed within **ten (10) business** days of the Case Decision. The purpose of the Needs Assessment is to assess the medical, social, educational, safety, risk and other needs of the Vulnerable Adult. The Needs Assessment will outline what needs the Vulnerable Adult has that will eliminate his/her risk and safety factors. The Needs Assessment is completed by the Case Manager in the Treatment Services line in the Risk Assessment Tab. The Vulnerable Adult's needs and risk must be reassessed by completing the Needs Assessment every 4 to 6 months in CAPSS or when there is a significant change in the client's life. This assessment must include specific behavioral descriptions of what collaterals have witnessed or what the Case Manager has observed, as well as the client's perception of the situation. The contacts with collaterals must be documented in CAPSS under the "Assessment" component in the Activity Notes prior to the completion of the Needs Assessment. The Needs Assessment must contain but is not limited to the following:

- Medical and/or mental condition (The assessment may require obtaining evaluations completed by service providers);
- Physical Needs (and/or ability of the adult client to perform activities of daily living); must be taken into account when rating each factor.
- Social and/or emotional status; Housing and/or physical environment; Family and/or support system; Vocational and/or educational needs;

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- Independent living skills and/or abilities; Level of functioning.

131 THE NEEDS ASSESSMENT INTERVIEW

The following information is a guide for conducting a Needs Assessment interview:

Nature of the Needs Assessment: For every person eligible for social services, it is important that there be an assessment of the need for services. The purpose of the Needs Assessment is to enable the Case Manager to understand and individualize the client's social need(s), and to identify relevant factors in a particular situation. A Service Plan is always completed with the Vulnerable Adult when the client and the Case Manager agree that a specific service(s) will help the client obtain a predetermined goal. This material is designed to suggest items of information that might be used in the Needs Assessment of the client by the Case Manager.

Guide for the Needs Assessment: A Needs Assessment and Service Plan can best be developed within a climate which permits the client to freely discuss problems, helps the Case Manager understand what the problems are and what they mean to the client, and permits the sharing of pertinent information which may provide clues to underlying needs which are affecting the client adversely.

The Initial Interview: The Case Manager and the client start forming opinions of each other during the first interview. It is important for the Case Manager to convey a feeling of acceptance and empathy through which a mutual confidence may be established between the Vulnerable Adult and the Case Manager. Such a climate allows the Vulnerable Adult to disclose both facts and feelings, and permits the Case Manager to assume an effective helping role. Establishing and maintaining a good relationship with the client through the use of skillful interviewing techniques enables the Case Manager to gain knowledge about the client's strengths and weaknesses which are related to the client's risks and needs, and his/her ability and readiness to accept and use the agency's service(s).

Things to Avoid During the Needs Assessment Interview

It is essential for a Case Manager to refrain from:

1. Imposing moral judgements upon the Vulnerable Adult enabling the client to feel free to discuss personal feelings about pertinent matters without fear of disapproval.
2. Asking accusing questions which only arouse fear and suspicion, not cooperation.
3. Asking abrupt or tricky questions, as they are inappropriate in a Needs Assessment interview.
4. Doing all of the talking.

Things to Do During the Needs Assessment Interview

Clients soon recognize the attitude of their Case Manager and tend to respond best when they feel the presence of a real desire to understand and to help; therefore, the Case Manager should:

1. Conduct the Needs Assessment interview in an atmosphere of acceptance and openness.
2. Ask questions to obtain specifically needed information, and to direct the client's conversation from fruitless to fruitful channels.
3. Let the client talk. Sometimes the client will not only state the concern(s), but will also suggest a course of action to overcome the risk(s). In such a case the client's suggestions can be supported and

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strengthened by the Case Manager. The fact that the client regards it as his/her own solution makes the client more likely to follow through with it.

4. Respect the client's right to make decisions unless the client is unable to act in his/her own behalf.

Case Managers should be aware of, and make appropriate referrals to all community resources. The Case Manager should know what services are offered, how and to whom they are available, what demands are made upon the seeker, and other formal aspects of the service delivery plan. In addition, the Case Manager need to have knowledge of the delivery system. The Case Manager need to know what actually happens when a client tries to avail himself/herself of a particular resource. In other words, the Case Manager should have the pulse of the community at his/her fingertips and should update the inventory of resources with information learned in day by day contacts. Entailed here is firsthand knowledge amassed from actual contact with the resource(s). The Case Manager should become personally acquainted with related services so that he/she has adequate knowledge when suggesting various resources to the Vulnerable Adults.

The Needs Assessment Interview

Normally, the Needs Assessment is formulated by inquiry and client response. Careful consideration of all questions and responses should result in a reasonable, accurate assessment of the client's concerns(s) and/or need(s).

Identifying and Stating the Concerns(s) and Needs(s)

In order to develop a strategy for dealing with a concern or need, it is helpful for the Case Manager and client to have some understanding of what is producing it. Identification is a joint undertaking by the Case Manager and client, usually guided by the Case Manager's inquiries; i.e., With what concerns(s) does the client think he/she wants help with? How and when did the concern(s) begin? What has the client done or tried to do about the concerns(s)? What other people are involved in the concern(s)?

Analyzing the Dynamics of the Social Situation.

Before identifying alternative goals, objective(s), tasks, and strategies for the change which appears desirable for the client, the Case Manager must elaborate the initial statement of the problem(s) in a more detailed analysis of the dynamics of the problematic situation. The Case Manager needs to know how the pieces of the picture identified in the statement of the problem(s) or the need(s) fit together. In doing this, the Case Manager will not be directing efforts at pinpointing any single cause. Rather, the aim will be to develop an understanding of how various elements in the situation are operating to produce or maintain given behavioral or social conditions. As the Case Manager identifies the problematic situation, and the roots thereof, he/she must keep in mind the factors which impede the client's ability to cope with life tasks and determine why various resources previously attempted failed to provide the appropriate effect.

Establishing Goals, Objectives and Plans. On the basis of the Case Manager's understanding of the dynamics of the problem, he/she, with the client, must establish goal(s), and objective(s) for the planned change and decide upon tasks with respect to the objective. Aspects of goal and objective setting that are important to problem solving are feasibility and priorities.

Feasibility. The planned change goal to which the Case Manager and client shall be working must be feasible and relevant to the client's problem(s) or need(s). An unrealistic goal will lead to frustration, apathy, and withdrawal from any planned, changed effort.

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Priorities. Defining of priorities is basically about sorting through the value of one's needs. Priorities are not just a matter of long-term versus short-term goals. Goals should be given preference by the greatest need and available resources. Alleviating immediate distress and providing for the basic necessities such as food, housing and medical care have always been a priority in serving our clients.

Determining Tasks and Strategies. All of the steps in the Needs Assessment discussed earlier will affect the decisions the Case Manager makes regarding a course of action for a planned change effort. Identification and statement of problem, analysis of the dynamics of the situation, and the selection of goals, objectives, tasks, and targets provide help in three (3) specific areas:

(1) determining actual and potential needs of the client, action, and target systems with respect to method and outcome of the goal; (2) suggesting points of entry in dealing with the problem, and (3) indicating resources the Case Manager will be able to utilize, and the kinds of relationships to be established.

Intervention. A Case Manager's activities can be characterized under one of three (3) approaches to intervention which encompass all case management functions. These approaches are called education, facilitation, and advocacy.

Education. The educational approach involves the responsibility of the Case Manager to assume a number of roles such as teacher, expert, and consultant. Typical activities in which the Case Manager might engage are giving information and advice, providing feedback, teaching skills, and demonstrating behavior.

Facilitation. This will encompass such activities as eliciting information and opinions, facilitating expression of feelings, interpreting behavior, discussing alternative courses of action, clarifying situations, providing encouragement and reassurance, and practicing logical reasoning, etc.

Advocacy. This approach allows the Case Manager to assume a role of advocate on behalf of the client. The objective of this strategy is to help the individual obtain needed resource(s) or service(s), to obtain a policy change or concession from a resistant, disinterested individual or agency, and in many cases to monitor the activities of a program in which the client participates when the service is offered through another agency or community resource.

Stabilizing the Change Effort. The final consideration in problem assessment is anticipating what new problem(s) or need(s) might arise as a result of the change effort, and what can be done to see that the change is maintained once it is achieved. Changing one aspect of the client's social situation will have consequences for other aspects, and new problems may be brought to light. This is why helping to develop the coping and problem solving capacities of clients should always be one of the client's underlying goals.

Continued Needs Assessment. Contacts between the Case Manager and the client should be as frequent as necessary to carry out the agreed upon tasks, and to assess progress in relation to achieving or maintaining the designated goal/objective with the client. Therefore, the Needs Assessment continues throughout the process. While the initial assessment serves as a blueprint, it must be modified as ideas are tested out and new information and data are gathered. The Case Manager must continually reassess the nature of the problem, the need for supporting data, and the effectiveness of approaches chosen.

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The Needs Assessment is a decision making tool that guides the Treatment Services Case Manager to assign a rating of High, Medium, or Low on the assessment. All factors rated high or medium on the Needs Assessment must be transferred to the Service Plan in the form of obstacles and objectives. This will include identifying the individual's strengths and available resources which may be drawn upon to address the client's identified need(s), as well as problem areas which may hinder needs from being met. The focus must remain on risk/safety, medical, social, educational and other needs while completing subsequent re-assessment processes.

140 THE SERVICE PLAN

The Needs Assessment Tool must be completed prior to the development of the Service Plan. The purpose of the Service Plan is to address the risk identified by the Needs Assessment tool and improve well-being; thus, enhancing the Vulnerable Adult's quality of life. The client and/or caregiver must be involved in the development of the Service Plan. The Service Plan will address the risk factors identifying problems, medical, social, educational and other service needs of the Vulnerable Adult. The Service Plan can be updated at any time based upon the change in the needs of the client. The initial Service Plan must be completed within ten (10) **business** days of the Needs Assessment Tool, and completed annually thereafter. The factors that were rated as medium or high on the Needs Assessment must be addressed in the Service Plan in the form of goals, obstacles, objectives and tasks. The following terms and examples will assist the Case Manager in developing a functional Service Plan that is meaningful and will reduce risks to the client:

Goal: A goal is a broad spectrum, and provides an indication of program intentions. The goal focuses on eliminating risk, safety and enhancing well-being while improving the quality of life of the Vulnerable Adult.
Example: To assess risk and provide services to meet the needs of the client.

Obstacle: An obstacle is a barrier or constraint that stands in the way of literal or figurative progress.
Example: Ms. Smith has diabetes; her glucose level is extremely high.

Objective: An objective is measurable, defined, operational, simple steps, and specific. It should be behavioral, specific, relevant, and time-limited.
Example: Ms. Smith will receive services to bring her glucose level down to a manageable level.

Task: A task refers to a clearly defined piece of work, sometimes of short or limited duration, assigned to or expected of a person.

The Service Plan shall address, as appropriate, the following needs relative to the client:

1. Medical status;
2. Emotional status;
3. Family dynamics;
4. Individual/family support system;
5. Current living environment;
6. Elimination of risk;
7. Financial status;
8. Educational or vocational placement;
9. Community involvement;
10. Socialization and relationships with others;
11. Services received or needed from others.

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Subsequent updates and reviews can take place at any time when there is a significant change, i.e. hospitalization, death of a spouse or a child, change in caregiver, medical condition, etc. in the client's situation during the life of the case. These changes to the Service Plan must be discussed with the client and all parties involved with the client for input.

The Service Plan must document specific tasks that each service provider, family member, caregiver, etc. has agreed to provide to the Vulnerable Adult with the frequency, and ending date specified on the plan. Services are planned with the client to the extent that he/she is able to participate. The primary focus is on the client's protection and safety.

In addition to case management services from the Department, services from other state and local agencies may be needed. The Case Manager can enlist relatives, friends, neighbors, or church members to assist the client's receipt of holistic services and to eliminate unsafe conditions. This does not include releasing confidential and/or personal information to unauthorized individuals in this process. All contacts with the individuals stated above must be documented in the Activity Notes in CAPSS using the "Case Planning" component. Clients with sufficient income and/or assets should contribute financially to the provision of services to their benefit. The technical instruction to create a Service Plan is located in the CAPSS Users Guide.

141 ARRANGING FOR THE PROVISION OF SERVICES

When arranging for the provision of services to clients, the Case Manager must be aware of individual differences and consider the specific needs of the person with whom he/she is working. This is especially true in the provision of services to persons with physical and/or mental limitations, either directly or by referral. DSS staff need to be aware that each person comes with his or her own concerns and with varying abilities to cope or adjust. Others have been unable to face their issues realistically and have developed feelings of frustration, anger, shame, guilt or anxiety. Services provided must be those designed to help maximize their remaining capacities and to function within their limitations while respecting their right to self-determination.

APS Supervisor Responsibilities:

1. Makes available to its staff, resource directories which will inform staff members of services offered on state, regional and local levels
2. Updates resource file.

APS Treatment Services Case Manager & Client

1. APS Treatment Services Case Manager and client determines which concern/need is most urgent (the one with which the client is most concerned, is willing and ready to accept help and resource is available).

APS Treatment Services Case Manager

1. Interviews Vulnerable Adult, establishing a positive relationship, enabling individual to identify problems and/or the Case Manager to sense them.
2. Determines eligibility for services and authorizes services.
3. Determines which provider/resource has service(s) most appropriate to meet client's particular Needs.
4. Contacts provider/resource to substantiate availability of service(s) for client.
5. Describes what the provider/resource has to offer the client and encourages him/her to accept the service(s).

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6. With client's permission, provides information about individual to the agency or organization which will be helpful in the, provision of service (s) and make referral for services.
7. Determines if client needs transportation to service access. If necessary, assists in providing or arranging for this service.
8. Follows up on referral to see that client receives services from provider/resource.
9. If individual is ineligible for DSS services, makes referral to appropriate resource, follow up on services.
10. Annually, re-determines client's SSBG eligibility.

142 CERTIFICATION OF CITIZENSHIP/MEDICAID ELIGIBILITY

Changes under the Federal Deficit Reduction Act of 2005 requires all individuals to provide proof of citizenship and identity when applying for Medicaid benefits after July 1, 2006. The Deficit Reduction Act set forth changes in federal law impacting Medicaid administered by the South Carolina Department of Health and Human Services. This section outlines the procedure to follow when an adult needs to apply or be reviewed for Medicaid eligibility:

APS Treatment Services Case Manager Responsibilities

1. Contact the client or client representative to determine whether identifying information is available to verify citizenship.
2. Contact the Medicaid eligibility worker for assistance to obtain information about your client. (original document must be presented).
3. Completes Medicaid Application as required.
4. Use data match from government agencies like Social Security Administration, Veterans Administration, etc. to obtain identifying information.
5. Contact the Community Residential Care Facility or the Nursing Home Social Worker for clients in placement. Admission information serves as a resource.

Note: If other forms of documentation cannot be obtained, documentation may be provided by a written affidavit from two citizens not related to the applicant who have specific knowledge of the citizenship status. The applicant must submit an affidavit stating why the documents are not available.

Note: For clarification concerning appropriate forms of identification to verify citizenship, refer to DHHS form 1233A @ <http://medsweb.clemson.edu/formlisting.htm>.

143 SERVICE COORDINATION

After arranging the necessary services, it becomes the Case Manager's responsibility to coordinate with service providers, i.e. CLTC, Personal Care Aids, Home Health, Social Service Aids, family members, personal care physician (PCP), friends, etc. and build a support system or keep the existing support system in place. The Case Manager will maintain a minimum of one (1) semi- monthly contact with a service provider/caregiver on behalf of the client and one (1) monthly face to face visit with the Vulnerable Adult. The monthly face to face contact with the Vulnerable Adult must be made with the client in his/her home or residence to ensure the client's overall protection. During these contacts the tasks outlined on the Service Plan must be reviewed with the client and/or caregiver for status updates. Service coordination on behalf of our clients must be conducted under the "Referral & Linkage component." The Case Manager must document in writing to the service providers what services he/she is requesting for each client. The Case Manager must document in CAPSS contact with service providers with details of the services provided to the APS client on a monthly basis. Monthly contacts with service providers under the "Monitoring and Follow-up" component, must be conducted to ensure providers are

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following through with their service agreement with our clients. The Case Manager must document tasks on the Service Plan individualized for each client. These tasks must be agreed upon by all parties, i.e. client, service providers, caregiver, etc. The Case Manager must be an advocate to obtain these services for which the client is in need of to eliminate unsafe conditions and/or to provide a better quality of life. The case should be re-assessed using the Needs Assessment Tool in CAPSS in the Treatment Services line. If there is an overall rating of “Low,” the case should be staffed with the Supervisor for possible closure.

150 MEDICAL CONSENT

Adults are entitled to make decisions about their own medical care unless the court has ordered certain care or given the Agency authority to consent to medical care for the client. Consent for routine medical services may include:

1. a prescribed visit to the doctor’s office to relieve symptoms associated with illnesses, prevention and relief of suffering by means of early identification, and
2. comprehensive medical assessment and treatment of pain and other problems, physically, mentally, and psychosocial.

Examples of routine visits may include visits to an internist, urologist, cardiologist, ophthalmologist, orthopedic doctor and etc.

Clients may have an advance directive, i.e. (Health Care Power of Attorney and Living Will). If the client has a Health Care Power of Attorney and or a Living Will this information must be shared with the Case Manager to assist the client with services.

Clients who have not made advance directives and are able to understand should be encouraged to make these directives about the type of care they want should they become unable to consent. Clients should be encouraged to appoint a Health Care Power of Attorney where appropriate.

In the absence of a Court Order, DSS has no authority to agree to the withholding of medical treatment, food, or water.

The Department does not secure custody of adults for the sole purpose of giving consent for medical treatment. Guardians, and persons named as the Health Care Power of Attorney may give consent for medical treatment of impaired adults who are unable to give informed consent. In the absence of a designated decision-maker, the health care provider should follow procedures in the Adult Health Care Consent Act.

160 THE SIX MONTH REPORT TO THE COURT

After the court orders custody of the Vulnerable Adult to DSS or otherwise orders Protective Services, the Case Manager must evaluate the client's situation and submit a written report to the Court at least every six months. The report will address the client's continued need for court ordered services. These reports should be submitted to the county legal department which should then be responsible for ensuring that the appropriate parties/individuals are provided copies as is the Court. The report must be documented in LCMS so that information is transmitted to CAPSS. Before submitting the Six Month Report the Adult Protective Services Case Manager must conduct a comprehensive evaluation of the Vulnerable Adult. The evaluation must include, but is not limited to:

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1. The Vulnerable Adult's current address and with whom the Vulnerable Adult is residing;
2. a list of all persons or agencies currently providing services to the Vulnerable Adult and the nature of these services; a summary of services, if any, provided to the Vulnerable Adult by the Adult Protective Services Program;
3. if needed, a medical, psychological, social, vocational, or educational evaluation;
4. Recommendations for Protective Services which would serve the best interests of the Vulnerable Adult; however, when these services are to be provided by another state agency, these recommendations must be developed in consultation with the other agency.

A copy of the evaluation must be provided to the court, the Guardian ad Litem, and the Attorney at least five (5) working days prior to the due date. Reasonable expenses incurred for evaluations required by this subsection must be paid by the Adult Protective Services Program.

161 SPECIAL PROVISIONS

Special provisions may be included in Family Court Orders in response to the petition (complaint) or on the Court's initiative. Examples are, restraining provisions against persons who would interfere with service to the client, or the client's placement and authorization for routine and emergency medical care. In addition, the Court may find that the client is financially able to pay for third party services, and may order payment from the financial resources of the client. In exploitation cases, the Court may order that the financial records be made available for inspection. The Case Manager will request that the attorney representing the county office to make efforts to prevent the inclusion of provisions which would restrict the Department in service delivery, or would require additional court appearances by the Department for a change in plans. Case Managers should not ask the court for special provisions which conflict with APS Policy, state and federal regulations.

162 PROBATE COURT

Some issues that arise will not all be able to be resolved in Family Court. Some issues require the authority of Probate Court. Each county has a Probate Court and their operational procedures vary from county to county. Case Managers must be familiar with the procedures of the court in their county.

163 PROBATING ESTATES

The Probate Court is responsible for probating the estates of all deceased persons. All funds and bills of deceased persons will be turned over to the Probate Court. DSS can and should recover the cost of services ordered for the care and protection of the Vulnerable Adult from the estate.

164 GUARDIANSHIPS AND CONSERVATORSHIPS

The Probate Court may appoint a Conservator to manage the financial affairs of an incapacitated adult or appoint a Guardian for custody of the person. It is not appropriate for DSS staff, or county offices, to serve as Conservators or Guardians of clients. It would be appropriate to facilitate the appointment of a trusted relative or friend of the client. Guardians and Conservators must make annual reports to the Probate court and may be removed by the court if good cause is demonstrated in a hearing.

165 COMMITMENTS

APS Case Managers should always engage the Department of Mental Health to assist with the appropriate placement of clients with intellectual disabilities. Involuntary admissions to facilities for the mentally ill, alcohol/drug abusers and persons with intellectual disabilities are handled by the Probate Court. Case Managers may need to facilitate emergency involuntary admissions of mentally ill clients or clients abusing alcohol/drugs

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by completing the initial application at the Probate Court. County DSS Directors may petition the Court for involuntary admission of clients with intellectual disabilities who are in need of treatment.

170 CONTACTS WITH CLIENTS DURING TREATMENT SERVICES

The Case Manager conducts at least twice a month contacts for which one of these contacts must be a face-to-face interview with the client in his/her residence. The other contact may be conducted via telephone or with a service provider who is also visiting the client's residence on at least a monthly basis.

The face-to-face visit **MUST** include but not limited to a description of:

1. Living conditions of the home and food supply;
2. Medical condition of client;
3. Medication Needs;
4. Caretaker;
5. Client's ability to do ADL;
6. Medical and Social Needs;
7. Emotional state;
8. Financial state;
9. Status of Service Plan (tasks).

Clients residing in nursing homes or Residential Care Facilities must receive at least one (1) monthly face to face visit for the purpose of review of their plan of care unless court order otherwise.

All service providers must be contacted on a monthly basis to obtain the status of treatment services outlined on the client's service plan.

APS Treatment Services Case Manager Responsibilities

1. Case Managers will conduct monthly contact with the service providers as required in accordance with the service plan and/or client circumstances. Ensure that all contacts are entered into CAPSS before the last day of the month the actual visit occurred to avoid errors on CAPSS generated reports.
2. Case Managers will complete all Activity Notes and forms that are available on CAPSS within policy timeframes. Acceptable paper versions for the hard case file must be printed from CAPSS in order to be considered valid and signed/initialed by the Case Manager.
3. Case Managers will maintain current case files within APS policy standards in CAPSS.
4. Case Managers will enter in CAPSS before the last day of the action month all Activity Notes documenting a routine event (i.e. monthly contact to review/monitor service delivery, assess client functioning, non-eventful sharing of information, etc.)
5. Case Managers will enter in CAPSS within five (5) **business** days of the contact all case narratives documenting a critical event (i.e. injury, placement/address change, hospitalization of a caregiver, change in medication, arrest, status change, etc.)

180 FOLLOW THROUGH SERVICES

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Follow through services include but are not limited to monitoring the client in placement for three (3) to six (6) months, continuing to assess the risk and safety of the Vulnerable Adult, evaluating the ability of the service providers to meet the goals and objectives on the Service Plan, Re-directing funds to the placement resource and documenting the client's progress in CAPSS. Follow through services enables the Case Manager to provide the client with continuing support and encouragement while effectively utilizing the resources that have been procured for the client to reduce risks. The Case Manager and client can evaluate the client's movement toward his goal(s) and the need for other services by completing follow through. The Case Manager must have a clear understanding of his/her continuing role and responsibility for follow through in the case as well as the role assumed by the other agencies providing services to the client. The extent of follow through depends on many factors such as the client's need for supportive care, the nature of the client's needs and plans for dealing with them, services being received from other agencies, and the understanding between the two agencies as to the nature and extent of cooperative efforts. When the Department is referring a client to another agency for service(s) and there is no need for continued Department involvement, the Case Manager is still required to follow through on the referral. Follow through also assures the most reliable decision for termination of the case. At any point when service is to be discontinued by the Department or other service providers, the agency planning to discontinue the service should notify the APS Treatment Services Case Manager in advance. This is particularly important when the client has been unable to use the service. This policy enables the appropriate agency to help the client evaluate the risk(s) and consider other plans immediately.

181 RECORDING FOLLOW THROUGH SERVICES

Referrals, Service Plans and related activities must be made an integral part of the client's case record. This is particularly important with follow through services. All changes in Service Plans, the resources to which the client was referred, and the results achieved must be thoroughly documented in CAPSS. Recording these activities in CAPSS documents the client's progress or the lack thereof and allows the Case Manager to adjust the Service Plan as needed.

190 RELIEF OF CUSTODY

When the client's safety is no longer dependent on being in custody of the Department, the Family Court will be petitioned for relief of custody. Ex-Parte Orders do not expire at the end of forty (40) days. It is always necessary to return to court to be relieved of custody given to DSS by a court order. The agency must be relieved of custody of a client before the case can be considered for closure. It is not appropriate for the Department to seek or for the Family Court to provide that custody of a Vulnerable Adult be granted to another adult. Nor should the agency ask the Family Court to be granted temporary access to a Vulnerable Adult's funds when DSS no longer has custody of the Vulnerable Adult. Funds should be re-directed to placement resources prior to case closure.

191 CASE CLOSURE

Treatment Services cases will be closed when unsafe conditions (safety and risk) have been eliminated and the clients' safety and well-being no longer depends on the involvement of Adult Protective Services. A re-evaluation of the Needs Assessment must be completed by the Case Manager which indicates that the risk(s) have been reduced and the rating is "low." When the objectives and tasks on the Service Plan have been achieved by the client and his/her support system, caregiver or agency partners (i.e. DDSN, DMH, CLTC), the case must be staffed with the APS Supervisor for case closure. The Case Manager must ensure that **the Case Evaluation/Case Closure** (DSS Form 1599) is completed. This form requires the signatures of the APS Case Manager, the APS Supervisor and the client. If the client is unable to sign, a representative for the client may sign for him/her. Otherwise, the Case Manager should write on the form that the client was unable to sign

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and indicate in the CAPSS narrative the reason(s) why the client could not sign. The client is to receive a copy of this form ten (10) days before case closure. The case must be left opened for ten (10) days and then closed.

The Vulnerable Adult's or family member's refusal to answer the door or cooperate with the agency's requests to allow the Case Manager into their home is not a valid reason for closure of an APS case. If the client is in DSS custody or receiving services through court order, the agency will need to be relieved of custody by the court before the case is staffed for closure. A True certified copy of the court order signed by the Presiding Family Court Judge and stamped by the Clerk of Court must be filed in the case file prior to case closure.

The Case Manager must be mindful of the clients preferred life style and not impose his/her values on the client. Clients have freedom of choice in personal appearance, keeping pets, lovers and other matters which society leaves to individual choice. Adults have rights of self-determination and choice. Eccentric behavior does not necessarily endanger the client. The Case Manager's concern is with behavior and living arrangements that present danger to the client. Services must be provided in the least restrictive setting possible. All financial resources must be obtained and all financial arrangements must be completed with placement resources before a case is closed. The financial arrangements must be completed and the case must be monitored for at least three (3) to six (6) months to ensure that the Vulnerable Adult is stable before case closure. The case must be closed out in CAPSS through the program services tab and the Treatment Services line. The case file must be submitted to the APS Supervisor for case review. Preference is given to in-home services with out of home placement services as a last resort.

Referenced Documents:

S.C. Code of Laws, Title 43, Chapter 35: Omnibus Adult Protection Act
Case Transfer and/or Case Staffing (DSS Form 3062)
Adult Protective Services Risk Assessment (DSS Form 1565) Electronic Version
DHHS form 1233A
Adult Health Care Consent Act