Contents

Resources and References…….. 2

Using the MDS to Facilitate Opportunities to Live in the Most Integrated Setting
HHS MDS Guidance 2016…….. 3

MDS Section Q Guide…….. 9

MDS 3.0 Section V
Care Area Assessment Worksheet for CAA #20…….. 11

Open Doors (MFP) Transition Center
Regional Lead and Auxiliary Independent Living Centers…… 12

Public Health Live March 21, 2019
Best Practices for MDS Section Q

Resources and References:

1. New York State Money Follows the Person website
   http://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm

2. Money Follows the Person Program Evaluation information:
   https://www.mathematica-mpr.com/relatedcontent?itemID={E687F4B5-8B4A-4593-8D8F-28F50FBC7A41}&relatedcontent=Related%20Publications

3. National Money Follows the Person Success Stories
   https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/money-follows-the-person-tech-assist/success-stories/index.html

4. Olmstead's Role in Community Integration:
   http://kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief/

5. Information about the Olmstead decision
   https://www.ada.gov/olmstead/olmstead_about.htm

6. U.S. Department of Health and Human Services, Office for Civil Rights' Guidance and Resources for Long Term Care Facilities: Using The Minimum Data Set To Facilitate Opportunities To Live In The Most Integrated Setting
   https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf

7. NY State Department of Health Dear Administrator Letters:
   - 2017 NH DAL 16-10: MDS Version 3.0, Section Q
     https://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_16-10_mds_version_3_section_q.htm
   - 2018 NH 18-05 SUBJECT: Nursing Home Discharge Requirements
     https://www.health.ny.gov/professionals/nursing_home_administrator/dal/docs/18-05_discharge_requirements.pdf

8. New York's Local Contact Agency: Open Doors
   https://ilny.us/programs/open-doors

9. List of local Transition Centers (Local Contact Agencies) in NY State
   https://ilny.us/phocadownload/Regional%20Lead%20and%20Aux%20chart%208-13-18.pdf

10. Local Contact Agency (Open Doors) Referral Form
    https://ilny.us/phocadownload/48%20Open%20Doors%20referral%20form%2011-29-17.pdf

GUIDANCE AND RESOURCES FOR LONG TERM CARE FACILITIES: USING THE MINIMUM DATA SET TO FACILITATE OPPORTUNITIES TO LIVE IN THE MOST INTEGRATED SETTING

U.S. Department of Health and Human Services, Office for Civil Rights
May 20, 2016

The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is issuing this guidance to help long term care facilities comply with their civil rights obligations by administering the Minimum Data Set (MDS) appropriately so that their residents receive services in the most integrated setting appropriate to their needs. Failure to properly administer the MDS places a facility's Medicaid and Medicare reimbursements in jeopardy.[1] Furthermore, inadequate administration of the MDS threatens the state and administrative agencies' compliance with civil rights laws. The state and state administrative agencies must provide services to residents in the most integrated setting. The unnecessary placement of a resident in a long term care facility may constitute discrimination under Section 504 of the Rehabilitation Act (Section 504) and Title II of the Americans with Disabilities Act, as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.*[2]

OCR is responsible for enforcing Section 504 of the Rehabilitation Act as it applies to entities that receive HHS Federal financial assistance. Long term care facilities receive Federal financial assistance by participating in programs such as Medicare and Medicaid. Section 504 prohibits discrimination based on disability, including the unnecessary segregation of persons with disabilities. Unjustified segregation can include continued placement in an inpatient facility when the resident could live in a more integrated setting. This concept was set forth in the *Olmstead* decision which interpreted the same requirements in the Americans with Disabilities Act.

The MDS, a mandated quarterly assessment administered to all nursing home residents, has questions that can connect long term care residents with opportunities to live in the most integrated setting and assist the state in meeting its non-discrimination requirements under Section 504 and the Americans with Disabilities Act. Specifically, Section Q of the MDS provides a process that, if followed correctly, gives the resident a direct voice in expressing preference and gives the facility means to assist residents in locating and transitioning to the most integrated setting.

OCR has found that many long term care facilities are misinterpreting the requirements of Section Q of the MDS. This misinterpretation can prevent residents from learning about opportunities to transition from the facility into the most integrated setting. We are therefore providing a series of recommendations for steps that facilities can take to ensure

[1] See 42 CFR 483.1(b); 42 C.F.R. 483.20(b)(1)(xvi); and 42 C.F.R. 483.20(g)
[2] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Section Q of the MDS is properly used to facilitate the state's compliance with Section 504 and to avoid discrimination.

1. **Strong Relationships with the Local Contact Agency can Help Long Term Care Facilities Understand the Availability of Community Based Services**

All long term care facilities should know their Local Contact Agency and have a working relationship with it. A Local Contact Agency is a local community organization responsible for providing counseling to nursing facility residents on community support options. Long term care facilities must make referrals to the Local Contact Agency whenever a resident would like more information about community living or alternative living situations to the facility. If you do not have contact information for the Local Contact Agency, you should contact the State Point of Contact found at www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf.

When the long term care facility makes a referral to a Local Contact Agency, OCR recommends that a facility representative serve as a liaison to the Local Contact Agency staff member and maintain regular communication with the Local Contact Agency regarding the resident. The Facility must in no way impede the assessment, planning, and transitioning process triggered by the referral to a Local Contact Agency.

Facility staff members should work with the Local Contact Agency to incorporate the Local Contact Agency's Transition Plans for the resident into the resident's facility discharge plan and active care plan.

OCR also recommends that the facility invite the Local Contact Agency to provide seminars/presentations to residents and staff on a regular basis (*e.g.*, every six months), about the services it provides, community-based settings in which residents can choose to receive services, and the residents' opportunity to seek a referral regarding potential transition to the community.

2. **Proper Administration of MDS Section Q, Questions, Q0400, Q0500, and Q0600 is Critical in Assisting Residents to Receive Services in the Most Integrated Setting**

The goal of Section Q of the MDS is to "ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible."[3] Because Section Q is designed to assist residents in returning to the community or another more integrated setting appropriate to their needs, proper administration of Section Q of the MDS can further a state's compliance with civil rights laws.

[3] Resident Assessment Instrument (RAI) Manual at Q-14.

a. MDS Section Q, Q0400: Is active discharge planning already occurring for the resident to return to the community?[4]

OCR found in a survey of long term care facilities that many facilities misunderstand this question. If active discharge planning is not occurring, then the facility must ask the resident the follow up question "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" [5] Most facilities responding believe that they do not have to ask residents this question if the resident has a "discharge plan." However, the MDS process requires these individuals to be in ***active*** discharge planning, and it appears that some residents have a discharge plan that was created as a matter of course and not as part of an active transition process.

An ***active*** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge[6], and there is a target discharge date for the near future. If there is not an ***active*** discharge plan, residents should be asked if they want to talk to someone about community living and then referred to the Local Contact Agency accordingly. Furthermore, referrals to the Local Contact Agency are recommended as part of many residents' discharge plans.[7] Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.

OCR recommends that facilities continue to use the most current MDS assessment tool and answer MDS question Q0400 ("Is Active Discharge Planning already occurring for the Resident to Return to the Community?") "no" for all residents of the facility unless a referral to the Local Contact Agency occurred and the Local Contact Agency has met with the resident. MDS Question Q0400 should only be answered "yes" for permitted reasons, such as:

- The resident is currently being assessed for transition by the Local Contact Agency;
- The resident has a Transition Plan[8] in place, which has all of the required elements and has been incorporated into the resident's Discharge Plan; or,

[4] RAI Manual at Q-8.
[5] RAI Manual at Q-14.
[6] The MDS manual states that discharge instructions should include items such as, but not limited to: arrangements for durable medical equipment, arrangements for housing. and arrangement for transportation to follow-up appointments. *See* RAI Manual at Q-9.
[7] RAI Manual at Q-9.
[8] The term "Transition Plan" here means documentation completed and maintained by members of a Local Contact Agency pertaining to a particular resident of the facility, that identifies the direction for the care and services the resident needs to live in the most integrated setting, including the provision of necessary care and services to the resident in the most integrated setting and all other arrangements necessary to allow the resident to live in the most integrated setting.

- The resident has an expected discharge date of three (3) months or less[9], has a discharge plan in place with all the required elements, and the discharge plan could not be improved upon with a referral to the Local Contact Agency.

If the response to MDS question Q0400 is "no" (i.e., the resident does not have an active discharge plan in place), facilities should ask the resident MDS question Q0500, "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" Any resident who answers "yes" to Q0500 must be referred to the Local Contact Agency.

b. MDS Section Q, Q0500: Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?[10]

Another example of facilities misunderstanding Section Q includes confusion regarding the administration of Q0500. Most facilities never ask, or nearly never ask, Q0500 because they believe they do not need to ask the question because all residents have discharge plans in place. However, unless the resident has an ***active*** discharge plan, the resident must be asked Q0500.[11] If a resident answers "yes" to this question, a referral to the Local Contact Agency is required[12] and the Local Contact Agency will establish contact with the resident to discuss the availability of appropriate services in the community. When asking question Q0500, the RAI manual instructs nursing home staff to convey to residents that this question is intended to "provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care."[13] In other words, the resident should be encouraged to learn about possibilities by talking to the Local Contact Agency. Most residents do not know what alternatives to inpatient care may exist, so the word "possibility" in the question is essential. It is important for facilities to provide the residents a clear context as to the purpose of Q0500. Failing to provide context for the question could result in residents remaining in institutions longer than necessary.

c. MDS Section Q, Q0600: Has a referral been made to the Local Contact Agency?[14]

Residents who express interest in learning about living outside of the facility, either through answering affirmatively to question Q0500 or expressing an interest to direct

[9] The RAI Manual does not set a time frame for coding this item "yes"; however, OCR believes this timeframe is appropriate and should be considered a best practice concerning facilities' civil rights obligations.
[10] RAI Manual at Q-10.
[11] Unless the resident specifically requests to not be asked this question in their quarterly assessment. However, annual comprehensive assessments must ask Q0500. See MDS Q0490 at RAI Manual Q-12.
[12] RAI Manual at Q-16.
[13] RAI Manual at Q-15.
[14] RAI Manual at Q-20.

care staff[15] at other times, should be referred to the appropriate Local Contact Agency for assistance, including education on the process of obtaining community placement and any other appropriate services. Once any facility staff learns of the resident's interest, a referral to the Local Contact Agency must be made in a reasonable amount of time.[16] Furthermore, it is recommended that the referral be documented in the resident's Discharge Plan.

Facilities must recognize that residents can make a free choice about where to receive services and cannot be pressured to remain in the facility. Facilities must not deny residents a referral to the Local Contact agency for inappropriate reasons, including but not limited to:

- The facility inserts its judgment and overrides the resident's expressed interest based on factors such as a belief that the resident's disability is too severe to transition;
- A belief that discharge is not possible because the resident has no home or support in the community, or a previous transition was not successful; and/or
- The family or caregiver does not want the resident to move.

The only reason a facility may refrain from making a referral to the Local Contact Agency when requested by the resident is when the resident has an *active* discharge plan.[17]

3. The Facility Should Update its Policies and Procedures to Comply with this Guidance Document and Provide Periodic Training.

OCR recommends that facilities review and revise existing policies and procedures or develop new policies and procedures on: (1) discharge planning; (2) MDS administration, and; (3) the Local Contact Agency referral processes. The policies and procedures should comply with this guidance document, and the facility's practices must be consistent with this guidance.

In addition, OCR recommends that each facility train all staff involved in conducting, reviewing, assessing, implementing, or otherwise utilizing the MDS assessment (including direct care staff, care teams, the facility's senior management team members, and workforce members in any other relevant position) on Section Q of the MDS. OCR recommends using the State Resident Assessment Instrument Coordinator (RAI), who is responsible for coordinating MDS training in the State, or a trainer recommended by the RAI, to conduct the training on the MDS.

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[15] Direct care staff are the facilities' workforce members who personally interact with residents while providing health care or similar support services.

[16] RAI Manual at Q-16. The manual recommends ten business days as a "reasonable" amount of time to make this referral.

[17] See section 2. a. of this guidance document.

OCR also recommends that each facility train all staff, including direct care staff and Care Teams, the Facility's senior management members, and work force members in any other relevant position on:

- the Local Contact Agencies which serve the facility's geographic areas;
- the services the Local Contact Agencies provide and the role they play in assisting individuals interested in living in a community setting;
- when and how to contact the Local Contact Agency;
- how to work collaboratively with the Local Contact Agency for the benefit of residents of the facility; and
- home and community-based services provided by state agencies.

OCR recommends that individuals from outside the facility with extensive knowledge of the services and role of the Local Contact Agencies and the state home and community-based service systems provide the training. For example, Aging and Disability Resource Center (ADRC) staff, local center for independent living (CIL), Area Agency on Aging (AAA), or another agency that is familiar with transitioning residents to the community, may be able to train staff on these five issues. Furthermore, to fulfill these training recommendations, contact can be made with the State Point of Contact for MDS 3.0 Section Q Referrals for suggestions on trainers who have the recommended knowledge.[18]

4. Further Resources

For more information on the administration of the MDS and technical assistance please visit the following links:

- MDS 3.0 Technical Information at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

- State Operations Manual (SOM) at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html

- MDS 3.0 RAI Manual at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

- MDS 3.0 Training at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html

- Skilled Nursing Facilities Long-Term Care Open Door Forum at: www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_SNFLTC.html

[18] See www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf.

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
1. **No**
2. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
1. **No**
2. **Yes**
9. **Resident has no family or significant other**

Enter Code ☐

C. Guardian or legally authorized representative participated in assessment
1. **No**
2. **Yes**
9. **Resident has no guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

A0310E = 1: Admission Assessment

Enter Code ☐

A. Select one for resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **Unknown or uncertain**

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Answer YES **ONLY** if:
- LCA (Open Doors) already involved
- Discharge date **< 3 months** and referral to LCA cannot improve plan

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

02, 06, 99 = Quarterly Assessment types

Enter Code ☐

Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
0. **No**
1. **Yes** → Skip to Q0600, Referral

- Only applies to Quarterly Assessments
- **Q0500 MUST be asked on ALL annual or change-of-status**

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

MUST ASK THIS Question unless resident has ACTIVE discharge plan!! **DON'T judge** whether resident can be discharged to community.
If YES, MUST REFER TO LCA (Open Doors). LCA will provide information and explore possibility of alternate settings so resident can make informed choice.

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again

Enter Code ☐

A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.)
1. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment
2. **Yes**
8. **Information not available**

- A 'no' response only exempts question on quarterly Assessments
- **Q0500 MUST be asked on ALL annual or change-of-status**

Enter Code ☐

B. Indicate information source for Q0550A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0600. Referral

Enter Code ☐

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)

0. **No** - referral not needed
1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)
2. **Yes** - referral made

MUST MAKE referral to Open Doors for **ALL** who answer YES to Q0500

MDS 3.0 Section V
Care Area Assessment (CAA)
Worksheet for CAA #20

20. RETURN TO COMMUNITY REFERRAL

Review of Return to Community Referral

✓	Steps in the Process
☐	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B).
☐	2. Discuss with the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living. (Q0100)
☐	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1000) • Functional/mobility (G0110) or balance (G0300) problems • Need for assistive devices and/or home modifications if considering a discharge home
☐	4. Inform the discharge planning team and other facility staff of the individual's choice.
☐	5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care and discharge planning from previous items responses (Q0300 and Q0400B). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility? (Q0300, Q0400)
☐	6. Initiate contact with the State-designated local contact agency within approximately 10 business days, and document (Q0600). Follow-up is expected in a "reasonable" amount of time, 10 business days is a recommendation and not a requirement.
☐	7. If the local contact agency does not contact the individual by telephone or in person within approximately 10 business days, make another follow-up call to the designated local contact agency as necessary. The level and type of response needed by a particular individual is determined on a resident-by-resident basis, so timeframes for response may vary depending on the needs of the resident and the supports available within the community.
☐	8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan.
☐	9. Communicate findings and concerns with the facility discharge planning team, the individual's support circle, the individual's physician and the local contact agency in order to facilitate discharge/transition planning.

NEW YORK ASSOCIATION ON INDEPENDENT LIVING

155 WASHINGTON AVE | SUITE 208
ALBANY, NY 12210
518.465.4650 PHONE | 518.465.4625 FAX
INFO@ILNY.ORG | WWW.ILNY.ORG

Open Doors (MFP) Transition Center
Regional Lead and Auxiliary Independent Living Centers

Regions	Regional Lead Contact Information	Auxiliary Independent Living Centers
Albany North Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, Washington	Ashley Jarvis Southern Adirondack Independent Living Center (SAIL) 71 Glenwood Ave Queensbury, NY 12804 Email: ashleyc@sailhelps.org Tel: 518-338-2216 Fax: 518-792-0979	North Country Center for Independence, Plattsburgh Elizabeth Davies 518-563-9058
Albany South Albany, Columbia, Greene, Rensselaer, Schenectady, Schoharie	Debbie Abreu Independent Living Center of the Hudson Valley (ILCHV) 15-17 Third Street, Troy, NY 12180 Email: dabreu@ilchv.org Tel: 518-274-0701 x109 Fax: 518-274-7944	Capital District Center for Independence, Albany Laurie Milward 518-459-6422
Buffalo Cattaraugus, Chautauqua, Erie, Niagara, Orleans, Wyoming	Gerilyn Capps Western New York Independent Living (WNYIL) 3108 Main Street Buffalo, NY 14214 Email: gcapps@wnyil.org Tel: (716) 284-4131, ext. 203 Fax: 716-284-3230	Southwestern Independent Living Center, Jamestown David Marg 716-661-3010 Batavia WNYIL Jennifer Williams 585-815-8501 X410
Long Island Nassau, Suffolk	Michelle Darling-Downs /Eileen Thomas Suffolk Independent Living Organization (SILO) 755 Waverly Road Holtsville, NY 11742 Email: Mdarling-downs@siloinc.org ethomas@siloinc.org Tel: (631) 880-7929 x105 Fax: (631) 946-6377	

Lower Hudson Valley Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	Tracy Marcus Putnam Independent Living Services (PILS) *A Satellite Office of Westchester Independent Living Center, Inc.* 1441 Route 22; Suite 240 Brewster NY 10509 Email: tmarcus@putnamils.org Tel: 845-228-7457 Ext. 1129 Fax: 845-228-7460	Resource Center for Accessible Living, Kingston Nicholas Hall 845-331-0541 Rockland Independent Living Center, New City – Brittany Weiner 845-624-1366 Taconic Resources for Independence, Poughkeepsie Kathy Sheehan 845-452-3913 Westchester Disabled on the Move, Yonkers Yaw Adu Appiadu 914-968-4717
New York City Bronx, Kings, New York, Queens, Richmond	Dickey Dolma Lama Center for Independence of the Disabled in New York (CIDNY) 80-02 Kew Gardens Rd Suite 400 Kew Gardens, NY 11415 Email: dlama@cidny.org Tel: 646-368-8034 Fax: 347-561-4883	Brooklyn Center for Independence of the Disabled, Brooklyn Yvette Wilson 718-998-3000 Bronx Independent Living Services, Bronx Natasha Davis 718-515-2800 Staten Island Center for Independent Living Javier Reveron 718-720-9016
Rochester Genesee, Livingston Monroe, Ontario, Seneca, Wayne, Yates	Susan Stahl Center for Disability Rights (CDR) 497 State Street Rochester, NY 14608 Email: sstahl@cdrnys.org Tel: 585-546-7510 Fax: 585-546-7542	
Southern Tier Allegany, Broome, Cayuga, Chemung, Chenango Cortland, Delaware, Otsego, Schuyler, Steuben, Tioga, Tompkins	Krystal Pierre- Millien Southern Tier Independence Center (STIC) 135 East Frederick St. Binghamton, NY 13904 Email: krystalp@stic-cil.org Tel: 607-724-2111 Fax: 607-772-3606	AIM Independent Living Center, Corning Cindy Hamilton 607-962-8225 Access to Independence, Cortland Anne Marie Piche 607-753-7363 Catskill Center for Independence, Oneonta Rachel Brust 607-432-8000
Syracuse Madison, Onondaga Oswego, Herkimer, Lewis, Oneida, St. Lawrence, Jefferson	Juanita Clark-Abolafia ARISE Independent Living Center 635 James Street Syracuse, NY 13203 Email: jclark@ariseinc.org Tel: 315-671-2948 Fax: 315-671-2977	Massena Independent Living Center, Massena Tina Laflesh 315-764-9442 Resource Center for Independent Living, Utica Maxine Nasby 315-624-2523