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I. Introduction

Purpose

The Area Plan is the document submitted by the Area Agency on Aging/Aging and Disabilities Resource Center (AAA/ADRC) to the Lieutenant Governor's Office on Aging (LGOA) that defines how the AAA/ADRC will apply the Older Americans Act (OAA) and State grants for services in the comprehensive and coordinated service delivery system within the planning and service area (PSA). Through the Area Plan, the AAA/ADRC commits to administering funding activities in accordance with all OAA and LGOA requirements. The Area Plan describes the AAA/ADRC efforts for continual development and maintenance of a comprehensive and coordinated service delivery system for older adults, people with disabilities, and caregivers. The format and instructions for the development and submission of the Area Plan and annual updates are provided by the LGOA. The comprehensive and coordinated service delivery system described in the Area Plan shall facilitate older persons' access to, and utilization of, all existing services in the PSA, including access to the OAA in-home and community-based services. Elements of the coordinated service delivery system include:

- services that facilitate access such as transportation, outreach, information referral and assistance,

- services provided in the community, such as adult day care, congregate meals, employment services, insurance counseling, legal assistance, and wellness, recreational, educational, and cultural services delivered at multi-purpose senior centers;

- services provided in the home, such as home delivered meals, home maintenance, homemaker services, housekeeping, in-home respite care, and telephone reassurance;

- Ombudsman services to residents of care providing facilities; and caregiver support services in the home or in the community.

Service definitions and requirements for these services when delivered under the Area Plan are found in the July 2013 South Carolina Aging Networks Policies and Procedures Manual. The LGOA allocates federal funds to PSAs in conformity with the intrastate funding formula prescribed in the manual.

It is the intent of the Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center (SLAAA/ADRC) to apply all funding received from a comprehensive and coordinated service delivery system. This comprehensive and coordinated service

delivery system will not only assist seniors and people with disabilities to become more independent, but will allow for assessments of how prepared the SLAAA/ADRC and the service delivery network in the PSA are for any anticipated change in the number of older individuals during the 4 year period following the fiscal year in which the plan is submitted. Such assessments may include:

- the projected change in the number of older individuals in the PSA;
- an analysis of how such change may affect the populations targeted in the OAA;
- development of protocols and policies to address the ever-changing service delivery network;
- an analysis of how programs, policies, and services provided by the SLAAA/ADRC can be improved and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the PSA; and
- an analysis of how the change in the number of individuals aged 85 and older in the PSA is expected to affect the need for supportive services.

2014 – 2017 VERIFICATION OF INTENT

The Area Plan submitted for the SLAAA/ADRC Region for the period of July 1, 2013 through June 30, 2017, includes all activities and services provided by the Santee Lynches Planning Service Area (PSA) and Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC). The PSA and AAA/ADRC shall comply with applicable provisions of the Older Americans Act (OAA), as amended and other legislation that may be passed during this period identified. The PSA and AAA/ADRC will assume full authority to develop and administer this Area Plan in accordance with the Act and related State policy. In accepting this authority, the PSA and AAA/ADRC assumes responsibility to develop and administer this Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older persons in the planning and service area.

This Area Plan was developed in accordance with all rules, regulations, and requirements specified under the OAA and the Lieutenant Governor's Office on Aging (LGOA), including the South Carolina Aging Network's Policies and Procedures Manual and the LGOA Multigrant Notice of Grant Award's (NGA's) Terms and Conditions. The PSA and AAA/ADRC agrees to comply with all standard assurances and general conditions submitted in the Area Plan throughout the four (4) year period covered by the plan. This Area Plan is hereby submitted to the South Carolina Lieutenant Governor's Office on Aging for approval.

The Santee-Lynches PSA and AAA/ADRC certifies that it is responsible for overseeing the provision of Aging Services throughout the Santee-Lynches region. This responsibility includes, but is not limited to, the following functions:

1. Contract management
2. Programmatic and fiscal reporting activities
3. Oversight of contracted service delivery

4. Coordination of services and planning with the LGOA, service contractors, and other entities involved in serving and planning for the older population in the planning and service area
5. Provision of technical assistance and training to providers/contractors and other interested parties
6. Provision of public information and advocacy related to aging program activities and issues
7. Provision of all activities, programs, and services contained within the South Carolina Aging Network's Policies and Procedures Manual, and compliant with all Notice of Grant Award's (NGA's) Terms and Conditions, and assurances from the Administration on Aging (AoA) and Lieutenant Governor's Office on Aging (LGOA).

_____ _____

Date — Signature of Executive Director
Planning Service Area (PSA)

_____ _____

Date — Signature of Aging Unit Director

The Area Agency Advisory Council has reviewed and approved this Area Plan.

_____ _____

Date — Signature of Chair, Area Agency
Advisory Council

The Governing Board of Planning Service Area (PSA) has received and approved this Area Plan.

_____ _____

Date — Signature of Governing Board Chair

2014 – 2017 AREA PLAN

VERIFICATION OF ADMINISTRATION ON AGING'S (AoA'S) AND LIEUTENANT GOVERNOR'S OFFICE ON AGING'S (LGOA'S) STANDARD ASSURANCES AND GENERAL CONDITIONS

ASSURANCE CATEGORIES

A. PLANNING AND SERVICE AREA (PSA) AND AREA AGENCY ON AGING (AAA)/AGING AND DISABILITY RESOURCE CENTER (ADRC) GENERAL AND ADMINISTRATIVE ASSURANCES
B. AAA/ADRC TRAINING RESOURCES ASSURANCES
C. CLIENT DATA COLLECTION ASSURANCES
D. FISCAL ASSURANCES
E. MONITORING AND COMPLIANCE ASSURANCES
F. PROCUREMENT AND CONTRACTUAL ASSURANCES
G. COORDINATION, OUTREACH, AND INFORMATION AND REFERRAL ASSURANCES
H. STATE PLAN ASSURANCES FROM THE ADMINISTRATION ON AGING (AoA)

2014 – 2017 AREA PLAN ASSURANCES

A. PLANNING AND SERVICE AREA (PSA) AND AREA AGENCY ON AGING (AAA)/AGING AND DISABILITY RESOURCE CENTER (ADRC) GENERAL AND ADMINISTRATIVE ASSURANCES

1. The Planning Service Area (PSA), Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC), and the AAAs'/ADRCs' providers/contractors must comply with the policies and procedures set by the Older Americans Act (OAA), the current South Carolina Aging Network's Policies and Procedures Manual, current Notices of Grant Award (NGA) Terms and Conditions, and any Program Instructions (PI) issued by the Lieutenant Governor's Office on Aging (LGOA) and the Administration on Aging (AoA) during the Area Plan period.

2. The AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas. (**OAA 306(a)(4)(C)**)
3. The PSA, AAA/ADRC, and the AAAs'/ADRCs' providers/contractors shall comply with all applicable Federal and State laws, regulations, and guidelines.
4. The PSA and AAA/ADRC shall have a comprehensive, written policies and procedures manual for complying with all of its functions as prescribed by the OAA, the LGOA, and the South Carolina Aging Network's Policies and Procedures Manual. These written policies and procedures shall be available for inspection upon request and are subject to the South Carolina Freedom of Information Act (FOIA) requirements. The AAA/ADRC may not adopt the South Carolina Aging Network's Policies and Procedures Manual as a substitute for developing a regional manual, but may use it as a guide for what should be included in the regional manual. A summary of the written policies and procedures should be noted in the Area Plan.

5. The AAA/ADRC accepts the standards and programmatic requirements issued for all services authorized by the Lieutenant Governor's Office on Aging. All providers/contractors and/or vendors of services shall be monitored for compliance with such standards and carry out the standards and requirements in the delivery of each service to be reimbursed with funds awarded under this plan.

6. The PSA and AAA/ADRC shall maintain professional office policies and procedures which reflect effective (best) business practices in order to ensure the quality delivery of programs and services to South Carolina's aging population and adults with disabilities.

7. The AAA/ADRC shall provide a qualified full-time director of the aging unit and an adequate number of qualified staff to carry out the functions required under the Area Plan. (**CFR 1321.55(b)**)

8. The AAA/ADRC shall maintain a Regional Aging Advisory Council (RAAC) whose purpose is:

    a. to advise the AAA/ADRC on all matters related to the development of the Area Plan;

    b. to advise on the administration of the plan; and

    c. to advise on operations conducted under the plan.

The RAAC shall have no decision-making authority that is binding on the AAA/ADRC staff or on the AAA/ADRC Executive Board. (**OAA 306(a)(6)(D)**)

9. Through its Area Plan, the AAA/ADRC shall provide the LGOA information on how board members are selected, appointed, or elected; the established terms of office; and RAAC by-laws.

10. The PSA and AAA/ADRC directors shall be expected to be engaged and informed aging advocates who work to promote senior matters and educate the community on issues facing the aging network and their respective regional AAA/ADRC.

11. Each PSA are encouraged to have at least one (1) board meeting annually that is dedicated to aging issues and shall invite the LGOA Director and senior staff to attend.

12. All Planning Service Area (PSA) Directors are required to attend quarterly and scheduled PSA Directors' meetings at the LGOA, or to send an appropriate representative, approved by the LGOA Director.

13. All AAA/ADRC Directors are required to attend monthly and scheduled ADRC meetings or to send an appropriate representative, approved by the LGOA Director.

14. PSA Directors and their governing board members shall be encouraged to provide a minimum of six (6) hours of community service annually in their region. Options for community service may be conducted through, but not limited to, working at a group meal site; delivering home-delivered meals; or volunteering in an adult day care, assisted living facility, or a multipurpose senior center. The desired goal of this community service is for the PSA leaders to see firsthand the many challenges and obstacles facing older persons, persons with disabilities, and their families and caregivers and to seek solutions in order to improve the aging network in their regions.

15. The PSA director shall ensure that all contact information for all respective PSA board members provided to the LGOA is accurate and up-to-date and comply with the South Carolina Freedom of Information Act (FOIA).

16. The AAA/ADRC shall use grants made under the Older Americans Act (OAA) to pay part of the cost of the administration of the Area Plan, including preparation of plans, evaluation of activities carried out under such plans, development of a comprehensive and coordinated system for delivery of services to older adults and

caregivers, development and operation of multipurpose senior centers, and the delivery of legal assistance as required under the OAA of 1965, as amended in 2006, and in accordance with the regulations, policies, and procedures established by the LGOA, the Assistant Secretary of the AoA, the Secretary of the U.S. Department of Health and Human Services and State legislation. (**OAA 303 (c) (1) and (2) and CFR 1321.11**)

17. The AAA/ADRC shall assure through the Area Plan that it has protocols in place to provide technical and programmatic assistance and training opportunities for AAA/ADRC staff and providers/contractors as required by the South Carolina Aging Network's Policies and Procedures Manual.
18. The AAA/ADRC is responsible for designing and implementing a regional training and education plan. This plan should be comprehensive in nature and reflect the training requirements identified by the AAA/ADRC, address the service priorities in the Area Plan, and complement State efforts. The training should address geographical characteristics, demographics, infrastructure, GIS Mapping, and local and community partnering resources. The annual needs assessment is the blueprint necessary to identify the types of trainings necessary in the region. Regional training shall also address all required LGOA client data tracking systems, as well as any other fiscal or programmatic requirements of the LGOA.
19. The AAA/ADRC and providers/contractors shall not means test for any service under Title III. When contributions are accepted, or cost sharing implemented, providers/contractors shall not deny services to any individual who does not contribute to the cost of the service. (**OAA 315(b)(3) and CFR 1321.61(c)**)
20. The AAA/ADRC shall comply with Title VI of the Civil Rights Act of 1964 and shall require such compliance from all providers/contractors under the Area Plan. (**CFR 1321.5(c)**)
21. The AAA/ADRC shall comply with all the appropriate Titles of the Americans with Disabilities Act of 1990, require such compliance from all contractors under the Area Plan, and assure that otherwise eligible older individuals shall not be subjected to discrimination under any program or activity under the Area Plan. (**CFR 1327.5 and 1321.5 (c)**)
22. The AAA/ADRC shall assure that residency or citizenship shall not be imposed as a condition for the provision of services to otherwise qualified older individuals.
23. The AAA/ADRC shall assess the level of need for supportive services including legal assistance, transportation, nutrition services, and multipurpose senior centers within the planning and service area. (**OAA 306(a)(1)**)
24. The AAA/ADRC shall assure that the special needs of older individuals residing in rural areas are taken into consideration and shall describe in the Area Plan how those needs have been met and how funds have been allocated to services to meet those needs. (**OAA 307(a)(10)**)

25. The AAA/ADRC shall utilize Geographic Information System (GIS) mapping in order to determine if Older Americans Act (OAA) targeted client populations are being served in its planning and service areas.

26. The AAA/ADRC shall establish effective and efficient procedures for coordination of entities conducting programs under the OAA and entities conducting other Federal programs for older individuals at the local level. (**OAA 306(a)(12)**)

27. Where there are an identifiable number of older individuals in the PSA who are Native Americans, the AAA/ADRC shall require outreach activities to such individuals and encourage such individuals to access the assistance available under the OAA. (**OAA 306(a)(6)(G)**)

28. The AAA/ADRC shall assure the coordination of planning, identification and assessment of needs, and provision of services for older individuals with disabilities, (with particular attention to those with severe disabilities) with agencies that develop or provide services for individuals with disabilities. (**OAA 306(a)(5)**)

29. The AAA/ADRC, in carrying out the State Long Term Care Ombudsman program, shall expend not less than the total amount of funds appropriated and expended by the agency in fiscal year 2000 in carrying out such a program under the OAA. (**OAA 306(a)(9)**)

30. The AAA/ADRC, when seeking a waiver from compliance with any of the minimum expenditures for priority services, shall demonstrate to the LGOA that services furnished for such category within the PSA are sufficient to meet the need for those services and shall conduct a timely public hearing upon request. (**OAA 306(b)**)

31. The AAA/ADRC shall, to the maximum extent practicable, coordinate services under the Area Plan with services that may be provided under Title VI in the planning and service area. (**OAA 306(a)(11)(B) and (C)**)

32. The AAA/ADRC shall ensure that clients receive an initial assessment and then reassess service recipients no less than annually, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas, and eligible individuals, as defined in the Older Americans Act of 1965 (OAA) §518, 42 U.S.C. §3056p, as amended in 2006. Assessments must be recorded on the LGOA Assessment Form. No reimbursements will be made without proper and current assessments.

33. Based on that assessment, the AAA/ADRC shall assure that services delivered with resources under the Area Plan are provided to individuals with the highest priority scores.

34. Assessed individuals who must be terminated because of low priority scores shall be provided an opportunity to continue to receive services as a private pay recipient or as a partial-pay recipient subsidized through local resources, if available.

35. The LGOA requires that the AAA/ADRC directly provide ombudsman, information and assistance, insurance counseling, and family caregiver services. **(OAA 307(a)(8)(A)and(C))**

36. The AAA/ADRC shall provide other direct services, only with a waiver approved by the State agency, and only when such direct provision is necessary to assure an adequate supply of such services, or where such services are directly related to the AAA's/ADRC's administrative functions, or where such services of comparable quality can be provided more economically by the AAA/ADRC. **(OAA 307(a)(8)(A)and(C))**

37. The AAA/ADRC shall administer the nutrition programs with the advice of a dietitian (or an individual with comparable expertise). Whenever the AAA/ADRC allows providers/contractors to purchase catered meals directly, or has providers/contractors who prepare meals on site, the AAA/ADRC shall assure that such providers/contractors have agreements with a registered dietitian who provides such advice. **(OAA 339(G))**

38. The AAA/ADRC shall conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who:
    a. reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
    b. are patients in hospitals and are at risk of prolonged institutionalization; or
    c. are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them. **(OAA 307(a)(18))**

39. The AAAs/ADRCs are responsible for developing emergency/disaster preparedness and response plans for their planning and service area regions that are updated and reviewed annually. These plans should incorporate all requirements of the South Carolina Aging Network's Policies and Procedures Manual regarding Emergency Management and Disaster Preparedness.

40. In addition, the AAA/ADRC shall ensure that each of its providers/contractors has a disaster preparedness plan that is reviewed and updated annually.

41. AAAs/ADRCs shall meet with county emergency management directors in their regions to ensure that there is a working relationship between the counties and the AAAs/ADRCs. AAAs/ADRCs are expected to maintain current and up-to-date emergency contact information for AAA/ADRC staff, directors of providers/contractors, and county emergency management officials in the event of a disaster or emergency, and submit this information with their Area Plans. The AAA/ADRC will designate staff to be on call throughout the duration of the

declared disaster and this staff shall maintain communications with the LGOA Emergency Preparedness Coordinator.

42. The AAA/ADRC must ensure that lists of clients compiled under any programs or services are used solely for the purpose of providing or evaluating services. AAAs/ADRCs shall obtain written assurance from providers/contractors stating that they will comply with all LGOA confidentiality requirements, as well as any and all applicable Federal and State privacy and confidentiality laws, regulations, and policies. The AAA/ADRC shall provide the LGOA with confidentiality assurances through its Area Plan, annual Area Plan updates, or as changes are made.

43. The AAA/ADRC and its providers/contractors under the grant must have written procedures for protecting the identifying client information against unlawful distribution through any means, physical or electronic. All identifying client data must be protected through limited access to electronic records. Each employee with access to identifying client information must sign a notice prepared by the grantee specifying the requirement to maintain confidentiality and the penalty for failure to comply.

44. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936.

45. Each AAA/ADRC shall meet with its provider(s)/contractor(s) to discuss questions, concerns, obstacles, and/or technical assistance required to be successful, either in group or one-on-one sessions. A summary of these meetings shall be maintained on file. Issues raised, and any resolutions achieved, in these meetings shall be addressed in the quarterly AAA/ADRC and providers/contractors meetings.

46. Each AAA/ADRC shall host a quarterly regional meeting with its providers/contractors. At a minimum, each quarterly meeting shall address the following topics:

Quarter One:	**Quarter Two:**
• AAA/ADRC Area Plan; • Needs assessment; • Comparison of service delivery to GIS mapping to ensure that all clients with the greatest needs within the entire county are being served; • Challenges in business operations (what is working and what isn't working); • Training requests and topics for providers/contractors; • Best practices; • AAA/ADRC goals and mission for the year; and • Other issues and concerns.	• Career development; • Continuing education training or Continuing Education Units (CEU); • Educational workshops; and • Other issues and concerns.
Quarter Three:	**Quarter Four:**
• Modernizing operations; • Community resources and new partnerships; • Aging focus; • Business development; and • Other issues and concerns.	• End of year Area Plan review; • Strategic planning and forecasting session for specific regional needs and concerns; • Analyzing end of the year data (comparing data to the GIS mapping that the AAAs/ADRCS are required to provide to the LGOA); and • Other issues and concerns.

47. The following constitutes a substantial change in the approved Area Plan and requires an amendment to the Area Plan:

    a. change or termination of a service contractor;

    b. reduction in the funding for priority services procured; and/or

    c. loss or change in the services available in any county in the region.

B. **AAA/ADRC TRAINING RESOURCES ASSURANCES**

1. The AAA/ADRC shall appoint an AAA/ADRC Training Liaison for its planning and service area region. This liaison shall serve as the LGOA point of contact for AIM operations in its region. The liaison shall provide program overview information for AAA/ADRC providers/contractors for general aging network structure and operations. In addition, his/her primary role shall be to assure earned service units and client data are being captured, tracked, and reconciled in the AIM system for reimbursement.

2. The AAA/ADRC Training Liaison shall have a firm understanding of programmatic operations and overall knowledge of finance and accounting operations for the aging network. The AAA/ADRC shall appoint the person within the AAA/ADRC who provides quality assurance and reconciliation of the provider/contractor invoices for OAA services in the AAA/ADRC region. (Note: The best candidate may be the financial manager and/or accounting reimbursement officer/manager. This person should have a strong working relationship with the person authorized to approve payment of funds to the provider/contactor for service units earned.) The liaison shall be responsible for assuring that the AAA's/ADRC's providers/contractors are appropriately tracking service units earned in the AIM system for all OAA funds.

3. The AAA/ADRC Training Liaison shall train new providers/contractors, field questions in the region, and provide assistance with challenges of the AIM tracking system. The liaison shall be the only person authorized to make contact with the LGOA AIM Coordinator. On the rare occasion that the liaison cannot assist the provider/contractor, he/she may contact the LGOA AIM Coordinator for assistance. The liaison shall be responsible for forwarding the information received from the AIM Coordinator to the providers/contractors. The liaison shall be the point of contact for providers/contractors needs and shall ensure accurate, quality tracking, and monitoring for reimbursement of OAA services, prior to billing the LGOA.

4. The AAA/ADRC shall assure on-going training within its region of operation for its providers/contractors. At a minimum, the AAA/ADRC shall do the following:
   - assure that a minimum one monthly e-mail is disseminated to their providers/contractors regarding a variety of aging issues, including but not limited to outreach opportunities, outreach events, national initiatives, activity development, resources, etc.
   - host an aging orientation meeting within the first thirty (30) days of a new contract agreement for all new providers/contractors in their region. Materials provided in the orientation shall include, but are not limited to, the following:
     - a general overview of the LGOA and ADRC network operations and roles;

- a LGOA two-sided flyer;
- a LGOA benefits guide;
- a SC Access flyer;
- a copy of the AAA/ADRC Area Plan;
- a copy of the SC Aging Network's Policies and Procedures Manual;
- a summary of structure of the aging network in South Carolina;
- a copy of general AAA/ADRC goals for that operating year;
- an AAA/ADRC staffing contact sheet; and
- a copy of the AAA/ADRC Strategic Plan.

5. The AAAs/ADRCs shall assure that an Advanced Information Manager (AIM) training session is provided by the AAA/ADRC Training Liaison and an operation manual shall be given to the new provider/contractor within the first thirty (30) days of a new contract agreement.

C. CLIENT DATA COLLECTION ASSURANCES

1. The AAA/ADRC and its providers/contractors will utilize the Advanced Information Management (AIM) system to document and track units of services delivered. Reimbursements for service funds will be supported by client data correctly entered into AIM. The AAA/ADRC will assure that service providers/contractors are trained properly and monitored accordingly, and that AIM data is inputted monthly by the tenth (10th).

2. The AAA/ADRC shall ensure that each group dining site uses the LGOA approved LG-94 sign-in sheet and that each client sign his/her name or make a mark on the sign-in sheet daily. In addition, home-delivered meal drivers must sign and date a document daily listing their clients and certifying that the meals were delivered. The provider/contractor dining manager will sign and date that document after the driver has returned to the operational site.

3. The AAA/ADRC shall utilize On-line Support Assistant (OLSA) to record contacts. The AAA/ADRC shall accurately input and monitor data, and provide training for appropriate AAA/ADRC staff and providers/contractors. All client contact data will be captured and immediately keyed into OLSA (preferably by an AIRS Certified Specialist) after a contact is made with a client, successfully ensuring accuracy and timeliness.

4. The AAA/ADRC shall utilize the State Health Insurance Program (SHIP) Talk system to input insurance-related data after a contact is made with a client, successfully ensuring accuracy and timeliness.

D. FISCAL ASSURANCES

1. The PSAs and AAAs/ADRCs shall be good stewards of OAA and LGOA funding and be accountable for programmatic budgeting, monitoring, and operation. The AAA/ADRC shall assure in writing, through its Area Plan, that I&R/A funding is

not being used to fund other programs outside of the I&R/A program area. Should the LGOA determine the AAA/ADRC is in violation of using I&R/A funds for other activities, then funding for I&R/A services may be withheld in the future.

2. The PSA and AAA/ADRC shall provide satisfactory assurance that such fiscal control and accounting procedures shall be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal and State funds paid under the Area Plan to the AAA/ADRC, including funds paid to the recipients of grants or contracts. **(OAA 307(a)(7)(A))**
3. The AAA/ADRC shall assure that funds received under the OAA shall supplement and not supplant any Federal, State, or local funds expended to provide services allowable under Title III. **(OAA 321(d))**
4. Each funding source shall have a distinct client population for the duration of the contract period or until the client's service is terminated. A new client, who is in need of the service and meets the eligibility criteria of that funding source, will be added when such vacancies occur.
5. The PSAs and AAAs/ADRCs shall include as part of their Area Plans, a breakdown of the components of the unit cost for each different unit of service and the methodology showing how the unit cost is determined. The cost justification shall include the assessment costs, activities costs, product costs, administrative costs, and any other relevant variable that contributes to the overall rate.
6. The AAA/ADRC shall ensure that it has a process in place to verify how the provider's/contractor's unit costs are determined and that the units are being earned.
7. All invoices and financial and program reports must be submitted in the format provided by the LGOA and on the schedule(s) set by the LGOA. Invoices and financial reports shall be submitted to the Accounting and Finance Division, while program reports will be submitted to the appropriate program manager as stipulated by the LGOA.
8. The AAA/ADRC shall submit a total aging budget, disclose all sources and expenditures of funds that the AAA/ADRC receives or expends to provide services to older individuals, and the cost allocation plan, or approval of the indirect cost rate from the funding agency, used to prepare such budget. **(OAA 306(a)(13)(E))**
9. The AAA/ADRC shall expend all prior year's funds first, before expending any new funds.
10. Planning and Administration funds for Titles III-B, III-C, III-C-2, and III-E must be expended before any program development of III-E service funds are expended

for subgrantee staff activities or internal operations.

11. The AAA/ADRC shall assure that any funds received under the Area Plan, or funds contributed toward the non-Federal share, shall be used only for activities and services to benefit older individuals and others specifically provided for in Title III of the OAA or in State legislation. This shall not be construed as prohibiting the AAA/ADRC from providing services by using funds from other sources. (**OAA 301 (d)**)

12. The LGOA requires that AAAs/ADRCs shall maintain proper records with all necessary supporting documents. Such records must be in a form, approved by the LGOA, which provides an accurate and expeditious determination of the status of all Federal and non-Federal funds at any time; including the disposition of funds received and the nature and amount of all expenditures and obligations claimed against OAA and State allotments. The AAA/ADRC shall enter the liability for the local matching funds in the appropriate accounts when payment is requested from the LGOA. The AAAs/ADRCs shall assure the LGOA that all funds requested for payment shall be for service units and services actually provided and earned by the providers/contractors. The AAAs/ADRCs shall provide and maintain written assurances through their Area Plans and annual updates to monitor and audit the payment requests for accuracy and integrity purposes.

13. Any AAA/ADRC that expends a total of $500,000 or more in Federal awards must monitor delivery and have an audit that complies with OMB Circular A-133. The audit shall be submitted to the LGOA within nine (9) months after the close of the organization's fiscal year.
14. The AAA/ADRC shall consult with relevant service providers/contractors and older individuals to determine the best method for accepting voluntary contributions that comply with the Cost Sharing policies of the LGOA and the OAA, as amended in 2006. (**OAA 315(b)(2)**)
15. The AAA/ADRC shall assure that any revenue generated from voluntary contributions or cost sharing shall be used to expand the services for which such contributions or co-pays were given. (**OAA 315(a)and(b)**)
16. The voluntary contributions system adopted shall be clearly explained to individuals who use the agency's services. The explanation shall be made both verbally and in writing at the time service delivery is arranged; and shall be posted in a conspicuous location accessible to clients within the site. The explanation shall include the voluntary nature of the contribution, confidentiality policies, and how contributions are collected and used. The AAA/ADRC shall ensure that this is included in procurement contracts and each provider's/contractor's policy shall be included in the AAA's/ADRC's Area Plan annual update.

17. The AAA/ADRC shall assure that amounts expended for services to older individuals residing in rural areas shall not be less than the amounts expended for such services in fiscal year 2000. (**OAA 307(a)(3)(B)**)

18. The AAA/ADRC shall assure that the AAA/ADRC and all its providers/contractors meet all matching requirements for funds awarded under the Area Plan.

19. The AAA/ADRC shall assure that any funds received from the State for Cost of Living Adjustment shall be used for personnel costs only.

20. The AAA/ADRC shall submit an independent audit to the Lieutenant Governor's Office on Aging (LGOA), Division of Finance and Accounting, within 180 days after the close of the project year.

21. A final financial report for the grant period shall be submitted to the LGOA, within forty-five (45) days of the close of each State fiscal year in the grant period (August 14) or within forty-five (45) days of the last payment made, whichever occurs first.
22. The AAA/ADRC shall assure that funds received for Nutrition Services Incentive Program (NSIP) shall be used only for the purchase of United States agricultural commodities or commercially prepared meals served in the Title III-C services and that NSIP funds shall be distributed throughout the region based on the percentage of eligible meals served by each provider/contractor. (**OAA 311(d)(2)**)
23. The AAA/ADRC shall not use funds received under the OAA to pay any part of a cost, including an administrative cost, incurred to carry out a contract or commercial relationship that is not carried out to implement the OAA. (**OAA 306(a)(14)**)

E. MONITORING AND COMPLIANCE ASSURANCES

1. The PSA Director and AAA/ADRC Director shall ensure that providers/contractors are earning their units in accordance with the OAA and LGOA policies.

2. The AAA/ADRC shall ensure that anyone compensated by an AAA/ADRC or provider/contractor cannot be counted as a service unit earned. When monitoring aging services, the AAA/ADRC must match service clients with a list of AAA/ADRC and provider/contractor employees to ensure funding and programmatic integrity.

3. The AAA/ADRC shall assure that no group dining facility shall be funded unless an average of twenty-five (25) eligible participants attends daily. All group dining sites must serve at least twenty-five (25) clients per day or request a LGOA Group Dining Waiver.

4. The AAA/ADRC shall assure that an OAA III C-2 home delivered meal shall be delivered to a participant for no less than five days a week unless it is documented that the participant is receiving meal(s) from another source. Further, in addition to federal eligibility requirements, special consideration shall be given to those eligible clients living alone, those in isolated rural areas, and those seventy-five (75) years of age or older. **(OAA 336)**

5. Each AAA/ADRC shall be provided copies of the group dining site activity calendars from the group dining providers/contractors monthly for approval. The AAAs/ADRCs shall scan and forward by email copies of approved monthly site activity calendars to the LGOA Policy and Planning Manager by the close of business on the last business day of the month.

6. As a means of monitoring for quality assurance, the AAA/ADRC Director, or designated appointee, shall personally deliver a minimum of three (3) home-delivered meals from three (3) different home-delivered meal routes monthly. Any issues that arise from these monitoring visits shall be corrected within three (3) business days. A monthly report of these home visits, including the name of the staff member making the visit, shall be provided in writing to the LGOA during the monthly AAA/ADRC Directors' meeting. In the report, the AAA/ADRC Director shall guarantee that all services contracted with the provider/contractor, which are to be reimbursed by the LGOA, are in fact being provided according to OAA and LGOA standards. The AAA/ADRC shall use the Monthly Home-Delivered Meal Monitoring Form provided by the LGOA to report the home monitoring visits.

7. The AAA/ADRC Director, or their designee, shall visit at least three (3) group dining sites monthly and provide the LGOA with a written report summarizing each visit. In the summary, the AAA/ADRC Director shall assure that all services contracted by the provider/contractor, and being reimbursed by the LGOA, are being provided.

F. PROCUREMENT AND CONTRACTUAL ASSURANCES

1. Service procurement contracts must incorporate all components of the South Carolina Aging Network's Policies and Procedures Manual. Through the direction of the South Carolina Aging Network's Policies and Procedures Manual,

each of the PSA's procurement contracts for aging services shall be based on meeting the unique regional needs of each planning and service area.

2. The PSA and AAA/ADRC shall require all programs funded under the Area Plan to be operated fully in conformance with the LGOA and all applicable Federal, State and local fire, safety, health and sanitation standards or licensing prescribed by law or regulation. **(CFR1321.75(a))**
3. The PSA and AAA/ADRC shall contract only with service delivery agencies that shall provide to the AAA/ADRC all program information and reports required by the Lieutenant Governor's Office on Aging. Provision of timely and correct data shall be in a format and contain such information as the LGOA may require the AAA/ADRC to submit. **(OAA 307(a)(6))**
4. All PSA and AAA/ADRC Requests for Proposal (RFP) shall provide direction, coordination, and planning in the fulfillment of contractual agreements with providers/contractors.
5. All contractual agreements must include a procedure for the resolution of grievances or concerns between the Planning Service Area (PSA), AAA/ADRC, and provider/contractor.
6. When there is grievance between the AAA/ADRC and a provider/contractor, all efforts shall be made by the AAA/ADRC to resolve the issue. Minimal contact should be made at the State level and only after all attempts have failed to resolve the issues locally. The Lieutenant Governor's Office on Aging (LGOA) shall serve only as a source of information to the AAA/ADRC regarding the resolution process. All grievances shall be handled by the AAA/ADRC and provider/contractor unless the grievance includes illegal, immoral, and/or unethical behavior, at which time the LGOA and proper authorities shall be notified. If the AAA/ADRC wants to include the LGOA, or cannot work out the issue, then the LGOA may be contacted to assist with the resolution process through guidance only.
7. The PSA and AAA/ADRC must advertise the Request for Proposal (RFP) in legal ads in newspapers throughout the region and post information in a prominent spot on its website at least thirty (30) days before the release of the RFP. The AAA/ADRC shall notify the LGOA Policy Manager so that the RFP can be posted on the LGOA web site.
8. The PSA and AAA/ADRC shall include in each solicitation for providers/contractors of any service under the OAA, a requirement that the applicant will:
    a. Specify how the organization intends to satisfy the service needs of low income minority individuals and older individuals residing in rural areas;
    b. Provide services to low income minority individuals in accordance with their need for such services;

c. Meet specific objectives set by the AAA/ADRC, for providing services to low income minority individuals; **(OAA 306(a)(4)(A))**
d. Make a good faith effort to obtain a client consent form from all service recipients to allow their information to be included in AIM for research and advocacy purposes.

9. All contracts for the procurement of services or goods which are supported with financial assistance through the LGOA, must adhere to applicable Federal and State procurement codes (COG: OMB Circulars A102 and A-87) (PN-P: OMB Circulars A110 and A-122).

10. The AAA/ADRC and providers/contractors shall have the Knowledge, Skills and Abilities (KSA) to use professional practices of performing, reporting, tracking, and administering their Older American Act (OAA) and State funding, and this should be reflected in all procurement contracts and RFPs.
11. The PSA and AAA/ADRC shall have legal representation on their RFP (Request for Proposal) Board.
12. The PSA and AAA/ADRC shall host a pre-RFP application informational meeting for potential providers/contractors three weeks following the public release of the RFP to explain the RFP process and aging network policies/procedures and to answer questions about the RFP. The date, time, and location of the meeting shall be included in the RFP packet. This shall assure fairness in the bid process. Opportunities for submitting written questions shall be provided by the AAA/ADRC before the pre-application meeting.
13. Prior to engaging in a contract, the PSA and AAA/ADRC shall assure through the RFP bid and contract that the provider/contractor has the necessary equipment, technology, software, and trained staff to operate in a professional manner and to execute or administer the duties.
14. An AIM Operational Manual shall be provided at the start of the bid process so that providers/contractors know what is expected in advance if the provider/contractor gets the contract.
15. The PSA and AAA/ADRC shall provide all potential providers/contractors with an overview of the LGOA organization and procurement process before submitting a bid for contract in order that they understand the proper procedures and policies.
16. The AAA/ADRC shall encourage each group dining provider to be a member of the National Council on Aging (NCOA) / National Institute of Senior Centers (NISC) or to operate according to NISC's national standards for senior centers and group dining sites.

17. The AAA/ADRC shall require, through the procurement contract, that the provider's/contractor's representative attend quarterly regional meetings. This representative shall be required to take the information provided and disseminate it appropriately and incorporate it into his/her organization immediately.

18. If the AAA/ADRC finds that a provider/contractor under the Area Plan has failed to comply with the terms of the contract or with Federal or State laws, regulations and policies, the AAA/ADRC may withhold that portion of the reimbursement related to that failure to comply. The Regional Aging Advisory Council (RAAC) shall recommend appropriate procedures for consideration by the Governing Board of the AAA/ADRC. **(OAA 306(e)(1))**

19. In the event that the PSA and AAA/ADRC finds that a provider/contractor has failed to comply with the terms of the contract or is unable to deliver services as contracted, the AAA/ADRC should initiate a thirty (30) day Corrective Action Plan (CAP) to resolve the issue. If the issue cannot be resolved the AAA/ADRC may determine the provider/contractor high-risk, in accordance with the South Carolina Aging Network's Policies and Procedures Manual.

20. The AAA/ADRC shall afford providers/contractors due process, such as that described for AAAs/ADRCs in OAA Section 306(f)(2)(B) before making a final determination regarding withholding providers'/contractors' reimbursements.

21. Electronic copies of procurement contracts and all amendments thereto, shall be provided to the LGOA's Policy and Planning Manager within thirty (30) days of execution or as amended.

22. The AAA/ADRC agrees to comply with the "Debarment and Suspension" terms and conditions of 45 C.F.R. § 92.35 or 45 C.F.R. § 74.13 as applicable to the AAA/ADRC and/or provider/contractor.

23. The AAA/ADRC shall only purchase services from providers/contractors that will provide the LGOA with all requested data in the format necessary to document the outcome of services purchased.

24. The AAA/ADRC shall assure that any facility authorized for use in programs operated under the Area Plan shall have annual certification that the facility complies with the appropriate fire, safety and sanitation codes. **(CFR 1321.17(4))**

25. The AAA/ADRC shall assure that a facility purchased for use as a multi-purpose senior center with OAA or State Permanent Improvement funds, shall

continue to be used for the same purpose for not less than ten (10) years after acquisition, or twenty (20) years after construction.

26. Prior to authorizing use of OAA or State Permanent Improvement funds for renovation, purchase or construction, the AAA/ADRC shall require assurance from the grantee that funding is, and shall continue to be, made available for the continued operations of these senior centers. (**OAA 312**)

27. The AAA/ADRC shall assure that group dining service facilities are located in as close proximity to the majority of eligible individuals' residences as feasible. Particular attention shall be given to the use of multipurpose senior centers, churches, or other appropriate community facilities for such group dining service. (**OAA 339(E)**)

28. When possible, the AAA/ADRC shall enter into arrangements and coordinate services with organizations that are Community Action programs and meet the requirements under section 675(c)(3) of the Community Services Block Grant Act. (**42 U.S.C.9904(c)(3)**) and (**OAA 306(a)(6)(C)**)

29. The AAA/ADRC shall take into account, in connection with matters of general policy arising in the development and administration of the Area Plan, the views of recipients of services under the Area Plan. (**OAA 306(a)(6)(A)**)

30. Where possible, the AAA/ADRC shall enter into arrangements with organizations providing day care services for children or adults, and respite for families, to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families. (**OAA 306(a)(6)(C)**)

31. The AAA/ADRC shall assure that demonstrable efforts shall be made to coordinate services provided under the OAA with other State services that benefit older individuals and to provide multi-generational activities involving older individuals as mentors to youth and support to families. (**OAA 306(a)(23)**)

32. The AAA/ADRC shall coordinate any mental health services provided with III B funds with the mental health services provided by community health centers and by other public agencies and nonprofit private organizations. (**OAA 306(a)(6)(F)**)

33. The AAA/ADRC shall maintain the integrity and public purpose of services provided, and service contractors, under the OAA, in all contractual and commercial relationships. (**OAA306(a)(13)(A)**)

34. The AAA/ADRC shall demonstrate that a loss or diminution in the quality or quantity of the services provided under the Area Plan has not resulted and shall not result from such contracts or commercial relationships, but rather, shall be enhanced. (**OAA 306(a)(13)(C) and (D)**)

35. The AAA/ADRC shall not give preference in receiving services under the OAA to particular older individuals as a result of a contract or commercial relationship. (**OAA 306(a)(15)**)

36. The AAA/ADRC shall require nutrition service providers/contractors to reasonably accommodate the particular dietary needs arising from health requirements, religious requirements, or ethnic backgrounds of eligible individuals and require caterers to provide flexibility in designing meals that are appealing to older individuals participating in the program. (**OAA 339 (A) and (B)**)

37. The AAA/ADRC shall enter into contract only with providers/contractors of legal assistance who can:

    a. demonstrate the experience or capacity to deliver legal assistance;

    b. assure that any recipient of funding for legal assistance shall be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act;

    c. require providers/contractors of legal assistance to give priority to cases related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect and age discrimination; and

    d. attempt to involve the private bar in legal assistance activities. (**OAA 307(a)(11)(A) through (E)**)

38. The AAA/ADRC shall make special efforts to provide technical assistance to minority providers/contractors of services whether or not they are providers/contractors of the AAA/ADRC. (**OAA 307(a)(32)**)

39. The AAA/ADRC is responsible for on-going contract management; establishing procedures for contract cost containment; reviewing and approving contracts; setting criteria for contract amendments; reviewing and analyzing provider/contractor fiscal and program reports; conducting quality assurance reviews; and reviewing meal vendor performance.

40. The AAA/ADRC shall collaborate with providers/contractors to develop an emergency service delivery plan for group dining and home-delivered meals, transportation, and home care. This emergency service delivery plan must be included in the Area Plan submitted to the LGOA by the AAA/ADRC, as well as included in each contract signed between the AAA/ADRC and an aging service provider/contractor. The emergency plan shall also cover general agency operations during periods of crisis, hazardous weather, emergencies, and unscheduled closings.

41. Providers/Contractors shall submit holiday schedules to their AAA/ADRC for approval and the providers/contractors shall adhere to their approved holiday schedule. The AAAs/ADRCs shall include their providers'/contractors' holiday schedules in their Area Plan. These scheduled closings shall be part of the contract established between the AAA/ADRC and providers/contractors. Any changes to the scheduled holiday closings must be noted in the Area Plan update.

42. The AAA/ADRC shall afford an opportunity for a public hearing upon request, in accordance with published procedures, to any agency submitting a plan to provide services; issue guidelines applicable to grievance procedures for older individuals who are dissatisfied with or denied services funded under the Area Plan; and afford an opportunity for a public hearing, upon request, by a provider/contractor of (or applicant to provide) services, or by any recipient of services regarding any waiver requested. **(OAA 307(a)(5) (A) through (C))**

G. COORDINATION, OUTREACH, AND INFORMATION AND REFERRAL ASSURANCES

1. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual.
2. The AAA/ADRC shall have a visible focal point of contact where anyone can visit or call for assistance, information, or referrals on any aging and/or adults with disability issue.
3. The AAA/ADRC shall require providers/contractors to use outreach efforts that shall identify individuals eligible for assistance under the OAA, with special emphasis on
   a. Older individuals residing in rural areas
   b. Older individuals with greatest economic need
   c. Older individuals with greatest social need

d. Older individuals with severe disabilities
e. Older individuals with limited English speaking ability
f. Older individuals with Alzheimer's disease or related disorders and caregivers
g. Low income minority individuals in each of the above populations. (**OAA 306(a)(4)(B)**)

4. The AAA/ADRC and those with whom they contract must take adequate steps to ensure that persons with limited English language skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this grant award.

5. The AAA/ADRC shall provide for the identification of public and private resources in or serving persons in, the planning and service area as part of their overall outreach and coordination efforts. Local aging partners should be brought into the AAA's/ADRC's planning process in order to better serve the region's older population. The AAA/ADRC shall work to coordinate the programs funded under the Area Plan with such resources to increase older persons' access to quality services. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual. Where appropriate, the AAA/ADRC shall consider joint funding and programming to better serve older persons.

6. The AAA/ADRC shall employ a fulltime (or fulltime equivalent) Information and Referral/Assistance (I&R/A) Specialist as a requirement of receiving Title III-B and Title III-E funding.

H. **ASSURANCES REQUIRED BY THE ADMINISTARTION ON AGING (AoA)**

(Taken directly from the Program Instructions for the 2013 State Plan)

These assurances are required by the Administration on Aging (AoA) and the Lieutenant Governor's Office on Aging (LGOA) for the Planning Service Area (PSA) and AAA/ADRC (AAA)/Aging and Disability Resource Center (ADRC) as part of the 2013 State Plan submission. (The assurances below are from the 2013 State Plan Instructions provided by the AoA.) By signing this document, the PSA and AAA/ADRC have assured they shall adhere to these Older Americans Act requirements.

Section 306(a) of the Older Americans Act (OAA), AREA PLANS

(2) Each AAA/ADRC shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area shall be expended for the delivery of each of the following categories of services

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the AAA/ADRC shall report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the AAA/ADRC shall—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub clause (I);

(ii) provide assurances that the AAA/ADRC shall include in each agreement made with a provider/contractor of any service under this title, a requirement that such provider/contractor shall—

(I) specify how the provider/contractor intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider/contractor;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the AAA/ADRC, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan

is prepared, each AAA/ADRC shall

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the AAA/ADRC met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall use outreach efforts that shall identify individuals eligible for assistance under this Act, with special emphasis on

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(4)(C) Each AAA/ADRC shall provide assurance that the AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas.

(5) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each AAA/ADRC shall:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the AAA/ADRC with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each AAA/ADRC shall provide assurances that the AAA/ADRC, in carrying out the State Long Term Care Ombudsman program under section 307(a)(9), shall expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each AAA/ADRC shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including:

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the AAA/ADRC shall pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the AAA/ADRC shall, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the AAA/ADRC shall make services under the Area Plan available; to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall maintain the integrity and public purpose of services provided, and service providers/contractors, under this title in all contractual and commercial relationships.

(13)(B) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall disclose to the Assistant Secretary and the State agency

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall

demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and shall not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall demonstrate that the quantity or quality of the services to be provided under this title by such agency shall be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each AAA/ADRC shall provide assurances that the AAA/ADRC will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each AAA/ADRC shall provide assurances that funds received under this title shall not be used to pay any part of a cost (including an administrative cost) incurred by the AAA/ADRC to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title shall be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212.

The AAA/ADRC certifies compliance with all of these assurances and requirements of the OAA, as amended, the Federal regulations pertaining to such Act, and the policies of the LGOA throughout the effective period of this Area Plan. Should any barriers to compliance exist, the AAA/ADRC shall develop procedures to remove such barriers. Some assurances may be modified by Federal regulations issued or the OAA reauthorization during the plan period. In such event, a revised list of assurances shall be issued.

Santee-Lynches Region
Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center
June 3, 2013

By signing this Assurances document, the Planning and Service Area (PSA) and Area Agency on Aging (AAA) and Aging and Disability Resource Center (ADRC) accept the assurances mandated by the Older Americans Act (OAA), Administration on Aging (AoA) and Lieutenant Governor's Office on Aging (LGOA), and will ensure that components of these assurances are included in the 2014 – 2017 Area Plan.

_____	_____
Date	Signature of Executive Director Planning Service Area (PSA)
_____	_____
Date	Signature of Aging Unit Director

The Area Agency Advisory Council has reviewed and approved these Assurances.

_____	_____
Date	Signature of Chair, Area Agency Advisory Council

The Governing Board of Planning Service Area (PSA) has received and approved these Assurances.

_____	_____
Date	Signature of Chair, PSA Governing Board

II. Executive Summary

The Area Plan is the document submitted by the Area Agency on Aging/Aging and Disability Resource Center (AAA/ADRC) to the Lieutenant Governor's Office on Aging (LGOA) to define how the AAA/ADRC will apply the Older Americans Act (OAA) funding and State grants for services in the comprehensive and coordinated service delivery system within the planning and service area (PSA).

The Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center (SLAAA/ADRC) operates within the Santee-Lynches Regional Council of Governments (SLRCOG). The PSA is located in the Eastern Midlands of South Carolina. It consists of four counties--Clarendon, Kershaw, Lee and Sumter. All four counties are located 30 to 60 miles from the state capital, Columbia. The SLAAA/ADRC will demonstrate and outline the actions that will be taken over the next four years to ensure a comprehensive and coordinated service delivery system for older adults in the Santee-Lynches Region. The Area Plan is just one of many tools used to prepare the SLAAA/ADRC, the community, and especially the senior services network for the increased demand for services and the increased demands of a diverse aging population.

Each Area Agency on Aging (AAA) is required by the OAA to periodically conduct a needs assessment to determine the needs of seniors in the PSA. The purpose of the needs assessment is to identify barriers and gaps in the service delivery system, outline solutions to meet identified needs and bridge the gaps. Findings from the needs assessment offer the most recent and comprehensive demographic and service-related data available in the region, providing a strong foundation for future planning and program development for older adults.

In the summer of 2012, nine (9) of the ten (10) AAA/ADRCs decided to combine resources to develop/create a statewide region specific needs assessment. In the past, all AAA/ADRCs in South Carolina either performed the needs assessment in-house or contracted with an outside organization to conduct the needs assessment. The SLAAA/ADRC was the lead agency in this endeavor.

According to the 2012 needs assessment, the services most needed by seniors in the SLAAA/ADRC region include transportation, home delivered meals, health care, and caregiver support. The needs assessment revealed the services most needed by disabled individuals in the SLAAA/ADRC region include transportation, health care, and caregiver support.

The aging of the American society will place unprecedented pressures on the economy, health care system, emergency planning and long term care resources. It will affect families who are being called upon in ever increasing numbers to care for their elderly loved ones. The aging network needs a coordinated system of long term care that offers

individuals a choice of living arrangements, regardless of their economic means. The aging network also needs communities that allow individuals to age successfully in place. The AAA/ADRC's work is more important than ever as South Carolina's older population continues to grow!

America and its communities are aging and aging rapidly. As the Baby Boom generation-born between 1946 and 1964-reaches retirement age, the number of Americans over age 65 is expected to reach 71.5 million by 2030, twice their number in the year 2000. At that point, one out of every five people in the nation will be an older adult. The fastest growing segment of America's aging population are those over the age of 85. They are the ones most likely to need the support of family, friends and the community to remain living independently.

The vast majority of older Americans want to age in their homes and communities for as long as possible. However, the aging of the population will pose new challenges for the delivery of local services like health care, recreation, housing, transportation, public safety, employment and education. While these services assist a broad segment of the population, they also have a major impact on the quality of life of all older Americans.

The Area Plan includes a ten year forecast that addresses the changing demographics of the region, population shifts and growing cultural diversities in communities throughout the region. Along with the rest of the country, South Carolina faces two very distinct challenges in the area of aging. The first challenge is to continue to provide support and opportunities to the remaining members of the senior population. The second is to prepare for the "baby boomers" into retirement age. The boomers will transform the age structure of the State and bring a new generation of older adults with some of the same historical challenges. These factors will affect how the SLAAA/ADRC coordinates service delivery, manages resources and identifies possible solutions to barriers during the next four years. It is essential to provide new, innovative, social and prevention activities for the more active older adults. However, SLAAA/ADRC must continue to provide supports for those "at risk" seniors identified in the OAA.

Given the expected increase in the number of individuals in need of Medicaid-sponsored services and the corresponding increased financial burden on the Medicaid Programs currently being funded in South Carolina, federal, state, and regional aging partners are researching new and innovative service delivery alternatives that respond effectively to the unique local needs and circumstances facing individuals at high risk for premature institutionalization. Premature institutionalization for Medicaid eligible seniors translates into an unnecessary and burdensome cost to South Carolina taxpayers who are called on to provide the matching State dollars required to bring the federal funds to the State.

As the senior population increases, there will be a need for additional resources. Unfortunately, over the past several years federal funding continues on a downward

spiral, while funding from the state is used to fill those gaps created by the lack of federal funding. On top of that challenge, the uncertainty of sequestration presents another challenge.

The Area Plan also includes objectives and methods for services to OAA targeted populations. To assist in the identification and delivery of services the SLAAA/ADRC will use GIS mapping to show/identify the locations of home delivered meal recipients, group dining recipients, transportation routes, home care recipients and health promotions recipients currently being served in the region. GIS mapping identifies the cities, towns, rural, and low income communities for which the SLAAA/ADRC purchases services or directly provides services for older adults. Maps and service locations will be included in the Request for Proposal (RFP) for this Area Plan period. As a requirement in the RFP, prospective bidders must ensure they can and are capable of providing services to the entire county for which they are proposing.

The role of the AAA/ADRC as identified in the newly revised 2013 South Carolina Aging Network's Policies and Procedures Manual is to plan, coordinate, administer, and assess a comprehensive and coordinated delivery system of services to older persons in the planning and service area. The SLAAA/ADRC is confident that through its Area Plan, it will meet the intent of the newly revised South Carolina Aging Network's Policies and Procedures Manual. The SLAAA/ADRC is aware that there are protocols, internal policies and procedures and systematic changes that have to be created and implemented during the plan period for the Area Plan to be successful.

One of the major changes in the newly revised South Carolina Aging Network's Policies and Procedures Manual is the requirement that one entity cannot conduct the assessment, select the client and deliver the service (i.e. meals, homecare, etc.). The SLAAA/ADRC has been successful in providing case management in Clarendon County for the past five (5) years. Unfortunately, while case management is an authorized function of the OAA, in South Carolina, it is not a practical activity due to budgetary restrictions (limited funding). The SLAAA/ADRC has decided to conduct "client selection" as its role in delivery of home and community based services.

Through the Area Plan, improvements in monitoring, fiscal responsibility, and service delivery can be expected during the Area Plan period. Such improvements include, but are not limited to, an increased and diverse monitoring system in which the Aging Director or his designee is responsible for conducting the delivery of home delivered meals and unscheduled visits to group dining sites (and all services delivered to vulnerable populations) to determine if the sites are operating properly. The SLAAA/ADRC shall immediately contact the LGOA in writing if operational issues are found and a Corrective Action Plan (CAP) will be submitted.

Improvements in monitoring will also include monthly review of units, levels of service, review of activity calendars and review of assessments to ensure that every recipient has a current and valid assessment. The SLAAA/ADRC will be held accountable and must hold providers/contractors accountable as it relates to service delivery and integrity.

The SLAAA/ADRC will be fiscally responsible. The SLAAA/ADRC will only reimburse providers/contractors for earned service units. If it is determined that a unit has not been earned the SLAAA/ADRC will withhold that payment to the provider/contractor. The improvements in monitoring, fiscal responsibility, and service delivery will improve the overall operations of the aging network within the region.

The SLAAA/ADRC will ensure that all required activities of the OAA and the LGOA are being followed and properly administered throughout the four-year Area Plan period. This will be measured by the increased monitoring, use of GIS mapping, training of SLAAA/ADRC and provider/ contractor staff, participation of PSA constituents and the development of new and innovative systems of service delivery. The SLAAA/ADRC will diligently work with providers/contractors and aging staff to establish region specific protocols to improve efficiency and service delivery.

The SLAAA/ADRC, through the Area Plan, seeks to inform the general public and policymakers about the planning, coordination and delivery of services designed to promote independence and to improve the quality of life for older adults, caregivers, and adults with disabilities. On-going, focused and collaborative effort is needed in order to effectively implement activities and to evaluate outcomes described in the Plan. The SLAAA/ADRC requests that the LGOA provide the grant funding under the OAA of 1965 (as amended) and State funding in order to support the coordination and implementation of the Plan.

III. Overview of Area Agency on Aging

A. Mission Statement

The **mission** of the Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center (SLAAA/ADRC) is to enable older persons in Clarendon, Kershaw, Lee and Sumter Counties to lead meaningful and dignified lives in their communities by providing leadership, direction, and support for a comprehensive continuum of aging and long term care services. Therefore, incorporated into this Plan are benchmarks, outcomes, and future initiatives on which to measure SLAAA/ADRC's achievement towards developing a comprehensive service delivery system for older adults, persons with disabilities, and caregiver and their families.

B. Vision for the four (4) years covered by this plan

The **vision** of the Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center (SLAAA/ADRC) is to support a region where seniors enjoy an enhanced quality of life, contribute to their communities, have economic security, and receive those supports necessary to age with choice and dignity.

C. Organizational Structure

The Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center (SLAAA/ADRC) operates within the Santee-Lynches Regional Council of Governments (SLRCOG). Since 1971, the SLRCOG has been assisting local governments in development of local and regional plans within the four Santee-Lynches counties (Clarendon, Kershaw, Lee, Sumter) of South Carolina.

Currently, the SLAAA/ADRC employs nine (9) employees including an Aging Director. Although not employed as aging staff, the SLAAA/ADRC receives ongoing support from the SLRCOG Finance Department. Since 2006, the SLAAA/ADRC continues to serve as a single point of entry for long-term support and service systems for older adults and people with disabilities in the Santee-Lynches region.

Sometimes referred to as a "one-stop shop" or "no wrong door" system, the SLAAA/ADRC addresses many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. Through integration or coordination of existing aging and disability service systems, the SLAAA/ADRC programs raise visibility about the full range of options that are available; provide objective information, advice, counseling and assistance; empower people to make informed decisions about their long term supports; and help people more easily access public and private long term supports and services programs. Through this

concept, the SLAAA/ADRC seeks to cross train all aging staff as it relates to an ADRC. The following staff functions within the SLAAA/ADRC:

D. Staff Experience and Qualifications

Note: Although the SLAAA/ADRC staff is employed by the SLRCOG, the aging unit functions only as the AAA/ADRC for the purpose of carrying out the nine (9) AAA/ADRC functions specified in the Older Americans Act (OAA).

See Appendix A (Organizational Chart)

Aging Unit Director

Shawn V. Keith serves as the Aging Unit Director. Shawn has been in this position since December 2007. Shawn has over twenty (20) years of experience in the field of human service. Shawn has worked in various State agencies such as the South Carolina Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs. Shawn also served as the Director of Regulatory Compliance at Midlands Center and the Director of Residential Services at Babcock Center in Columbia, South Carolina. Shawn obtained his MA degree in Management from Webster University and is CIRS-A certified.

Shawn's overall function/job responsibility as the Aging Unit Director is to oversee and proactively carry out a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation designed to create a comprehensive and coordinated community based system.

Deputy and Finance Director

Kathy Powell, Deputy and Finance Director for SLRCOG, has worked for SLRCOG for over twenty-five (25) years and has actively contributed to the aging program's financial and administrative functions during her entire tenure with the agency. She is responsible for: budget planning and preparation for the AAA, as well as the COG; aging contract negotiation and analysis; managing contract payments and making requests for payments; oversight of contract revisions/amendments; contract monitoring; and financial technical assistance.

Finance Manager

Amanda Ridgeway serves as the Finance Manager for SLRCOG and has been in this position since August 1999. Amanda is the Accounts Payable clerk for SLRCOG and processes checks for the Aging program, as needed. She oversees all Aging Contractor

reporting and AIM data. She also reviews and reports on service vs. budget usage on a monthly basis. Amanda assists the Aging Unit Director, as well as the Finance Director with Area Plan and budget revisions. She also compiles financial data as needed for various Aging programs. Most recently, Amanda assisted in developing the Case Management process at the AAA level. She assists in monitoring and analyzing all Aging data on a monthly and quarterly basis and reports to the Finance Director and Aging Unit Director on a regular basis as well as communicates with the Contractors.

Data Clerk

Lakeisha Govan serves as a Data and Administrative Clerk within the SLAAA/ADRC. Lakeisha has been with the SLAAA/ADRC since August 2012. Prior to this, Lakeisha was a volunteer in the SLAAA/ADRC Senior Medicare Patrol program. Lakeisha's volunteer work was so helpful to the SLAAA/ADRC that the agency decided to establish a part-time position to input aging and disability client information into the AIM, SCACCESS, and SHIP data systems. Lakeisha also assists with other essential administrative duties as needed and generates requested reports. Lakeisha has a Bachelor's Degree in Business Administration; she is currently working to receive her Associate's Degree in Computer Technology. Lakeisha is also a certified VITA volunteer worker. The work Lakeisha performs for the agency frees up the direct services staff so they can assist additional clients. Her work also helps ensure all statistical data is captured to justify future funding.

E. Regional Aging Advisory Council Board

Advocacy continues to be vitally important to the SLAAA/ADRC Regional Aging Advisory Committee (RAAC). The SLAAA/ADRC RAAC committee has proven to be a strong and supportive advocate for seniors in the region. Several of the members are seniors, minorities and caregivers. Some have leadership experience in the private, public and voluntary sectors. The RAAC has no decision making authority, however it does advise the SLAAA/ADRC on:

- all matters relating to the development of the Area Plan;
- administration of the plan; and
- operations conducted under the plan.

In addition, the RAAC represents the interests of older persons by reviewing and commenting on policies, programs, and actions in the PSA that affect older persons with the intent of assuring maximum coordination and responsiveness to older persons.

The RAAC also has the opportunity to review the Area Plan before public hearings on the plan, and again prior to final submission of the plan to the LGOA. The RAAC carries out advisory functions that further the AAA mission. The SLAAA/ADRC RAAC committee truly enhances the leadership role of the SLAAA/ADRC by being actively engaged in the aging network. To further enhance the RAAC, the SLAAA/ADRC is currently looking at the possibility of combining the RAAC with the ADRC Advisory Committee. The role of the ADRC Advisory Committee is to advise the ADRC staff on the design and operation of the Resource Center. It is composed of individuals representing all populations serviced by the initiative, including consumers of ADRC programs, public and private agencies that provide services to individuals served by the Resource Center, and others participating in the initiative.

To carry out this role effectively, members of the Advisory Committee will:

- Work positively to influence strong community support for the ADRC and actively encourage inter-organizational collaboration;
- Support and advocate as appropriate for the ADRC;
- Advise the ADRC Staff on how to obtain meaningful stakeholder input, review that input, and make recommendations to improve the services provided by the ADRC.
- Monitor the progress toward achieving the mission and vision of the ADRC; and
- Meet regularly to provide guidance on specific program/operational issues.

The SLAAA/ADRC also publishes a monthly ADRC Newsletter that is distributed both region and statewide.

By combining both committees, information provided can be greatly streamlined while enhancing the diversity and expertise of the committees.

See Appendix J (RAAC By-Laws)

See Appendix K (ADRC Newsletter)

F. Current Funding Resources for AAA/ADRC Operations

Use	Source	Amount
Planning and Administration	OAA/SCLGOA – Title III P&A –federal funds	$ 108,413
Planning and Administration – local match required	Local Member government appropriations	$ 36,139
Potential overmatch		$ 762
Planning and Administration – supplemental funds requested	SCLGOA – state funds	$ 15,000
Program Development	OAA/SCLGOA – Title III Program Development - federal funds	$ 58,712
	SCLGOA- Required State match	$ 3,454
Program Development-local match required	Local Member government appropriations	$ 6,907

There are currently no known discretionary or foundation grants for planning and administration. The SLAAA/ADRC does not have any grants/programs it currently administers through the aging unit that prohibit administrative expenditures. The SLAAA/ADRC does not and will not use funds received under the OAA to pay any part of a cost incurred to carry out a contract or commercial relationship that is not necessary to implement OAA requirements.

- Distinct client population for each funding source: The SLAAA/ADRC's contracts with its service providers include a requirement that each funding source has a distinct client population.

- Ensuring fiscal integrity of the SLAAA/ADRC and its providers/ contractors: The SLAAA/ADRC, as a part of Santee-Lynches Regional Council of Governments (COG), has access to the COG's financial staff to assure fiscal integrity. The SLRCOG's finance department has a written financial policies and procedures manual, internal control policies and procedures and separation of duties within its financial department. Accounting records are kept on a proven accounting system using generally accepted accounting principles. Monthly financial reports are provided to the COG's Board of Directors comparing budget to actual revenues and expenses. The COG, and therefore, the AAA, is subject to an annual A-133 (single) audit and is monitored by SCLGOA. The SLRCOG's financial department is also monitored by other state and federal agencies for compliance with various programs' financial requirements.

- When providers/contractors of the SLAAA/ADRC are procured, historically there have been fiscal-viability related questions asked through the RFP. Once provider/contractor relationships are established, SLRCOG financial staff, on behalf of the SLAAA/ADRC, interacts with provider financial staff on an as needed basis for financial technical assistance. SLRCOG financial staff perform annual monitoring of provider/contractor service documentation records and provide annual confirmations of payments made to contractors/providers upon request from the providers'/contractors' auditors. Because the funds paid to SLAAA/ADRC contractors lose their federal identity when they leave the AAA, there is no requirement by SLAAA/ADRC for a single audit. However, most contractors/providers of SLAAA/ADRC have an annual audit of some type by an independent audit firm.

G. Written Procedures

The following are a current list of SLAAA/ADRC written policies and procedure:

- Santee-Lynches ADRC Assisted Rides Program Policies and Procedures Manual for Volunteer Drivers
- Veteran Directed Home and Community Based Program
- Family Caregiver Support Program
- Family Caregiver Support Program Policies and Procedures for Service Delivery
- Family Caregiver Support Program Eligibility Procedures
- SC LIEUTENANT GOVERNOR'S OFFICE ON AGING MANUAL OF POLICIES AND PROCEDURES (October 2006)
- SLAAA/ADRC Standard Operating Procedures to accomplish during client appointments, emergency walk-in visit or call-in
- SLAAA/ADRC SHIP/MIPPA Activity Report

The goal of the SLAAA/ADRC is to develop and implement a formal comprehensive Policies and Procedures Manuals that will comply with all functions prescribed by the OAA and LGOA. In the past, SLAAA/ADRC has always accepted the LGOA Policies and Procedures Manual as its own. Since this practice is no longer accepted, a formal comprehensive manual will be created.

See Appendix I (SLAAA/ADRC Goals and Objectives)

When completed and approved by the SLRCOG Board of Directors, these written policies and procedures shall be available at the SLAAA/ADRC for inspection upon request.

H. Sign-in Sheets

Currently, the SLAAA/ADRC staff periodically checks sign-in-sheets and meal reservations when visiting group dining sites. If deficiencies are found during these checks, the contractor is notified immediately and corrections are made. Sign-in-sheets are also checked during the annual quality assurance reviews.

The SLAAA/ADRC will develop protocols to ensure that its providers/contractors are using the LGOA approved sign-in sheet (LG-94) for group dining sites. This requirement will be placed in all procurement contracts. Sign-in-sheets will be checked every time SLAAA/ADRC staff visit group dining sites and will be reviewed monthly, along with the (a) daily records of participant attendance, including (b) daily records regarding the number of complete meals ordered, received, and served; (c) daily records of hot and cold food temperatures; (d) action on any shortages or temperature discrepancies, as applicable; (e) comments on the participants' satisfaction with the meals served; and (f) daily program activity and monthly site activity calendars by the Aging Unit Director or designee.

The SLAAA/ADRC will also develop and implement a protocol to ensure that home-delivered meals are being provided in accordance with the South Carolina Aging Network's Policies and Procedures Manual, as well as the procurement contracts signed by the SLAAA/ADRC and its providers/contractors. This protocol will include the process for the driver signing the meal route document daily and being certified by the provider/contractor.

See Appendix I (SLAAA/ADRC Goals and Objectives)

I. Activity Calendars

Currently, the SLAAA/ADRC Nutrition Coordinator receives activity calendars, along with an activity review form. The SLAAA/ADRC put this process in place to ensure that each nutritional site offers a variety of programs and/or activities. This process is monitored monthly. A protocol will be developed in accordance with the 2013 South Carolina's Aging Network's Policies and Procedures Manual.

See Appendix I (SLAAA/ADRC Goals and Objectives)

J. Service Units Earned

The SLAAA/ADRC ensures its provider/contractors are earning their units in accordance with OAA and LGOA policies by reimbursing all units that have been inputted into the AIM system only. Annually, financial staff performs financial monitoring of providers/contracts. At least one month is selected at random in which units and documentation are examined on a sample basis to verify documentation of service for the units sampled. If the monitoring finds undocumented units, such units are disallowed and removed from AIM. Financial staff prepares a written monitoring report and follows up to assure appropriate responses and actions taken, including confirming removal of disallowed units from AIM. In this way, the SLAAA/ADRC obtains recoupment of funds from its providers/contractors in the event service units paid for are determined to be unearned. A formal policy as it relates to unit verification that coincides with the 2013 South Carolina's Aging Network's Policies and Procedures Manual will be developed to include the use of an AAA/ADRC Training Liaison, monthly monitoring of service units availability, review of the monthly MUSR, etc.

The SLAAA/ADRC shall continue to require financial recoupment and/or other actions when a LGOA review or investigation by appropriate enforcement agency determines that service units that were reimbursed by the SLAAA/ADRC were not earned by the provider/contractor.

K. Reimbursement for Services

The SLAAA/ADRC, as well as, the other AAAs', last procured for services in 2009. During that time as a part of the RFP, prospective contractors were not asked, nor were they required, to provide a breakdown of the components of the unit cost for each different unit of service as is requested in the current Area Plan instructions or the specific methodology showing how the unit was determined. When an RFP is released for FY 13-14, one of the requirements in the RFP will be for prospective contractors to provide the required information. Also, a requirement to provide this information on an annual basis at contract renewal may be included in all new contracts.

- Process used to verify the provider's/contractor's unit costs: Once the unit rate per service was established by procurement for each contractor, their respective unit rates were included in the contracts by service. Input of unit rates into AIM is verified against contracts and contract amendments. Annual contract renewals have not typically included an increase in unit rate since original procurement, with the exception of raw food cost increases, which are limited to the CPI increase annually. For the extension of one provider's contract for FY 13-14, an increase in unit rates will be

negotiated because the SLAAA/ADRC will no longer provides care management/assessment services for that provider.

- Ensuring providers/contractors earn their units in accordance with OAA and LGOA policies: On a monthly basis, SLAAA/ADRC staff verifies that requests for reimbursement of services provided match the units inputted in AIM. Financial staff annually monitor each direct service provider and examine representative samples of service delivery documentation. The sampled units documented as served are compared to AIM data entry documents, the SC13 report and the request for payment for the month(s) sampled. A written report of such monitoring is generated and a written response is required if there are findings. If units are found in the sample that are undocumented, they are disallowed and the SLAAA/ADRC requires removal of those units from AIM, thereby recovering costs paid for disallowed units.

L. Client Data Collection

Currently, the SLAAA/ADRC utilizes the Ombudsman reporting system to log information and data that relate to the functions of the SLAAA/ADRC Long Term Care Ombudsman Program, Legal Services Program, Advanced Directives, and the Friendly Visitors Program (currently, there is no Friendly Visitor Program activity). The Ombudsman Program records information and data that pertains to complaints, concerns, and inquires on behalf or Residents in LTC facilities. Other information entered that pertains to Ombudsman activity includes facility friendly visits, consultations, staff in-services, resident rights training, and community education. The Legal Services Program utilizes the Ombudsman reporting system to document the number of legal services contacts, the date of contact, and the amount of time spent with the contact. Lastly, SLAAA/ADRC LTC Ombudsman Program utilizes the Ombudsman reporting system to track data and information that pertains to Advance Directives. Information captured includes the date of witness, the amount of time spent on the activity, and the type of Directive.

This data is available to the State LTC Ombudsman who uses it to meet state and federal requirements. The Legal Services and Advanced Directives data is also provided to other programs within the SLAAA/ADRC as needed or required by the various programs.

The SLAAA/ADRC utilizes the On-Line Support Assistance (OLSA) system to record contacts in an accurate and timely manner. All SLAAA/ADRC staff members are required to immediately provide the SLAAA/ADRC Data Entry Clerk with all data that

needs to be keyed into OLSA after a contact has been made. The SLAAA/ADRC SHIP Coordinator periodically performs quality assurance reviews on random client files to ensure client information is correct. If issues are presented, additional training is provided to all SLAAA/ADRC staff. In addition, annual OLSA training is provided to all SLAAA/ADRC staff.

The SLAAA/ADRC's current protocol does not include direct entry into the State Health Insurance Program (SHIP) Talk system. Instead, all data is entered into SC ACCESS immediately after assisting clients. All SHIP contacts are then transferred from SC ACCESS to the SHIP Talk system. The SHIP Talk system is utilized by the SMP/SHIP Coordinator on a monthly basis to strictly pull reports and monitor each counselor's monthly SHIP contact numbers.

The SLAAA/ADRC will develop a protocol to ensure that each of its providers/contractors accurately input client data into the authorized LGOA client data collection system. This will be accomplished and included in all procurement contracts, quarterly regional meetings with providers/contractors, and regional training. This will also become a function of the SLAAA/ADRC Coordinator.

The SLAAA/ADRC will develop a policies and procedures for the Advanced Information Management (AIM) system to document and track service units. This will also include procedures used to certify the AIM data is being inputted accurately according to procedures set by the LGOA.

The SLAAA/ADRC will develop a policies and procedures to show how it utilizes the On-line Support Assistant (OLSA) to record contacts, accurately input and monitor data, and provide trainings. All client contact data will be captured and immediately keyed into OLSA after a contact is made with a client, successfully ensuring accuracy and timeliness.

The newly developed policies and procedures policies and procedures manual will also describe how it utilizes all other LGOA required client data information systems such as SHIP Talk and the Ombudsman system.

See Appendix I (SLAAA/ADRC Goals and Objectives)

- SLAAA/ADRC utilizes the On-Line Support Assistance (OLSA) to record contacts in and accurate and timely manner. All SLAAA/ADRC staff members are required to immediately provided the SLAAA/ADRC Data Entry Clerk with all data that needs to be keyed into OLSA after a contact has been made to the agency. The SLAAA/ADRC SHIP Coordinator periodically performs quality assurance reviews on random client files to ensure client information is correct. If issues are presented

additional training is provided to all SLAAA/ADRC staff. In addition, annual OLSA training is provided to all SLAAA/ADRC staff.

- The SLAAA/ADRC utilizes the Ombudsman reporting system to log information and data that relate to the functions of the SLAAA/ADRC Long Term Care Ombudsman Program, Legal Services Program, and Advanced Directives. The Ombudsman Program records information and data that pertains to complaints, concerns, and inquires on behalf or Residents in LTC facilities. Other information entered that pertains to Ombudsman activity includes facility friendly visits, consultations, staff in-services, resident rights training, and community education. The Legal Services Program utilizes the Ombudsman reporting system to document the number of legal services contacts, the date of contact, and the amount of time spent with the contact. Lastly, SLAAA/ADRC LTC Ombudsman Program utilizes the Ombudsman reporting system to track data and information that pertains to Advance Directives. Information captured includes the date of witness, the amount of time spent on the activity, and the type of Directive.

This data is available to the State LTC Ombudsman who uses it to meet state and federal requirements. The Legal Services and Advanced Directive data is also provided to other Programs within the SLAAA/ADRC as needed or required by the various programs.

M. Client Assessments

The SLAAA/ADRC will ensure that a single entity does not conduct the assessment, choose the client, and deliver the service. The SLAAA/ADRC will also ensure that its contractors maintain updated and prioritized waiting list that score client placement through regular assessments in order to ensure that those seniors with the greatest needs are being served.

The SLAAA/ADRC has decided to allow its contractors to conduct the assessment and deliver the service. The SLAAA/ADRC will implement a process that allows for the selection of the client. Since the SLAAA/ADRC has been performing case management in Clarendon County since 2009, we feel that a thorough selection process throughout the entire region is attainable. After an initial assessment/reassessment by providers/contractors, an eligible senior would be given a specific number of units or funding needed for service(s). Once those units/funds are near depletion, the senior would possibly be reassessed depending on need to determine if additional services are required. This procedure would totally eliminate a person requiring the same level of services for an extended period of time and again would reinforce that the most in need are being served. A draft of the client assessment/selection process to include client termination is provided.

See Appendix L (SLAAA/ADRC draft Policy and Procedure for Client Administration)

N. General Fiscal Issues

- The SLAAA/ADRC has, and will continue, to have procedures in place to assure expenditure of prior year funds before expending new funds if such a situation arises.
- Procedures exist to expend Planning and Administration funds for Titles III-B, C-1and C-2 before any program development funds are expended. For III-E funds, administrative funds are expended prior to III-E service funds being expended for AAA/ADRC staff activities.
- For internal operations, costs are incurred and then reimbursement is requested. Non-federal revenue required for match is posted when federal revenue is received and posted. For flow-through/contractor costs, monthly reimbursement for units served is requested; therefore, contractor/provider has incurred costs before being paid for service. Non-federal share/match is assured by the SLAAA/ADRC because it only pays 90% of requested unit rate reimbursement by contractor/provider.
- Invoices and financial/program reports have been, and will continue to be, submitted in the format provided by the LGOA and on the schedule set by the LGOA.
- The MUSR report in AIM documents each contractor's unit cost and can be submitted to the LGOA if it is determined that a paper/scanned copy is necessary. The SLAAA/ADRC currently retains a hard copy of the MUSR that documents units paid each month in its files along with the request for payment submitted to the LGOA. The signature of either the Executive or Finance Director on the monthly request for payment confirms SLAAA/ADRC staff verification of units costs and units earned at the time of submission. A new procurement will provide the means by which the SLAAA/ADRC can provide the required methodology for calculating unit costs.
- The SLAAA/ADRC has submitted, and will continue to submit, monthly invoices as required by LGOA.
- As stated elsewhere in this document, the SLAAA/ADRC, through the SLRCOG, has an annual A-133 audit performed and submits it to the LGOA within 9 months of the fiscal year end.

O. General Provisions for the AAA/ADRC

The SLAAA/ADRC will develop protocols for complying with all applicable Federal and State laws, regulations, and guidelines, as well as the policies and procedures of the LGOA.

The SLAAA/ADRC will develop protocols for the AAA/ADRC and its providers/contractors to comply with the policies and procedures set by the South Carolina Aging Network's Policies and Procedures Manual and any Program Instructions (PI) issued during the grant period.

The PSA and SLAAA/ADRC utilize Geographic Information System (GIS) mapping in order to determine if Older Americans Act (OAA) targeted client populations are being served in their planning and service areas. See information provided in Section IV of the Area Plan.

The SLAAA/ADRC protocol to ensure that persons with limited English language skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this grant award are as follows. The SLAAA/ADRC will begin coordinating with Central Carolina Technical College (CCTC), Shaw Air Force Base, St. Jude Catholic Church, and St. Ann Catholic Church to form partnerships and in return provide SLAAA/ADRC clients with language assistance when needed free of charge. The SLAAA/ADRC hopes to establish these partnerships in the next few months. If all parties are willing, the SLAAA/ADRC will establish an MOA. The SLAAA/ADRC will develop formal protocols for those with whom they contract to ensure that persons with limited English language skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this grant award.

See Appendix I (SLAAA/ADRC Goals and Objectives)

P. High-Risk Providers/Contractors and Corrective Action Plans (CAP)

In the past, the SLAAA/ADRC has identified providers/contractors as "high risk." The SLAAA/ADRC has either elected to run the day to day operations of those providers/contractors (Clarendon County Council on Aging) or as a provision of their contract, elected to have other providers/contractors run the day to day operation (Lee County Council on Aging). Both of these actions were enforced prior to and during the last procurement cycle.

The SLAAA/ADRC will develop within its policies and procedures manual, as well as procurement contract, protocols and procedures the PSA and AAA/ADRC will set for the four-year Area Plan period in the event that a provider/contractor does not deliver services or is not capable of adhering to the terms set by the procurement contract (for example calendars, activities, and/or other contracted services). Procedures will include methods used to determine if a provider/contractor is high-risk and how Corrective Action Plans (CAPs) will be employed to correct the situation. Specific examples of CAPs and how the PSA and AAA/ADRC will de-designate a provider/contractor, if warranted, include but are not limited to:

- a history of unsatisfactory performance;
- is not financially stable;
- has a management system that does not meet the standards in 45 CFR Part 92 or 45 CFR Part 74, as applicable;
- has not conformed to terms and conditions of previous awards;
- is otherwise irresponsible and irresponsive to fulfilling LGOA and AAA/ADRC data collection policies and procedures;
- has misrepresented material facts regarding funding reimbursements or service units earned; or
- has engaged in unethical, immoral, or illegal behavior or activities.

The SLAAA/ADRC decides to impose such conditions, it shall notify the “high-risk” provider/contractor in writing. The notification shall include:

- the nature of the special conditions/restrictions imposed upon the provider/contractor;
- the issues which necessitated the “high-risk” designation;
- the corrective actions that must be taken by the provider/contractor before conditions are removed;
- the time allowed for completing the corrective actions;

- the consequences for failing to take corrective actions; and

- a method of requesting reconsideration of the conditions or restrictions imposed.

See Appendix I (SLAAA/ADRC Goals and Objectives)

IV. Overview of the Planning and Service Area Region

a. Service Delivery Areas (SDAs)

The SLAAA/ADRC planning and service area is located in the Eastern Midlands of South Carolina. It consists of four counties including Clarendon, Kershaw, Lee and Sumter. All four counties lie 30 to 60 miles from the state capital of Columbia. The total land area of the region is 2,409 square miles, which makes up 8 percent of the area of the State of South Carolina. It has a population of approximately 223,406. Since 2000 the overall population of the planning and service area has increased by over 3.3%. It is assumed that the senior population of 60+ increased by the same percentage. This trend is expected to continue over the next four (4) years and beyond. The following is county specific information of the planning and service area: Service Delivery Areas.

CLARENDON COUNTY

According to the U.S. Census Bureau, the county has a total area of 696 square miles of which 88 square miles is water. In 2012, Clarendon's population estimate from the Bureau was 34,357, representing a 5.7 percent increase over Census 2000. Clarendon's county seat is Manning.

As of Census 2010, Clarendon's racial composition was 47.0 percent white, 50.1 percent African American, 0.6 percent Asian, and 2.3 percent Other. Only 2.6 percent of the county population was of Hispanic or Latino origin, compared to 5.1 percent for the state of South Carolina at the time.

In regards to the county's total population at Census 2010, which was 34,971, a total of 24.1 percent were 60 or older (8,436 seniors). An additional 2,553 "baby boomers" were in the 55-to-59 year old cohort in 2010. A total of 7,809 residents, or 22.3 percent, were 17 or younger at the time. The median age for the county was 41.4 years old in 2010, significantly higher than the state median age of 37.9.

Also, as of 2010, the Census showed there were 13,132 occupied housing units in the county. A total of 5,916 units, or 45.1 percent, were composed of a husband-wife family. Of those 13,132 housing units, 25.0 percent, or 3,283 units, featured a parent(s) with their own children under 18 residing with them. Additionally, 20.6 percent of the county's households (or 2,699) featured only a female householder with no husband present, and 1,289 of these female households had their own children under 18. In regards to seniors living alone, 10.9 percent of the county's households (1,435) featured a 65-or-older individual living alone – up from 10.3 percent in 2000.

In regards to income and poverty, Clarendon's median household income was $33,355 in 2007-201. Estimates are from the Census Bureau. This was 25.2 percent less than the state average of $44,587. A total of 20.7 percent of Clarendon residents were below the poverty level in the same Census measurements (state: 17.0 percent). For seniors 65 and older, the poverty rate was 15.3 percent – significantly higher than the state rate of 10.9 percent.

KERSHAW COUNTY

According to the U.S. Census Bureau, the county has a total area of 740 square miles, of which 14 square miles is water. In 2012, Kershaw's population estimate from the Bureau was 62,343, representing an 18.4 percent increase over Census 2000. Kershaw's county seat is Camden.

As of Census 2010, Kershaw's racial composition was 71.3 percent white, 24.6 percent African American, 0.5 percent Asian, 0.3 percent American Indian/Alaska Native, and 3.3 percent Other. A total of 3.7 percent of the county population was of Hispanic or Latino origin, compared to 5.1 percent for the state.

In regards to the county's total population at Census 2010, which was 61,697, a total of 20.9 percent were 60 or older (12,902 seniors). An additional 4,407 "baby boomers" were in the 55-to-59 year old cohort in 2010. A total of 15,139 residents, or 24.5 percent, were 17 or younger at the time. The median age for the county was 40.2 years old in 2010, higher than the state median age of 37.9.

Also, as of 2010, the Census showed there were 23,928 occupied housing units in the county. A total of 12,348, or 51.6 percent, were composed of a husband-wife family. Of those 23,928 housing units, 29.6 percent, or 7,074 units, a parent(s) had their own children under 18 residing with them. Additionally, 15.1 percent of the county's households (or 3,614) featured only a female householder with no husband present, and roughly half of these female households (1,833) had their own children under 18. In regards to seniors living alone, 9.7 percent of the county's households (2,328) featured a 65-or-older individual living alone – up from 8.9 percent in 2000.

In regards to income and poverty, Kershaw's median household income was $43,509 in 2007-2011. Estimates are from the Census Bureau; the state's was roughly 2.5 percent higher at $44,587. A total of 15.8 percent of Kershaw residents were below the poverty level in the same Census measurements, which was below the state average of 17.0 percent. For seniors 65 and older, the poverty rate was 10.5 percent, which was slightly lower than the state average of 10.9 percent.

LEE COUNTY

According to the U.S. Census Bureau, the county has a total area of 411 square miles, of which only 1 square mile is water. In 2012, Lee's population estimate from the Bureau was 18,654, representing a 7.3 percent decrease from Census 2000. Lee's county seat is Bishopville.

As of Census 2010, Lee's racial composition was majority-minority – with 64.3 percent of the population being African American, 33.4 percent white, 0.3 percent American Indian/Alaskan Native, 0.3 percent Asian, and 1.7 percent Other. Only 1.7 percent of the county population was of Hispanic or Latino origin mostly due to the county's poor economy, compared to 5.1 percent for the state.

In regards to the county's total population at Census 2010, which was 19,220, a total of 19.7 percent were 60 or older (3,789 seniors). An additional 1,411 "baby boomers" were in the 55-to-59 year old cohort in 2010. A total of 4,263 residents, or 22.2 percent, were 17 or younger at the time. The median age for the county was 38.9 years old in 2010, compared to the state's 37.9.

Also, as of 2010, the Census showed there were 6,797 occupied housing units in the county. A total of only 2,551, or 37.5 percent, were composed of a husband-wife family. Of those 6,797 housing units, 25.1 percent, or 1,704 units, featured a parent(s) with their own children under 18 residing with them. Additionally, 24.0 percent of the county's households (or 1,630) featured only a female householder with no husband present, and nearly half of these female households (753) had their own children under 18. In regards to seniors living alone, 11.0 percent of the county's households (750) featured a 65-or-older individual living alone – up from 10.6 percent in 2000.

In reference to income and poverty, Lee median household income was just $27,011 in 2007-2011. Estimates are from the Census Bureau. This was 39.4 percent below the state average of $44,587. A total of 26.9 percent of Lee residents were below the poverty level in the same Census measurements, far exceeding the South Carolina average of 17.0 percent. For seniors 65 and older, the poverty rate was 22.0 percent; also well above the state mean of 10.9 percent.

SUMTER COUNTY

According to the U.S. Census Bureau, the county has a total area of 682 square miles, of which 17 square miles is water. In 2012, Sumter's population estimate from the Bureau was 108,052, representing a 3.3 percent increase over Census 2000. Sumter's county seat is the City of Sumter.

As of Census 2010, Sumter's racial composition was 48.2 percent white, 46.9 percent African American, 0.4 percent American Indian/Alaskan Native, 1.1 percent Asian, and 3.4 percent Other. A total of 3.3 percent of the county population was of Hispanic or Latino origin, compared to 5.1 percent for the state.

In regards to the county's total population at Census 2010, which was 107,456, a total of 18.2 percent were 60 or older (19,547 seniors). An additional 6,517 "baby boomers" were in the 55-to-59 year old cohort in 2010. A total of 27,431 residents, or 25.5 percent, were 17 or younger at the time. The median age for the county was 35.4, below the state median age of 37.9.

Also, as of 2010, the Census showed there were 40,398 occupied housing units in the county. A total of 18,030, or 44.6 percent, were composed of a husband-wife family. Of those 40,398 housing units, 30.8 percent, or 12,452 units, featured a parent(s) with their own children under 18 residing with them. Additionally, 20.2 percent of the county's households (or 8,156) featured a female householder with no husband present, and over half of these female households (4,400) had their own children under 18. In regards to seniors living alone, similar to Kershaw County, 9.7 percent of the Sumter's households (3,915) featured a 65-or-older individual living alone – up from 8.5 percent in 2000.

In regards to income and poverty, Sumter's median household income was $40,542 in 2007-2011 (estimates from the Census Bureau), – 9.1 percent below the state average of $44,587. A total of 18.3 percent of Sumter residents were below the poverty level in the same Census measurements, exceeding the state norm of 17.0 percent. For seniors 65 and older, the poverty rate was 13.3 percent, which was above the state average of 10.9 percent.

The GIS map of the region provided in Appendix H (Required Document) shows the location of home delivered meal recipients, group dining recipients/ transportation routes and home care recipients currently being served in the region. Many of these recipients receive multiple services. Maps and service locations will be included in the Requests for Proposals (RFPs) for this Area Plan period. The GIS map identifies the cities, towns, and communities for which the SLAAA/ADRC is purchasing services or directly providing services for older adults. As a requirement in the RFP, prospective bidders must ensure that they can and will provide services to the entire county for which they are bidding.

The provided GIS maps of the region also show that the clients currently being served in the planning and service area meet the requirements (at-risk clients) specified by the Older Americans Act. The maps pay particular attention to rural and low-income clients and show where each category of "at-risk" senior clients within the planning and service area are located. For those areas with a lower

percentage of poverty, the SLAAA/ADRC will work with providers/contractors to create private-pay options.

Note: The Santee-Lynches region is one of the smallest and most rural regions in South Carolina with an insignificant percentage of non-English speaking residents. This factor must be taken into consideration when targeting "at–risk clients".

As a component of monitoring/contract compliance, the SLAAA/ADRC will use GIS mapping to analyze the clients being served in the region at least twice a year. The use of GIS mapping will ensure that those clients with the greatest needs are being served.

b. Objectives and Methods for Services to OAA Target Populations

As listed above the expected demographics of the targeted population will continue to increase for the next four (4) years for each county in the planning and service area.

The specific objectives that the SLAAA/ADRC will set for Requests for Proposals (RFPs) and service contracts for meeting the targeted populations in each of these areas are as follows:

1. To ensure that "at-risk" clients are targeted for services.
2. To ensure that specific areas in each county receive services.
3. To provide funding for home delivered meals, home care, group dining, transportation and health promotion services.
4. To ensure that the most in need are being served.
5. To ensure providers/contractors have the organizational capacity to perform all functions.
6. To ensure providers/contractors have financial management and strength to perform all functions.
7. To ensure providers/contractors can meet quality management.
8. To ensure providers/contractors can meet OAA requirements.
9. To ensure providers/contractors can meet South Carolina's Aging Network Policies and Procedures requirements.

The criteria for evaluating the methods proposed in the response to the RFPs for meeting those targeted objectives are as follows:

See Appendix N (RFP Evaluation Criteria)

c. Ten-year Forecast for the Planning and Services Area Region

As listed above the expected demographics of the targeted population will continue to increase for the next four (4) years for each county in the planning and service area. There will also continue to be a change in demographics due to the varied population shifts and growing cultural diversity in the communities throughout the region.

The increased life expectancy has impacted the region, specifically disabled older adults and older adults with Alzheimer's disease. This increase has been noted in the number of calls we get in the office inquiring about services, and the number of caregivers caring for loved ones with Alzheimer' s inquiring about respite. All AAA/ADRCs around the state hope that a partnership can be reached between the LGOA and the Alzheimer's Association that will possibly make more resources available at the AAA/ADRCs.

The following is a list of challenges that regional demographic and economic changes create for the SLAAA/ADRC.

Transportation systems

Reports and national statistics have classified the "Baby Boomer" Generation as the fastest growing segment of the population. In order to bring this into perspective, one must understand the "new age" seniors – Baby Boomers. They are generally more active; they plan to work beyond retirement age, due in part to the economic recession of 2009; they are not solely dependent upon social security, however they anxiously await social security as an earned benefit; they generally will retire in place, with the exception of those who relocate to their place of birth or acquire a summer home in states with warmer weather and they are more apt to use alternative transportation options to remain healthy. Moreover, due to the medical advances, Baby Boomers will live longer; yet, Baby Boomers will not be able to escape "Father Time". Thus, many will encounter various health related issues, resulting in seniors having multiple disabilities such as loss of motor skills, degenerative eye disease, and dementia. Therefore, the challenge is to ensure all seniors, as they age, can live independently as long as possible. One such method is to ensure seniors can obtain transportation in order to acquire life enriching/enhancing activities. This challenge may seem overwhelming based on national statistics:

- 37% of seniors have a disability
- 9% of all disabled seniors never leave home
- 21% of individuals with a disability are below the poverty line
- 600,000 seniors who are 70 or older cease driving each year

Our region almost mirrors national data.

Seniors make up a larger portion of the general population, which is based on 2010 Census:

- Clarendon County 5,867 seniors which represents 16.8% of total population
- Kershaw County 8,797 seniors which represents 14.3% of total population
- Lee County 2,596 seniors which represents 13.5% of total population
- Sumter County 13,921 seniors which represents 13% of total population

An alarming number of householders (owner or renter occupied) who are 65 and older have no access to an automobile, based on 2006 – 2010 U.S. Census American Community Survey:

- Clarendon County 419 households
- Kershaw County 476 households
- Lee County 379 households
- Sumter County 1,313 households

Looking at the statistical data from the Social Security Administration, individuals over 65 who receive disability Social Security benefits are as follows:

- Clarendon County 477 individuals
- Kershaw County 276 individuals
- Lee County 440 individuals
- Sumter County 940 individuals.

Baby Boomers may have multiple incomes as they retire. However, living on a fixed income, with housing cost estimated at 30% of an individual's income plus transportation costs taking at least an additional 15%, coupled with the advancement in age where seniors are no longer able to drive due to health related diseases, may cause seniors to go without medicines and essential nutritious food. There may be times when they purposely miss medical appointments, social engagements, etc., which creates additional issues such as depression, anxiety, and loneliness. Undoubtedly, residing within the urban area of Sumter, there are more opportunities to acquire taxi and public transportation, which come with a cost that may be doable. However, in the rural areas of Sumter, Clarendon, Kershaw and Lee Counties, there is very limited access to outside transportation services; and where transportation services are available, it comes with an exorbitant cost. Subsequently, in these regions, the transportation demands for life

enriching and enhancing activities for seniors may fall on the following: senior centers which are on a limited budgets; faith-based organizations; family members, if available; local communities; Santee-Lynches Area Agency on Aging sponsored home delivered meals; seniors trying to find their own resources, which creates the need to maintain the Santee-Lynches Aging and Disability Resource Center (ADRC); seniors getting needed services through volunteer transportation, such as the Santee-Lynches ADRC Assisted Rides Program; or seniors may find it more convenient to simply drop out of society's view – never leaving the house. Subsequently, it is essential for leaders to determine how to address this vital issue of transportation in the region now, versus waiting until the young "Baby Boomers" are well into their 70s and beyond with limited resources and multiple disabilities. Therefore, the question: Is there time to fix the transportation dilemma now or later?

Nutrition services (group and home-delivered)

The SLAAA/ADRC nutrition program continued the trend of declining participation in the Group Dining program since 2009-10. The decrease in meals can be attributed to the reduction of available resources and possibly the lack of group dining activities. The characteristics of the population being provided nutrition services show minor changes. Meal service to the rural elderly has increased by 7.8%, low income individuals served remains around 72%, 80.4% of seniors receiving meals are African American, 19.2% Caucasian, and less than 1% served are of another race. The number of Hispanics provided meals has also remained unchanged.

During the last four years, the SLAAA/ADRC region was able to open two group dining sites, one being temporary, which is now closed. Four other group dining sites were also closed due to lack of funding and/or participation.

Based on the declining trends in the nutrition program over the last four years, it would seem that without an increase in funds and/or resources this trend will continue to diminish, causing a greater challenge for the SLAAA/ADRC, with the inevitable increase in the senior population. Also, if the trend continues group dining sites as we know it may no longer exist.

Information and referral

There are several challenges within the I&R/A program which provide obstacles now and will continue over the next ten (10) years. The first challenge will be the major influx of people (particularly Baby Boomers) who will be coming into the aging system within the next ten years. This large increase in the number of potential clients will impact the amount of services available and how much services and resources they will be eligible to receive.

The second challenge will be the available resources for clients. The SLAAA/ADRC region currently has limited resources on hand. With the expected senior growth, these resources and services will be strained to maximum capacity. It will be imperative that the SLAAA/ADRC make every effort to locate additional resources for its clients.

A third challenge is the fact that the SLAAA/ADRC region has one of the lowest educational levels in the state. This places an extra burden on the I&R/A program to help these clients in explaining the various programs and requirements.

A fourth challenge is not knowing what the impact of sequestration and the Affordable Care Act will have on funding for resources and programs across the state.

Affordable housing

Housing problems are described in two ways: the type of housing problem, and the degree of the problem. The degree or seriousness of the problem is categorized as moderate or severe. The nature or type of the housing problem falls into three categories:

- Housing cost burden
- Quality of housing, or
- Overcrowding

Housing problems and barriers to accessing safe, affordable living environments are more concentrated in the low and extremely low-income population categories and impact people who live in both renter and owner households. Furthermore, the most serious housing problem – severe housing cost burden – is highly concentrated among the poorest people and often affects the most vulnerable; i.e. the elderly and children. Data implies that home ownership does not protect low-income people from housing problems, and that current affordable housing programs are not able to address the current needs. Housing cost burden tends to become prevalent as seniors adjust to their retirement and/or social security income.

In order to serve people affected by housing problems, it is important to understand any trends in the distribution of housing problems by age. This allows agencies to target their efforts and supportive services. Seniors and children are closely monitored target populations. Seniors are defined as individuals 65+ and 18.8% live below the poverty level in the Santee-Lynches region. This rate is higher than South Carolina's senior poverty rate of 13.9%.

As the elderly tend to live in the oldest parts of the housing stock, their housing units can be difficult to maintain or require more maintenance. Home modification and repair remains the most common priority need in allowing older individuals to remain in their

homes and communities. A significant impediment has been the lack of funds, and providers who older clients trust with the skill to make home modifications and repairs.It is projected that this trend will continue.

Medical facilities (physical and mental)

Access to medical facilities (physical and mental) is more acute in rural communities. The SLAAA/ADRC region has many rural communities that have severe medical professional shortages. Another factor is that few of the nation's medical professionals practice in rural areas, and rural health professionals themselves are aging. Also fewer professionals are being trained in primary care and fewer new professionals are being educated and trained. Medicare and Medicaid—major components of rural medical care—pay rural medical providers and facilities less than do private insurers and less than providers in urban areas. All of these exist at a time when, in general, rural people have greater medical care needs than do non-rural people.

A key component to address this is the Patient Protection and Affordable Care Act (PPACA), which is a federal health care reform law created to expand health insurance coverage and a resulting improvement in health outcomes through access to affordable and timely medical care.

Workforce availability

There are many issues that seniors now and in ten years will face as it relates to workforce availability. The following is based on the unemployed senior who might have lesser skills and employed seniors with high-demand skills.

For seniors who are currently unemployed with potentially lesser skills, there are many impediments that they face at entering the workforce. Many of these seniors might not have the technical skills to work in the 21st Century workplace, which is a "high-skills jobs environment." Additionally, employers often prefer hiring younger workers for various reasons, such as fewer anticipated health care costs and expected longevity in the position. Given training costs, employers naturally desire workers they can keep for the long term and younger workers offer this.

Additionally, long-term unemployed seniors face more difficulty at getting employed because of the loss of skills over time. This scenario is similar for the long-term unemployed in any age group.

Also, given high unemployment rates today, only the top candidates for positions are getting hired by employers. This may leave many seniors out of work.

The opposing scenario of seniors with high-demand skills creates problems for employers and schools. Many "baby boomers" have begun to retire in industries, such as advanced manufacturing, which have much lesser appeal today to youth and the young adult population.

Students choosing to major in STEM (Science, Technology, Engineering and Math) areas today are too low to replace the "baby boomers," which will be leaving the labor market. This will create an insufficient labor supply in advanced manufacturing, engineering and computer science, among other fields. All across the U.S., regions are facing labor shortages in high-demand occupations, such as machine operators in manufacturing, and other technical positions.

It is projected that both these trends will continue over the next ten (10) years.

Long term care systems

Long term care (LTC) systems are a broad area of concern. For the purpose of the Area Pan, Medicare and Medicaid will be discussed briefly.

Medicare and Medicaid are the two major public funding sources for long-term care. The circumstances under which elderly persons receive long-term care assistance under each of these programs are very different. Persons who receive long-term care assistance from these two public programs generally fall into two categories: (1) Medicare enrollees who are recovering from an acute illness; and (2) poor elderly persons who are eligible for Medicaid and who qualify for Medicaid-covered long-term care benefits.

The Medicare program provides limited long-term care coverage as an entitlement, without means-testing. Thus, while almost all elderly persons are eligible for Medicare, the long-term care benefits provided under Medicare are limited. Many elderly persons still do not realize that Medicare does not protect them from most of the associated costs.

Unlike Medicare, State Medicaid programs have always provided coverage for both skilled care related to acute illnesses and custodial care for persons with long-term disabilities. However, the breadth of the Medicaid benefit package varies from State to State. Medicaid is also a means-tested program--only the elderly poor qualify for Medicaid coverage.

Long term care spending is expected to continue to increase as a result of the growth of the older population. Approximately 64% of LTC spending is from public sources, with Medicaid being the primary funder followed by Medicare and lastly private insurance and out of pocket cost. LTC and aging are important in rural communities because far more elderly reside in rural communities' verses urban. This contributes to less access to health resources.

As it relates to LTC system verses home and community based services, it costs the Medicaid system about $60,000 a year to maintain a person in a nursing home bed. If that person was maintained in their home using home and community based services, the cost would be substantially less.

Service expectations of seniors and caregivers

Service expectations of seniors and caregivers are on the rise and will continue to rise over the next ten (10) years. As many seniors age they continue to look and expect resources to be readily available. The SLAAA/ADRC, like all other AAA's, is challenged with both a waiting list for services and services being limited or unavailable.

This area will continue to be a concern as the senior population continues to grow and as funding and resources are starting to diminish.

Distribution of existing resources

As mentioned above with service expectation, distribution of existing resources will continue to be a challenge now and in the next ten (10) years as the senior population continues to grow and resources start diminishing. Now more than ever, the SLAAA/ADRC must ensure that the most in need are being targeted and served within the region.

Creation of new resources

There must continue to be a creation of new resources to address the continued growth in the senior population. The SLAAA/ADRC will continue to advocate for additional funding to provide needed services.

Policy changes

In order to meet the needs of the region's elderly now and in ten (10) years, advocating for a system that awards funds to a region in a one lump sum rather than specific services would be required. This can also be accomplished with the flexibility of funds for Home and Community Based Services. The SLAAA/ADRC will continue to advocate for such a system and funding.

Legal assistance

Legal assistance for the elderly continues to be both a challenge and a need in the region since our region is one the poorer regions in the state. The additional IIIB funds for legal and the use of "Model Approaches" will leverage funds and services for seniors.

Development and location of multipurpose senior centers

The SLAAA/ADRC nutrition program has continued the trend of declining participation in the Group Dining program since 2009-10. The decrease in meals can be attributed to the reduction of available resources and possibly the lack of group dining activities. Even though the senior population continues to increase, there is not much attraction to group dining sites or multipurpose senior centers in the region. Again, many factors can be attributed to the declining participation. If trends continue, there may not be a need for a multipurpose senior center in the region in the next ten (10) years. Senior centers must create activities and functions that attract the entire community especially seniors. One of the major stigmas that have to be addressed to attract others is the perception that group dining sites and multipurpose senior centers are for the poor and minorities.

Emergency preparedness

The SLAAA/ADRC has constantly worked within its region to provide leadership to its constituents, their family members and service providers so that all entities are aware and prepared for any and all emergencies which may cause service disruptions to the region. Currently, this is being achieved by working with each contractor to determine if emergency contact information is collected for all people receiving services. Contractors also have partnerships with local law enforcement, fire departments and emergency preparedness agencies in their perspective counties. Our agency's primary role in disaster preparation is to make sure that all service providers have the necessary support structure in place for its clients so that re-establishing services and providing assistance can begin shortly after a catastrophic event. The SLAAA/ADRC works with service providers to get emergency plans updated annually so that the SLAAA/ADRC has knowledge of what plans are in effect to contact every client within the service provider's area, as well as identify any potential weaknesses or coverage gaps to overcome.

As a region, we must honestly question whether we are we truly prepared for a catastrophic event. Located in a rural area, of the state issues surrounding effective communications, transportation and supplies will always be a challenge. SLAAA/ADRC will begin to coordinate emergency preparedness services within the region as it will gauge preparedness for emergencies.

The SLAAA/ADRC feels that the top four (4) issues expected to have the most impact on older adults in the region are:

1. Transportation
2. Affordable Housing
3. Nutrition Services
4. Policy Changes

Unfortunately, as it stands the SLAAA/ADRC has limited control over all of the aforementioned issues. The SLAAA/ADRC will continue in its advocacy efforts for policy changes and nutrition services. The SLAAA/ADRC is willing to partner with other organizations to address transportation as it continues to be the number one need identified in the needs assessment and affordable housing issues.

We must honestly question if we are truly prepared for a catastrophic event. Located in a rural area of the state, issues surrounding effective communications, transportation and supplies will always be a challenge. The SLAAA/ADRC will begin to coordinate emergency preparedness services within the region as it will gage preparedness for emergencies.

The SLAAA/ADRC realizes that it is lacking in the development of a formal emergency/disaster preparedness and response plan. As this is a major endeavor SLAAA/ADRC will incorporate this process into its goals of objectives.

See Appendix I (Goals and Objectives)

The SLAAA/ADRC currently updates its emergency contact information annually for AAA/ADRC staff, directors of providers/contractors agencies, and county emergency management officials in the event of a disaster or emergency. This is accomplished by either calling or emailing agencies on the list for updates. In the future once an emergency/disaster preparedness and response plan is developed updates will be made more frequently.

See Appendix I (Emergency Preparedness Contact Information)

Currently, the SLAAA/ADRC Director coordinates any emergency preparedness response activities and keeps updated emergency contact information for the local EMD officials, AAA/ADRC staff, and the LGOA Emergency Preparedness Coordinator. The SLAAA/ADRC Director is also designated to be on call throughout the duration of a declared disaster. The SLAAA/ADRC Director will maintain communications with the LGOA Emergency Preparedness Coordinator in the event of an emergency. The SLAAA/ADRC Director will also establish that all providers/contractors develop an

Emergency Preparedness protocol. All protocols will be implemented during contract renewals.

The SLAAA/ADRC does not currently, but will, provide information on any and all Memorandum of Agreement (MOA) with other AAAs/ADRCs regarding mutual aid provisions of staff and/or equipment to maintain operation of an AAA/ADRC impacted by an emergency or disaster.

d. Holiday Closings

The SLAAA/ADRC will include its providers/contractors holiday schedules in the Area Plan. These scheduled closings will be part of the contract established between the the SLAAA/ADRC and providers/contractors. Any changes to the scheduled holiday closings will be noted in the Area Plan update.

See Appendix I (Required Forms)

V. AAA/ADRC Operational Functions and Needs

A. Assessment of Regional Needs

The aging of the SLAAA/ADRC population will place unprecedented pressures on the region's economy, health care system, emergency planning and long term care resources. It will affect families who are being called upon in ever increasing numbers to care for their elderly loved ones. The SLAAA/ADRC aging network needs a coordinated system of long term care that offers individuals a choice of living arrangements, regardless of their economic means. The network also needs communities that allow individuals to age successfully in place. The SLAAA/ADRC's work is more important than ever as South Carolina's older population continues to grow!

America and its communities are aging and aging rapidly. As the Baby Boom generation-(born between 1946 and 1964) reaches retirement age, the number of Americans over age 65 is expected to reach 71.5 million by 2030- twice their number in the year 2000. At that point, one out of every five people in the nation will be an older adult. The fastest growing segment of America's aging population are those people over the age of 85 who are most likely to need the support of family, friends and the community to remain living independently.

The vast majority of older Americans want to age in their homes and communities for as long as possible. However, the aging of the population will pose new challenges for the delivery of local services such as health care, recreation, housing, transportation, public safety, employment and education. While these services assist a broad segment of the population, they also have a major impact on the quality of life of older Americans.

The primary function of AAA/ADRCs is to plan and develop a comprehensive and coordinated service delivery system for Aging services. In order to accomplish the aforementioned goals, the AAA/ADRCs must undertake a systematic assessment of older persons' needs in the community by identifying barriers and gaps in the service delivery system, and by outlining solutions to meet these needs and bridge the gaps. None of this can be addressed unless a good comprehensive plan is developed to measure these needs.

The Older Americans Act (OAA), as amended, is intended to establish a comprehensive and coordinated network of services for older Americans at state and regional levels. It seeks to do this by encouraging and providing financial assistance to state and regional efforts to plan, administer and deliver a wide range of needed services. Such efforts should bolster existing services, coordinate short and long-range development efforts, and facilitate creation of new services needed to fill current gaps. As a result of this definition, the intent of the OAA could not be accomplished without an assessment of the needs of seniors.

Each Area Agency on Aging (AAA) is required by the Older Americans Act to periodically conduct a needs assessment to determine the needs of seniors in the planned service area (PSA). In the summer of 2012, nine (9) of the ten (10) AAAs/ADRCs decided to combine resources to develop/create a statewide region specific needs assessment. In the past, all AAAs/ADRCs in South Carolina either performed the needs assessment in-house or contracted with an outside organization to conduct the needs assessment.

According to the 2012 needs assessment, the services most needed by seniors in the SLAAA/ADRC region include transportation, home delivered meals, health care, and caregiver support. The needs assessment revealed the services most needed by disabled individuals in the SLAAA/ADRC region include transportation, health care, and caregiver support.

The last three (3) needs assessments showed transportation as the number one need for seniors and people with disabilities in the SLAAA/ADRC region. To address transportation needs within the region, the Assisted Rides Program was designed in 2009 and implemented in 2011 at SLAAA/ADRC to fill the transportation gap facing individuals 21 and older with disabilities and individuals 60 and over, in order to enhance their quality of life by enabling them to obtain needed services. The Assisted Rides Program is a volunteer based program to assist/drive passengers to and from their desired destination. The purpose of the Assisted Rides Program is to provide transportation to individuals who still reside on their own, continue to help individuals to live independently, and help individuals obtain life-essential and enriching activities. Destinations for passengers include; pharmacies, assisted living facilities, hospitals, doctors, dentists, grocery stores, human service agencies, etc. The Assisted Rides program will continue to assist the disabled and elderly with transportation needs throughout the SLAAA/ADRC region.

The 2012 needs assessment revealed home delivered meals as being a service that is significantly needed for seniors. In the future, the new policy and procedures will ensure a viable priority system is implemented to serve the most in needs within the SLAAA/ADRC region. The SLAAA/ADRC plans, and will continue, to serve home delivered meals to the most in need. However, due to the rising number of seniors and diminished resources, it has been, and will continue to be, a challenge to serve home delivered meals to home bound individuals within the region.

According to the 2012 needs assessment, health care was determined to be a significant need throughout the SLAAA/ADRC region. The SLAAA/ADRC Insurance Counseling Assistance Referral for Elders (I-CARE) and Information and Referral/Assistance (I&R/A) programs assist/connect clients with services. I-CARE is an insurance counseling and assistance program for people on Medicare. I-CARE provides up-to-date, accurate information on appropriate health insurance for seniors and disabled persons. I-CARE counselors are not affiliated with any insurance company. They do not sell or promote any insurance products. The SLAAA/ADRC I&R/A program works to help

seniors and those with disabilities connect with much-needed services to assist them and their family members to maintain or improve their quality of life. The primary goal is to assist and empower clients to seek out much-needed services and provide them with as many viable options as possible (i.e. referrals to community health centers). The SLAAA/ADRC plans to improve partnerships with community health centers to connect people to services more efficiently. These organizations assist those who are uninsured, underinsured, low-income or those living in areas where little access to primary health care is available. However, due to the increase of seniors and limited resources, it has been, and will continue to be, a challenge nationwide to provide insurance and services to clients.

The 2012 needs assessment showed caregiver support as being a need within the SLAAA/ADRC region. The SLAAA/ADRC Family Caregiver Support Program is instrumental in providing residents with education and support. The SLAAA/ADRC receives funding for caregivers as it relates to respite (short term care), supplemental services (i.e. nutritional supplements, incontinence supplies, assistive technology devices etc.) and grandparents raising grandchildren. Currently, caregivers can choose their respite provider and are given a voucher in the amount of $500. In addition to caregivers caring for loved ones, it is estimated that 5.4 million Americans have Alzheimer's disease and are being cared for by nearly 15 million unpaid caregivers including family, friends, partners and neighbors. Often the equivalent of a full-time job, 80 percent of at-home care for people with Alzheimer's or another dementia is provided by family caregivers. We continue to see an increase in Alzheimer's in the region and hope to partner with the Alzheimer's Association to address this rising need. This partnership would create additional resources and supports for caregivers. Without continued caregiver support, we would truly see an increase in nursing home and assisted living cost.

See Appendix B (Needs Assessment)

Please note that the Appendix is only the SLAAA/ADRC portion of the Needs Assessment. The entire Needs Assessment is available upon request.

B. Program Development

The SLAAA/ADRC will continue to advocate for and assist consumers as it relates to consumer choice. Currently, the Family Caregiver Support Program allows caregivers/care recipients to choose who they want to perform their respite services. Caregivers/care recipients can either choose from a list of agencies in the region, or they can choose a neighbor or friend of the family to provide respite services.

Also, as component of the SLAAA/ADRC Veterans Directed Home and Community Based Program, veterans who are able to self-direct can choose who they want as their employees. This program has been designed to help those veterans who are nursing home eligible remain in their homes independently, healthy and safe with the proper

services/supports. The veteran or a designated representative would be able to hire, employ, and supervise workers of their choice to provide those services such as attendant care, housekeeping, transportation and minor home modifications.

The SLAAA/ADRC will work with providers/contractors in the region to both educate and identify opportunities for consumer choice and private pay. The SLAAA/ADRC, through GIS mapping, will also identify areas in the region where a private pay program can be piloted.

C. Program Coordination

The SLAAA/ADRC will work with directors and staff of providers/contractors, other service delivery agencies, and programs operating in the region to coordinate program activities for efficient and effective use of limited resources to meet identified needs. Program Coordination is, and will continue to be, accomplished through the SLAAA/ADRC Advisory Committee since many of the partnering agencies are encountering the same budgetary issues and challenges as it relates to limited resources. This will also give agencies the opportunity to brain storm and possibly pull resources together to more effectively address the needs in the region.

The SLAAA/ADRC researched, and will continue to research, the possibility of creating a private nonprofit entity. Creating a private nonprofit will enable The SLAAA/ADRC to tap into grants and other resources that at present are not possible.

D. AAA/ADRC and Long Term Care

The SLAAA/ADRC will continue to operate a Long Term Care Ombudsman program and a Legal Assistance program. To ensure that the targeted populations are aware of these services, The SLAAA/ADRC will conduct presentations. The SLAAA/ADRC will also contract with attorneys in the region to provide legal services and continue its partnership with both the South Carolina Bar Association and South Carolina Legal Services to effectively leverage legal services.

Since its formal opening in 2006, the Santee-Lynches Aging and Disability Resource Center (ADRC) has made great strides in developing a region that promotes quality of life, independence, and choice for older people and adults with disabilities. Partners (public, private, and faith-based organizations) from across the four counties are working together to create a complete and responsive system of services. The ADRC concept has become fully and strongly integrated into all program areas of the AAA. Through our combined efforts and strengths, we are enabling individuals to remain independent and in their own communities as long as possible.

The SLAAA/ADRC ever-rising consumer counts demonstrate that residents are becoming more and more aware of this "one stop" resource center. They either reach the central office in Sumter or visit the SLAAA/ADRC table during outreach events in the region. Regardless of the location, the SLAAA/ADRC conducts a sound public education campaign and provides individual support to its area residents. The SLAAA/ADRC has truly become a visible and trusted source that people turn to for information on all available support options. The SLAAA/ADRC has empowered individuals with the information provided. Individuals can then make informed choices and decisions concerning their immediate needs and their long-term care plans. Not only is the SLAAA/ADRC addressing the concerns of lower-income older people, adults with disabilities, and the traditionally underserved groups, but also reaching out to the needs of every member, regardless of income level, in the region.

In the past, feedback received by the Center of Health Services and Policy Research, University of South Carolina, indicated that consumers and partners are more than satisfied with the services they received from the SLAAA/ADRC. Residents stated that they appreciate the personalized and consumer-friendly assistance the agency provides. They reported that staff not only let them know about the benefits for which they are eligible and, the different options that are available, but most importantly, how to access those services. Many times consumers are even helped with gathering needed documents and provided assistance with completing applications. Because of the outstanding working relationship, the SLAAA/ADRC has, with its partners, streamlined the intake, assessment, and eligibility determination process that has significantly reduced frustration.

The SLAAA/ADRC has become the primary referral point for numerous programs, especially SHIP, SMP, information and referral, and prescription drug assistance. In prior years, The SLAAA/ADRC leased a mobile unit whose primary purpose was to enter rural areas where seniors and people with disabilities had a difficult time accessing services. Unfortunately, due to lack of funding, the mobile unit was discontinued in 2012. The SLAAA/ADRC continues to be mobile in the region and assists those who normally would not have access to services and information. Through its Family Caregiver Support, Ombudsman, and Case Management programs, the SLAAA/ADRC works closely with the consumer, family members, and the caregiver to remove barriers to needed services.

E. Advocacy

The SLAAA/ADRC will advocate on behalf of older adults and those with disabilities within its region to ensure that all services to which they are entitled are received. The SLAAA/ADRC will also assist with the development of services and supply information about benefits to ensure consumers remain independent in their homes with dignity.

As a member of the South Carolina Association of Area Agencies on Aging (SC4A), The SLAAA/ADRC participates in all advocacy events held at the South Carolina State House on an annual basis, such as Advocacy Day and Disability Advocacy Day. During these events, seniors, individuals with disabilities, their family members and service providers meet with legislators at the state house where self-advocates speak about current aging and disability issues that are of great concern to them. Advocates gather to see the S.C. General Assembly at work and personally urge their representatives and senators to take whatever measures are necessary to continue essential services for seniors, children and adults with disabilities.

SC4A also partners with other advocacy organizations like the South Carolina American Association of Retired Persons (AARP). AARP has a wealth of knowledge and resources that addresses issues pertaining to older adults.

Another key and important form of advocacy is the work that Lt. Governor McConnell is doing that relates to additional funding for Home and Community Based Services. These additional resources assist seniors who choose to remain in their homes. Research shows that states that invest in home and community-based services over time slow their rate of Medicaid spending growth, compared to states that remain reliant on nursing home care.

Consider the Facts:

- The average number of monthly nursing home residents in 2010 was approximately 11,000 and has remained at this level or higher over the past seven years.

- The ten year average cost for Community Long Term Care has risen slightly, approximately $10 as opposed to nursing home care that has jumped from below $80 in 1999 to around $110 today.

- The average daily net paid claim in 2010 for a South Carolina Medicaid individual participant in a Community Choices waiver program was $32 compared to $127 for a nursing home.

- An expenditure of approximately $600 to $1,500 per senior may result in a savings up to $40,429 ($12,129 state funds) per senior in Medicaid funded institutional long term care services per year.

The SLAAA/ADRC may also conduct public hearings that relate to advocacy. With the information obtained from the public hearings; the legislature; and news and events, the SLAAA/ADRC will conduct presentations throughout the region to ensure that the targeted population is kept informed and to solicit comments from the targeted

population. The SLAAA/ADRC will assist these individuals with access to services and benefits that may enhance their quality of life. The SLAAA/ADRC will continue to assist the Silver Hair Legislative delegation in representing the interests of older persons to local level and executive branch officials along with public and private agencies or organizations within the region.

Lastly, The SLAAA/ADRC will continue to advocate on a local basis as it has the luxury of having three State Representatives and a State Senator on its Board of Directors. Advocacy issues are discussed on a routine basis during committee meetings.

In the future, The SLAAA/ADRC will have a designated representative attend programs, community actions, public hearings, and events held within its region. This will ensure the agency remains updated on issues, plans, grants, etc. The agency will also review policies that affect the SLAAA/ADRC region. This designated representative will keep an active summary of events attended that benefit the regions constituencies. The SLAAA/ADRC shall provide the LGOA with a written summary upon request. The SLAAA/ADRC will also use its connections through the SLRCOG to address issues, plans, grants, etc. that affects older persons and adults with disabilities within the following areas:

- Health and Human Services;
- Land Use;
- Housing;
- Transportation;
- Public Safety;
- Workforce and Economic Development;
- Recreation;
- Civic Engagement;
- Emergency Preparedness; and
- Services Determined by the Needs Assessment.

The SLAAA/ADRC will make presentations when appropriate. Advocacy efforts will include attention to legislative and budgetary matters of concern to older persons and adults with disabilities. When requested, the SLAAA/ADRC shall assist individuals with access to all services and benefits for which they qualify.

F. Priority Services

The SLAAA/ADRC uses a simple method to determine the amount of III-B funding needed to purchase an adequate supply of each priority services identified in the OAA. III-B funding is assigned to the priority services based on prior usage and demonstrated need for service(s), as well as consideration of other sources of funding that can supply the service(s). Simply put, The SLAAA/ADRC reviewed what services (and how much) were offered in the past, along with the level of services proposed in the RFPs. Next, the needs assessment is reviewed, since it indicates the needs in the region. Finally, other sources of funding that might be available from outside sources are considered.

G. Priority Services Contractors

The eligibility of contractors is determined in the procurement process through the request for proposal (RFP). The RFP is a solicitation made, often through a bidding process, by an agency interested in procurement of a commodity, service or valuable asset, to potential suppliers to submit business proposals. The RFP will:

- inform suppliers that an organization is looking to procure and encourage them to make their best effort;
- require the company to specify what it proposes to purchase;
- alert suppliers that the selection process is competitive;
- allow for wide distribution and response;
- ensure that suppliers respond factually to the identified requirements; and
- generally, be expected to follow a structured evaluation and selection procedure, so that an organization can demonstrate impartiality - a crucial factor in public sector procurements.

Through this process, the qualifications and history of responders is thoroughly investigated. This screening process is completed using scoring models, as well as internal discussions.

H. Transportation

Transportation continues to be the biggest need in the region. According to the recent needs assessment, transportation is the number one need for both seniors and people with Disability. This challenge may seem overwhelming based on national statistics:

- 37% of seniors have a disability;
- 9% of all disabled seniors never leave home;
- 21% of individuals with a disability are below the poverty line;
- 600,000 seniors who are 70 or older cease driving each year.

The SLAAA/ADRC region almost mirrors national data.

Seniors make up a larger portion of the general population, which is based on 2010 Census:

- Clarendon County 5,867 seniors which represents 16.8% of total population
- Kershaw County 8,797 seniors which represents 14.3% of total population
- Lee County 2,596 seniors which represents 13.5% of total population
- Sumter County 13,921 seniors which represents 13% of total population

And alarming number of householders (owner or renter occupied) who are 65 and older have no access to an automobile. Based on 2006 – 2010 U.S. Census American Community Survey:

- Clarendon County 419 households
- Kershaw County 476 households
- Lee County 379 households
- Sumter County 1,313 households

Examining the statistical data from Social Security Administration, individuals over 65 who receive disability Social Security benefits are as follows:

- Clarendon County 477 individuals
- Kershaw County 276 individuals
- Lee County 440 individuals
- Sumter County 940 individuals.

To address this need, The SLAAA/ADRC implemented an Assisted Rides Program in the region. Through a grant from the Department of Transportation, this program was created to provide transportation to seniors and people with disabilities. Rides are provided by volunteers who transport people to places like doctors' offices, grocery stores, Wal-Mart, etc.

The SLAAA/ADRC ensures that transportation providers/contractors are earning their units in accordance with the OAA and LGOA policies through monthly monitoring of the contractor's MUSR. Units are also monitored in AIM to ensure that units are earned. With the current funding levels being an issue, The SLAAA/ADRC will develop a hierarchy for the use of transportation to ensure that funds are available throughout the year to take people to and from the meal sites and to doctors' appointments. Contractors would have to get approval from the SLAAA/ADRC to transport to other outings and events. The SLAAA/ADRC alerts its contractors quarterly/as needed regarding over serving and undeserving of units in all service delivery areas.

I. Nutrition Services

The SLAAA/ADRC nutrition program has continued the trend of declining participation in the Group Dining program since 2009-10. The number of Group Dining contracted meals served has declined by 11.2% from 69,013 units in Fiscal Year 2009-2010 to 61,293 units for fiscal years thereafter. The decrease in meals can be attributed to the reduction of available resources and possibly the lack of group dining activities.

Between Fiscal Year 2009-2010 and the current fiscal year, the number of Home Delivered Meals (HDM) provided decreased by 21.7% from 131,018 to 102,595 units per year. Although a large decline is shown, the demand for HDMs appears to be continuously increasing. Currently, the region's waiting list for HDMs is over 200. The demand and need for HDMs continue to increase, as people are remaining in their homes

longer. In the past, the SLAAA/ADRC moved money from Title III C-1 to C-2 of the OAA in response to shifting needs and demands for meal services. In the future, the need for HDMs may exceed the SLAAA/ADRC's ability to transfer OAA funds from C-1 to C-2. Therefore, alternative funding is being sought, and utilized when available, to meet growing HDMs needs.

FY 2009/2010		
Total Clients: 2003	African American: 1,596	Divorced: 143
Male: 569	American Indian/Alaskan: 1	Married: 439
Female: 1,434	Asian: 1	Separated: 54
60 and above: 1,817	Hawaiian/Pacific Islander: 1	Single: 193
59 and below: 186	White: 399	Unknown: 269
Low Income: 1,519	Other: 5	Widowed: 905
	2 or More Races: 0	Rural: 1245
	Hispanic: 7	Urban: 758
Units served: Congregate Meals: 69,013.00 / Home Delivered: 131,018.00		

Santee-Lynches Region
Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center
June 3, 2013

<table>
<tr><td>FY 2010/2011</td><td rowspan="5">African American: 1,547

American Indian/Alaskan: 1

Asian: 2

Hawaiian/Pacific Islander: 1

White: 369

Other: 7

2 or More Races: 1

Hispanic: 8</td><td rowspan="2">Divorced: 129

Married: 408

Separated: 56

Single: 203

Unknown: 263

Widowed: 869</td></tr>
<tr><td>Total Clients: 1928</td></tr>
<tr><td>Male: 522

Female: 1,406</td><td rowspan="2">Rural: 1,279

Urban: 649</td></tr>
<tr><td>60 and above: 1,780

59 and below: 148</td></tr>
<tr><td>Low Income: 1,379</td><td></td></tr>
<tr><td colspan="3">Units served: Congregate Meals: 68,580.00

Home Delivered: 108,038.00</td></tr>
</table>

Santee-Lynches Region
Santee-Lynches Area Agency on Aging/Aging and Disability Resource Center
June 3, 2013

<table>
<tr><td>FY 2011/2012</td><td rowspan="5">African American: 1,393

American Indian/Alaskan: 1

Asian: 1

Hawaiian/Pacific Islander: 3

White: 323

Other: 3

2 or More Races: 1

Hispanic: 5</td><td rowspan="3">Divorced: 127

Married: 370

Separated: 46

Single: 158

Unknown: 243

Widowed: 781</td></tr>
<tr><td>Total Clients: 1,725</td></tr>
<tr><td>Male: 451

Female: 1,274</td></tr>
<tr><td>60 and above: 1,606

59 and below: 119</td><td rowspan="2">Rural: 1,177

Urban: 548</td></tr>
<tr><td>Low Income: 1,214</td></tr>
<tr><td colspan="3">Units served: Congregate Meals: 61,354.50

Home Delivered: 101,573.75</td></tr>
</table>

<table>
<tr><td>FY 2012/2013</td><td rowspan="5">African American:1,321

American Indian/Alaskan: 0

Asian: 0

Hawaiian/Pacific Islander: 2

White: 302

Other: 2

2 or More Races: 2

Hispanic: 6</td><td rowspan="2">Divorced: 122

Married: 370

Separated: 44

Single: 147

Unknown: 238

Widowed: 708</td></tr>
<tr><td>Total Clients: 1,629</td></tr>
<tr><td>Male: 435

Female: 1,194</td><td rowspan="2">Rural: 1,138

Urban: 491</td></tr>
<tr><td>60 and above: 1,521

59 and below: 108</td></tr>
<tr><td>Low Income: 1,142</td><td></td></tr>
<tr><td colspan="3">Units served: Congregate Meals: 61,293.00 (projected)

Home Delivered: 102,595.00 (projected)</td></tr>
</table>

The SLAAA/ADRC ensures that nutrition providers/contractors are earning their units for reimbursement purposes as indicated by ensuring that nutrition providers/contractors are responsible for inputting their units into the Advanced Information Manager (AIM) system, with the exception of Clarendon County. For Clarendon County, weekly rosters are provided to the SLAAA/ADRC for input into the AIM system. Once all data from all contractors is put into the system, a monthly finance report is completed by the contractors and provided to the SLRCOG's finance department. Reports are compared to the MUSR for accuracy and monitoring of units. The SLAAA/ADRC ensures its contractors are earning their units in accordance with the OAA and the LGOA policies by

reimbursing all units that have been inputted into the AIM system only. Yearly, the SLAAA/ADRC performs a random financial monthly monitoring/review of units to verify backup documentation for units paid.

If during the visit units are deemed disallowed, providers/contractors are notified and appropriate actions are taken. Once developed, the SLAAA/ADRC policies and procedure manual will clearly document what specific procedures to follow.

Also, the SLAAA/ADRC visits nutrition sites to observe the procedure used for sign in sheets and obtain a copy, if necessary. In the future, contractors will be required upon request to provide daily records of participant attendance to include copies of sign-in sheets (Report LG-94). The SLAAA/ADRC Director, or a designee, will also visit at least three (3) group dining sites monthly, allowing for additional monitoring.

In future contracts, the SLAAA/ADRC will ensure the nutrition service contractors are accurately inputting required client service data into the AIM client data collection system for each site and not collectively as an entire organization. The data must be inputted within one (1) week of the meal served and as requested by the terms, conditions, policies, procedures, and specifications of Title III-C of the OAA. This procedure will be implemented after procurement and will be included in the new contracts. Contractors will be required to enter all financial and service data into the AIM system by the fifth (5th) day of the month. Billing for service unit reimbursement is based upon the AIM system data originated by the contractor and approved by the SLAAA/ADRC. The SLAAA/ADRC will submit invoices to the LGOA by the sixteenth (16th) of each month.

The SLAAA/ADRC ensures that group dining sites have the minimum twenty-five (25) meal participants required each day. Each year the SLAAA/ADRC reviews its waivers to see if they are still relevant or if modifications are needed. Currently, there are six (6) waivers on file at the LGOA for either the minimum twenty-five (25) meal participants or operations less than five (5) days a week. The SLAAA/ADRC will review all waivers after the submission of the plan. The SLAAA/ADRC also checks its meal sites periodically to ensure required participation.

The SLAAA/ADRC ensures that group dining sites have planned activities by having staff members visit the sites to give educational presentations, offer assistance, and conduct site checks.

The SLAAA/ADRC created an activity review form for nutrition contractors to complete while creating their monthly calendars to ensure the nutritional site is offering a variety of activities that appeal to a wide range of clients. These opportunities include an assortment of ongoing recreational, informational, cultural, artistic, and musical activities. Currently, the nutrition sites send their calendars to the SLAAA/ADRC monthly for monitoring.

Effective July 1, 2013, nutrition sites will be required to submit detailed monthly activity calendars by the 5th day of the preceding month for approval by the SLAAA/ADRC. Detailed monthly activity calendars should include, but are not limited to, location name/address/phone number, hours of operation, and daily activities and/or programs including beginning and ending times. Approved calendars will be sent to the LGOA Policy and Planning Manager by the close of business on the last business day of the month. The SLAAA/ADRC Director, or a designee, will also visit at least three (3) group dining sites monthly, allowing for additional monitoring of activities and/or programs as well as the hours of operation.

In the most recent Request for Proposal, the SLAAA/ADRC used zip codes to define service delivery areas as several towns and cities crossed county lines. This was also a method to ensure the entire county was being served. In the future, to address the nutrition service delivery plan, the SLAAA/ADRC will use GIS mapping to determine where home delivered meal and home care recipients reside. GIS mapping is also able to determine group dining routes and where meal sites are located. The use of GIS mapping will enable the SLAAA/ADRC to determine if the entire county is being served and if the most in need are being served with particular attention to low income older adults, including low income minority older adults, older individuals with limited English proficiency, older individual residing in rural areas, and other individuals as defined in the OAA. The SLAAA/ADRC will ensure that during the procurement process and within it contracts this issue is addressed/required. The SLAAA/ADRC will also ensure that areas where seniors above the poverty level reside will be targeted to implement cost sharing/private pay options.

See Appendix H (GIS Mapping)

The SLAAA/ADRC will include in its policies and procedures and Request for Proposal how preference is given to those older persons in greatest social or economic need in the provision of services in 45 Code of Federal Register (CFR) 1321.17(f)(2). Methods used to target services may include location of service delivery and specialization in the types of services most needed by these groups. The SLAAA/ADRC shall assess the level of need for group dining and home-delivered meals within its planning and service area and establish criteria for service providers/contractors to use in the selection of individuals to participate.

The SLAAA/ADRC will design a detailed cost sharing plan for client services (using State funds) to include in it policies and procedures. The SLAAA/ADRC will develop an action plan to encourage its nutrition providers/contractors to enact cost sharing and private pay measures when procuring service contracts.

Please note that the following cost sharing plan is a concept the SLAAA/ADRC is attempting to develop.

OAA – Section 315 – Consumer Contributions states that in general a State is permitted to implement cost sharing for all services funded by this Act by recipients of the service. Exceptions are as follows:

- Information and assistance, outreach, benefits counseling, or case management services;
- Ombudsman, elder abuse prevention, legal assistance, or other consumer protection services;
- Congregate and home delivered meals;
- Any services delivered through tribal organizations.

Voluntary Contributions shall be allowed and may be solicited for all services for which funds are received under this act if the method of solicitation is non-coerced. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185% of the poverty line, at contribution levels based on the actual cost of services.

State funding does not have the voluntary contribution requirements, thus providing more flexibility. Clients using State funds shall be encouraged to cost share.

Federal Poverty Level	Percentage of Voluntary Contribution	Voluntary Contribution Amount
150 %	10%	.75 per day or $3.75 a week
175 %	15%	$1.13 per day or $5.63 a week
185 %	25%	$1.88 per day or $9.00 a week
200 %	50%	$3.75 per day or $18.75 a week
250 %	75%	$5.63 per day or $28.15 a week

(This chart is based on a reimbursement rate of $7.50 per meal)

When calculating a voluntary contribution, the self-declared income will determine the percentage of the contribution. The percentage will then be multiplied by the total reimbursement cost of their meal.

Example:

- **self-declared 1500.00 a month**
- **15 % (sliding scale percent)**
- **7.50 (reimbursement rate for meal)**

.15 x 7.50 = 1.125 (round up to $1.13) contribution for a meal.

In this scenario, anyone over 300% of Federal Poverty Level would be required to pay the total cost of the meal.

To review regional menus, including input from a registered dietitian and the appropriate LGOA staff, the SLAAA/ADRC Nutrition Coordinator meets with the food contractor quarterly to review draft menus and share participants' preferences for the following

quarter. Present at these meetings is the contractors' dietitian, assuring that each meal is planned according to LGOA nutrition requirements. Also, in attendance is a staff member of the LGOA, making suggestions and approving the menus.

To ensure all current certified meals are posted, the SLAAA/ADRC staff members frequently visit the group dining sites give educational presentations, offer assistance, and to conduct site checks. During these visits, staff members check to ensure the appropriate documentation is in place in the appropriate locations. The SLAAA/ADRC Nutrition Coordinator also provides the approved quarterly menus along with educational materials to each site once menus are finalized. In addition, the food contractor provides the same finalized quarterly menu, along with daily menus, to the nutrition sites before the quarter begins. For additional monitoring, the SLAAA Director, or a designee, will also visit at least three (3) group dining sites monthly to ensure protocol is being followed.

Draft menus are submitted from the food contractor to the SLAAA/ADRC at least two (2) weeks prior to the quarterly menu review. The SLAAA/ADRC Nutrition Coordinator sends the draft menu to each contractor for review, along with a change request form. Contractors have one (1) week to go over the draft menu with the participants. Changes must be requested in writing and sent to the SLAAA/ADRC by the end of the given week. The SLAAA/ADRC Nutrition Coordinator then acts on behalf of each site to ensure comments, suggestions, and/or changes are known. As a group, the food contractor, dietitian, LGOA representative, and SLAAA/ADRC representatives go over each menu item for changes and approval. Should special requests be made after menus have been approved due to seasonal/cultural menu items, the SLAAA/ADRC Nutrition Coordinator will request these changes directly through the food contractor. The SLAAA/ADRC plans to create and implement a customer satisfaction survey for additional feedback from participants in regards to meals, contractor services, and overall performance.

The SLAAA/ADRC will develop written policies, priorities, and methods for serving persons as stipulated by the OAA for targeted populations. The SLAAA/ADRC will assess the level of need for group dining and HDMs within the region and establish criteria for service providers/contractors to use in the selection of individuals to participate. This will also be addressed in the selection process of service delivery.

The SLAAA/ADRC will develop a plan to collaborate with local retail food businesses, school districts, hospitals, and other locations to promote and encourage intergenerational meal programs and meal variety. This will first be addressed by advertising in local papers to see if the aforementioned providers are interested. The SLAAA/ADRC staff will also visit aforementioned providers to gauge their interest.

J. Training and Technical Assistance

The SLAAA/ADRC will assure that it is providing technical and programmatic assistance and training opportunities to the SLAAA/ADRC staff and providers/contractors through the Area Plan. This will include components found in the Verification of AoA and the LGOA Assurances found in this guide, as well as the policies set by the South Carolina Aging Network's Policies and Procedures Manual.

The SLAAA/ADRC will provide information and technical assistance to public officials, agencies, organizations, associations or associated partners that are assisting caregivers, older adults and/or those with disabilities.

Following the protocols established by the South Carolina Aging Network's Policies and Procedures Manual, the SLAAA/ADRC will provide technical assistance to its providers/contractors. To ensure that services are delivered properly, the SLAAA/ADRC will use QA forms created based on the Request for Proposal (RFP) and conduct at least one technical assistance (TA) visit randomly and quarterly. Any issues or concerns found during TA visits will be addressed, documented and followed up by a visit to ensure those issues/concerns were addressed and have been corrected. The findings from the TA visits and annual QA reviews will be shared with all other providers/contractors in the region to ensure that corrective actions are implemented region wide. Findings and trends will also be addressed during quarterly provider/contractor trainings. The SLAAA/ADRC will also be available to provide TA on a monthly basis while performing HDM routes and group dining visits.

Technical Assistance will also be provided in a group or on a one-on-one basis. A summary of all meetings will be maintained on file, along with issues raised and resolutions achieved. The SLAAA/ADRC will also develop a regional training and education plan. The plan will be comprehensive in nature and will include geographical characteristics, infrastructure, GIS Mapping, and local and community partnering.

In the past and on a continuous basis, the SLAAA/ADRC will ensure that all new providers/contractors are provided TA on a regular basis. The SLAAA/ADRC will host an aging orientation meeting within the first thirty (30) days of a new contract agreement for all new providers/contractors in the region. Materials provided in the orientation shall include, but are not limited to, the following:

a. a general overview of the LGOA and ADRC network operations and roles;

b. a LGOA two-sided flyer;

c. a LGOA benefits guide;

d. a SC Access flyer;

e. a copy of the AAA/ADRC Area Plan;

f. a copy of the SC Aging Network's Policies and Procedures Manual;

g. a summary of the structure of the aging network in South Carolina;

h. a copy of general AAA/ADRC goals for that operating year;

i. an AAA/ADRC staffing contact sheet; and

j. a copy of the AAA/ADRC Strategic Plan.

K. Monitoring

The SLAAA/ADRC has designated February and March of each year to conduct its formal Quality Assurance Process visits (QA) to ensure that the regional analysis of reports, to include the QA recommendations for each service delivery provider/contractor, be submitted to the LGOA by June 3rd of each year. QA reviews will include both a programmatic monitoring and fiscal monitoring of each contractor to ensure compliance with the current policies and procedures manual, as well as provider contracts.

To ensure that services are delivered properly, the SLAAA/ADRC will use QA forms created based on the Request for Proposal (RFP) and perform at least one technical assistance (TA) visit quarterly to ensure that methods of service delivery are being followed and services are being delivered. Any issues or concerns found during TA visits will be addressed, documented, and followed up with a visit to ensure those issues/concerns were addressed and have been corrected. The findings from the TA visits and annual QA reviews will be shared with all other providers/contractors in the region to ensure that corrective actions are implemented region wide. Findings and trends will also be addressed during quarterly provider/contractor trainings. The SLAAA/ADRC will also be available to provide TA on a monthly basis while performing home delivered meal routes and group dining visits.

The SLAAA/ADRC will include in its policies and procedures manual policies regarding formal and unannounced visits to providers/contractors. Procedures and protocols will also be developed regarding corrective actions taken by the SLAAA/ADRC with providers/contractors who fail to deliver contracted services or who fail to follow the methods of service delivery described in the RFP response. The guidelines and protocol set forth by the LGOA will be imposed. The SLAAA/ADRC will revise and/or create all QA forms.

See Appendix M (Current Monitoring Forms)

L. Contract Management

Currently, the SLAAA/ADRC performs contract monitoring/QA reviews at different times during the year to ensure compliance and to ascertain whether extensions should be granted based on performance. In the past if contractors failed to perform, the SLAAA/ADRC met with those contractors, including their Board of Directors, to discuss corrective actions. If corrections were not made or disregarded, the SLAAA/ADRC either ran the day-to-day operations of the contractor's agency or sub-contracted with another provider to run the day-to-day operations. This, of course, was implemented after attempts had been made to correct issues of concern. In the future, if issues of concern are not corrected, the SLAAA/ADRC will impose the status of "high risk" to providers/contractors.

The SLAAA/ADRC designated February and March of each year to conduct its formal QA visits. This ensures that the regional analysis of reports, including the QA recommendations for each service delivery provider/contractor, be submitted to the LGOA by June 3rd. QA reviews will include both a programmatic monitoring and fiscal monitoring of each contractor to ensure compliance with the current policies and procedures manual, as well as provider contracts.

To ensure that services are delivered properly, the SLAAA/ADRC will use QA forms created based on the Request for Proposal (RFP) and at least one technical assistance (TA) visit will be completed quarterly to ensure that methods of service delivery are being followed and services are being delivered. Any issues or concerns found during TA visits will be addressed, documented, and followed up with a visit to ensure the issues/concerns were addressed and corrected. The findings from the TA visits and annual QA reviews will be shared with all other providers/contractors in the region to ensure that corrective actions are implemented region wide. Findings and trends will also be addressed during quarterly provider/contractor trainings. The SLAAA/ADRC will also be available to provide TA on a monthly basis while performing home delivered meal routes and group dining visits.

The SLAAA/ADRC will include in its policies and procedures manual policies regarding formal and unannounced visits to providers/contractors. Procedures and protocols will also be developed regarding corrective actions taken by the SLAAA/ADRC with providers/contractors who fail to deliver contracted services or who fail to follow the methods of service delivery described in the RFP response. The guidelines and protocol set forth by the LGOA will be imposed. The SLAAA/ADRC will revise and/or create all QA forms.

The SLAAA/ADRC ensure that the PSA and SLAAA/ADRC provide electronic copies of procurement contracts, and all amendments thereto, to the LGOA's Policy and Planning Manager in the Programs Services Division within thirty (30) days of execution.

Effective July 1, 2013, nutrition sites will be required to submit detailed monthly activity calendars by the 5th day of the preceding month for approval by the SLAAA/ADRC. Detailed monthly activity calendars should include, but are not limited to, location, name/address/phone number, hours of operation, and daily activities and/or programs including beginning and ending times. Each nutrition contractor shall offer a variety of activities that appeal to a wide range of clients. These opportunities include an assortment of ongoing recreational, informational, cultural, artistic, and musical activities.

The SLAAA/ADRC will ensure that all contracts for the procurement of services or goods that are supported with financial assistance through the LGOA adhere to applicable Federal and State procurement codes (COG: OMB Circulars A102 and A-87) (PN-P: OMB Circulars A110 and A-122).

M. Grievance Procedures

The SLAAA/ADRC will develop procedures and protocols to allow older persons who are dissatisfied with or denied services to file a grievance and to have their grievance heard. Once established, these procedures will either be displayed in a conspicuous place at the group dining site or become a part of the assessment packet when seniors are assessed for services. Seniors will understand that they have the right to voice a grievance with respect to such service that is or fails to be provided, without discrimination or reprisal as a result of voicing such grievance.

Currently, as required by the Area Plan, SLAAA/ADRC contactors are required to post "Grievance Procedures" at all senior centers and nutrition sites funded by the SLAAA/ADRC or maintain a copy in the client's file. Residence or citizenship will not be imposed as a condition for the provision of services. No handicapped older individual shall, solely by reason of handicap, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. A means test is not used to deny or limit an older person's receipt of service.

A free and voluntary opportunity for service recipients to contribute to the cost of service is provided. Any individual who feels he/she has been discriminated against because of race, color or national origin, residence citizenship, disability, or income should file a written complaint to the SLAAA/ADRC or the Director of the South Carolina Lieutenant Governor's Office on Aging. The SLAAA/ADRC will ensure that a prompt and complete investigation is conducted if a grievance is filed.

N. Performance Outcome Measures

The SLAAA/ADRC will develop procedures and protocols to measure performance outcomes of contracted services delivered throughout the region and the impact on recipients. Currently, outcome measures are determined through contract compliance, satisfaction surveys, and QA reviews to determine whether or not contracted services have a positive outcome to improve quality of life for older individuals. Performance outcomes are also measured when reviewing monthly reports and information submitted by the provider/contractor.

In the future, the SLAAA/ADRC will develop a more efficient method to measure performance measures. Performance measure will also be discussed at quarterly provider/contractor trainings and be required in provider/contractor contracts.

O. Resource Development

Resource development is a key and integral aspect of service delivery. The fact of the matter is that funds provided by the OAA is seed money and has recently decreased as State funding continues to increase. There is much uncertainty when it comes to future funding. Organizations and communities have to develop systems to generate additional resources to continue/maintain present levels of services. The SLAAA/ADRC will assist in proactive initiatives utilized to assist providers/contractors in developing methods to increase grant related income or institute cost-sharing for allowable services such as transportation, housekeeping, chore, homemaker, personal care, home living support, group respite, adult day care, wellness services, and senior center activities.

Providers/contractors are always encouraged to collect Grant Related Income (GRI) at their agencies. Every contractor has different methods of obtaining GRI for services. The SLRCOG's Finance Department verifies that GRI is being recorded properly while completing the yearly financial monitoring for each contractor. The following table indicates the GRI earned for FY 2011-12.

Activity	Funding Source	Grant Related Income	Units
Congregate Meals	Title III C1	$14946.28	2065
Home Delivered Meals	Title III C2	$4851.85	829
Transportation	Title III B	$3430.09	2663

P. Cost-Sharing and Voluntary Contributions

The SLAAA/ADRC shall assist in providing for the identification of public and private resources in, or serving persons in, the planning and service area as part of its overall outreach and coordination efforts. Local aging partners will be asked to assist the SLAAA/ADRC in the planning process in order to better serve the region's older population. The SLAAA/ADRC shall work to coordinate the programs funded under the Area Plan with such resources to increase older persons' access to quality services.

Currently, voluntary contributions system is clearly explained to individuals who use the agency's services. In the future, the explanation shall be made both verbally and in writing at the time service delivery is arranged, and shall be posted in a conspicuous location accessible to clients within the site or kept in individual files. The explanation shall include the voluntary nature of the contribution, confidentiality policies, and how contributions are collected and used. The SLAAA/ADRC shall ensure that this is included in procurement contracts, and that each provider's/contractor's policy shall be included in the SLAAA's/ADRC's Area Plan annual update.

See Section V: I for a draft sample of the sliding scale used by the SLAAA/ADRC to guide voluntary contributions for state funded meals that could be used for all aging services eligible for cost-sharing in the planning and service area region.

Q. Confidentiality and Privacy

The SLAAA/ADRC will ensure that lists of clients compiled under any programs or services are used solely for the purpose of providing or evaluating services. The SLAAA/ADRC shall obtain written assurances from providers/contractors stating that they will comply with all LGOA confidentiality requirements, as well as any and all applicable Federal and State privacy and confidentiality laws, regulations, and policies. The SLAAA/ADRC shall provide the LGOA with confidentiality assurances through its Area Plan, annual Area Plan updates, and/or as changes are made.

VI. AAA/ADRC Direct Service Delivery Functions

A. **Staff Experience and Qualifications**

Aging and Disabilities Resource Center Coordinator (ADRC)

Gena C. Kiber came to the SLAAA/ADRC after having a 32-year career with the Department of Defense as a Supervisory, Management Analyst. Gena became a full-time employee in November 2003 and has held several positions since that time (Administrative Employment Specialist, Aging Program Assistant, ADRC Coordinator, and ADRC Case Manager/Resource Coordinator). She received her initial AIRS-A Certification in 2006 and has recertified each year since then. Her initial State Health Insurance Program (SHIP) training was accomplished in 2005. Gena's major accomplishments to date were starting up the state's second ADRC in 2006 and performing as the region's leader for the White House Conference on Aging in 2005. Since 2010 she has been testing a Case Manager Program within the region (first in the state). As a result of this experience, she will be working with contractors/providers to develop new procedures to ensure adequate checks and balances are in place to throughout the region regarding client selection. See Appendix - L (Draft Policy and Procedure for Client Administration.)

Information and Referral/Assistance

Yolonda H. Russell became the Santee-Lynches AAA/ADRC full-time Information and Referral Assistance (I&R/A) Specialist on September 5, 2012. She was hired August 17, 2009 as Aging Insurance Counselor and was certified as I&R/A Specialist for Aging (CIRS-A) on June 10, 2010. She was recertified on June 9, 2012; and this recertification is good through June 9, 2014. Her primary responsibility is to help seniors and those with disabilities connect with much-needed services; and to assist them and their family members maintain or improve their quality of life. She has had four years' experience in the areas of aging and/or disabilities, including the months spent as a volunteer in the Aging Department.

This employees' training includes the following: I&R/A training: August 12, 2010 – 2.0 hours; January 13, 2011 – 2.0 hours; February 16, 2012 – 6.5 hours; and March 8, 2012 – 3.0 hours.

As far as anticipated turnover in the Aging unit, this employee will be eligible for Medicare in March 2014 and plans to retire by the summer of 2014. The SLAAA/ADRC looks to replace the current I&R/A Specialist prior to her planned retirement. The SLAAA/ADRC will ensure that the incumbent meets all noted qualifications in the South Carolina Aging Networks Policy and Procedure Manual.

SMP

Janae Allumbaugh serves as the SMP/SHIP Coordinator for the SLAAA/ADRC. Janae has served as the SMP/SHIP Coordinator since September 2012. Janae has successfully completed training for I-CARE and looks forward to obtaining her CIRS-A certification by the end of 2013. The SMP/SHIP Coordinator receives twelve (12) hours of required update training on an annual basis. In addition the SMP/SHIP Coordinator receives a minimum of four (4) hours of I&R/A update training on an annual basis. Janae earned her Associates Degree in Arts and is currently working on completing her B.S. in Health Care Administration.

Ombudsman

Janice Reed Coney currently serves as the SLAAA/ADRC LTC Ombudsman. Ms. Coney began her tenure with the Agency in July 2002 as the Information and Referral/Assistance Specialist. Ms. Coney brings a wealth of knowledge to the Agency, having worked on the local and federal levels for over 20 years prior to her start with the Agency. Ms. Coney holds certifications in Ombudsman training, Insurance Counseling (I-Care), and Ombudsman Witness for Living Wills through the LGOA; Information and Referral/Assistance through the Alliance of Information and Referral Systems (AIRS); and Dementia Dialogues Trainer through the University of South Carolina Arnold School of Public Health. Ms. Coney holds several degrees, including a master's degree in Information Systems.

Family Caregiver

Toni Y. Brew, Family Caregiver Support Program (FCSP) Advocate, has been employed by the SLAAA/ADRC since January 2000. Ms. Brew is a trainer for "Powerful Tools for Caregivers" and a dementia dialogues trainer. Also, Ms. Brew is a certified Information and Referral /Assistance Specialist for Aging (CIR-A) and a certified Arthritis Exercise Program Trainer.

Ms. Brew's qualifications, along with years of experience, help to strengthen and support caregivers and their families in the home. The caregiving process has now become a personal issue for Ms. Brew, since she is now a caregiver herself. The caregiving process has come full circle for Ms. Brew. At the end of the 2013 calendar year, she will retire to become a full-time caregiver for her husband. Since Ms. Brew plans to retire, the SLAAA/ADRC plans to hire and train her successor within thirty days of her departure.

Mobility Manager

Shalyse Edgar serves as the SLAAA/ADRC Assisted Rides Program Mobility Manager. Shalyse has been in this position since August 2011. The mission of the Santee-Lynches Assisted Rides Program is to fill the transportation gap currently facing individuals 21 years of age or older with a disability and individuals 60 years of age and older, in order to enhance their quality of life by enabling them to obtain needed services.

Shalyse is responsible for: scheduling and monitoring trips using the Assisted Rides Program database; collecting and analyzing data for monthly and quarterly reporting; obtaining a range of transportation options while also identifying and documenting unmet transportation needs; and recruiting and training volunteer drivers.

Shalyse became the Nutrition Coordinator in September 2012. She monitors the daily meal temperatures and monthly activity calendars, and conducts unscheduled site checks. Shalyse advocates for the nutrition sites at the quarterly menu reviews and ensures all sites have finalized menus, as well as up to date education materials. Shalyse also assists with I-Care as she is SHIP certified. Prior to these positions, Shalyse was a volunteer with the SLAAA/ADRC, assisting the Case Management program and providing data entry.

Veterans

Kristy Pritchard, Resource Coordinator, Care Coordinator for VDHCBS

Kristy Pritchard was hired June 2010 as an Aging Assistant to the Aging Director. Along with administrative duties, Mrs. Pritchard assisted the Case Manager in Clarendon County with assessments, care plans and over all case management functions. Mrs. Pritchard managed the Consumer Directed Cost Sharing Pilot Program that was deemed successful by the LGOA during her second year of employment with the SLAAA/ADRC. Mrs. Pritchard is currently the Care Coordinator for the Veterans Directed Home and Community Based Services (VDHCBS) program for the SLAAA/ADRC region. Mrs. Pritchard is currently working towards a Human Services Associates Degree with a certificate in Gerontology, which will be completed in the spring of 2014. Mrs. Pritchard is CIRS-A certified, as well as SHIP certified. Mrs. Pritchard attends regular meetings and trainings to remain updated with changes within the aging network.

The Veteran Directed Home Based Services Program is administered by the SC Lieutenant Governor's Office on Aging in partnership with the Santee-Lynches Aging and Disability Resource Center and the Wm. Jennings Bryan Dorn VA Medical Center. This program has been designed to help those Veteran's that are nursing home eligible remain in their homes independent, healthy, and safe with the proper services. The Veteran or a designated representative would be able to hire, employ, and supervise workers of their choice to provide those services needed for the Veteran to remain safely

in his/her home. A Care Coordinator will complete an assessment to determine eligibility and level of services needed. The Care Coordinator will support the Veteran or a designated representative with hiring employees, directing care and managing a monthly budget to meet his/her personal goals. Anyone interested in the program, should contact his/her Case Manager at Wm. Jennings Bryan Dorn VA Medical Center or Santee-Lynches Aging and Disability Resource Center.

Eligibility Requirements

- Veteran must be Nursing Home eligible
- Veteran or Designated Representative must be able to self-direct
- Veteran must be enrolled with Wm. Jennings Bryan Dorn VA Medical Center

Services Offered

- Attendant Care
- Housekeeping
- Transportation
- Minor home modifications

B. Long-Term Care Ombudsman Services

The SLAAA/ADRC Long Term Care (LTC) Ombudsman Program protects the health, safety, welfare, and rights of residents in long term care facilities. The four-county coverage area includes approximately 113 facilities with over 2,000 beds. Major aspects of the Ombudsman day-to-day responsibilities generally fall into one of four areas: investigation, training, reporting, and community education. The Ombudsman received specialized training and certification through the State Ombudsman Program. Yearly recertification is also obtained through training sessions at monthly Ombudsman's meeting at the State Office, as well as through a national sponsored training conference.

Investigation

By far, the SLAAA/ADRC Ombudsman spends the majority of her time on investigations (about 75 to 80 percent). An investigation usually begins with a phone call about a loved one in a long term care facility. On average, calls last about 45 minutes.

Once a call is completed, the Ombudsman transfers relevant information on a Nationally-developed form and a chronology form. Then, the Ombudsman places these forms in a file folder; label the folder with the Resident and facility name; and input data from the forms into the Ombudsman database system.

The system generates a number that become the case number. The Ombudsman places this number on the file folder and the forms. If appropriate, the Ombudsman obtain consent to investigate the complaint. During the course of an investigation, the

Ombudsman visits the facility to observe, interview, and obtain information. If relevant, the Ombudsman also request and obtain information from other sources, i.e., hospitals, doctors, eye witnesses, facility staff, family, friends, etc.

Once all relevant information is obtained, the Ombudsman determines if there is enough evidence to support the complaint. The Ombudsman then prepares a findings document, either verifying or not verifying the complaint, and send same to appropriate parties, i.e., facility administrator, Resident's responsible party, DHEC, OAG, etc. If the complaint is verified, the Ombudsman works with relative parties to correct and/or minimize the problem/damage.

Training

The SLAAA/ADRC LTC Ombudsman spends about 5 percent of her time conducting training sessions. The Ombudsman provides resident rights training to Residents and abuse, neglect, and exploitation training to staff. The Ombudsman works with facility staff to schedule the training. Then, the Ombudsman prepares, copy, and assembles training materials and creates folders for training attendees. After each training session, the Ombudsman records relevant information from the sign-in sheet into the Ombudsman reporting system.

Reporting

The SLAAA/ADRC LTC Ombudsman spends about 1 percent of her time on reporting. The Ombudsman runs a report quarterly as requested from the State Ombudsman. In order for the reports to be useful to the State, the data must be entered timely and accurately.

Community Education

The SLAAA/ADRC LTC Ombudsman spends about 5 percent of her time on community education. The Ombudsman, along with other AAA/ADRC staff, sets up booths at selective community events and provides literature on the Ombudsman program, Elder Abuse, and Advanced Directives, as well as information on resident's rights.

Additionally, the Ombudsman attends community interagency meetings and uses the opportunity to educate attendees about the Ombudsman program and long term care issues.

Other Activities

The SLAAA/ADRC LTC Ombudsman spends about 10 percent of her time on other activities. The Ombudsman is the SLAAA/ADRC designated Legal Services Coordinator as well as its Friendly Visitor's Program supervisor. The Ombudsman receives training for both of these programs through the Lt. Governor's Office on Aging. Additionally, in order to more adequately assist the other programs within the SLAAA/ADRC, the Ombudsman holds certifications in I-Care (SHIP) counseling and Information and Referral/Assistance (I&R/A). The Ombudsman receives training for both of these programs through various sources, such as webinars and events/trainings sponsored by organizations certified to do same. The Ombudsman is certified with the Alliance of Information and Referral Systems (AIRS). Lastly, the Ombudsman is certified by the Lt. Governor's Office on Aging to witness Advanced Directives executed in hospitals or long term care facilities.

See Appendix C (LTC Ombudsman Service Report)

C. Information, Referral, and Assistance Services

The Information and Referral/Assistance (I&R/A) Specialist in the SLAAA/ADRC region works to help seniors and those with disabilities connect with much-needed services to assist them and their family members maintain or improve their quality of life. The primary goal is to assist and empower clients to seek out much-needed services and provide them with as many viable options as possible.

The I&R/A Specialist will plan to increase awareness of the program and its benefits by establishing additional cooperative relationships with religious and community organizations throughout the region. Outreach events/presentations will be consistently scheduled within the region to link clients to resources that are available within their service area.

There are several weaknesses within the I&R/A program which provide obstacles for reaching these goals. The first challenge will be the major influx of people (particularly Baby Boomers) who will be coming into the aging system within the next ten years. This large increase in the number of potential clients will impact the amount of services available and how much services and resources they will be eligible to receive. The second challenge will be the available resources for clients. The SLAAA/ADRC region currently has limited resources available. With the expected senior growth, these resources and services will be strained to maximum capacity. It will be imperative that the SLAAA/ADRC make every effort to locate additional resources for its clients. A third challenge is the fact that the SLAAA/ADRC region has one of the lowest educational levels in the state. This places an extra burden on the I&R/A program to help these clients in explaining the various programs and requirements. A fourth challenge is

not knowing what the impact of sequestration and the Affordable Care Act will have on funding for resources and programs across the state.

There are several strengths within the SLAAA/ADRC I&R/A program's current configuration. The SLAAA/ADRC region currently has one (1) full-time I&R/A specialist who is Alliance for Information and Referral Systems (AIRS) certified. In addition there are four (4) SLAAA/ADRC staff members who are AIRS certified. All remaining staff members will obtain AIRS certification within one year. The SLAAA/ADRC State Health Insurance Program (SHIP) Coordinator is the backup staff member for the full-time IR&/A specialist. The I&R/A Specialist and the SHIP Coordinator are able to share information and rely on each other to help locate resources and advocate for clients and their family members.

SC ACCESS plays a vital role in the delivery of I&R/A services. SC ACCESS allows the I&R/A Specialist to find available services and resources for clients needing help. This database shows what agencies have the services desired by clients. It is helpful because it allows the Specialist to see where the services are located and what some of the criteria are to determine if clients will qualify for the services. SC ACCESS also allows for up-to-date reporting of contacts and updated information on resources new to the system. SC ACCESS can also be used as an educational tool for clients and their family members to allow them to seek help.

The SLAAA/ADRC region has additional options to aid in service delivery for clients and their families. The SLAAA/ADRC is able to schedule monthly outreach events/presentations within rural outlying areas throughout the region and educate the public regarding available services and programs. This aspect is of vital importance as the SLAAA/ADRC region has a large population who are unable to access transportation to agencies providing needed services. The SLAAA/ADRC is a participating member in various inter-agency groups throughout the region; these groups meet to share information with other local agencies and organizations. Through this network, the SLAAA/ADRC is able to inform interested persons and groups of services and how to access them.

The procedure used by the SLAAA/ADRC for follow-up on referrals made on behalf of older adults follows. Currently, when the SLAAA/ADRC works with clients, the sharing of options for services is provided. In some cases, the SLAAA/ADRC will contact the agency/organization and make the initial referral for the client while they are in the office. Once the process is done, staff will follow up by contacting the agency/organization within five (5) business days to determine what progress has been made toward resolving the client's issue(s). If the client and/or family member is able to contact the agency or organization on his/her own, the SLAAA/ADRC will follow up by first contacting the client or family member, then the agency to update the status in the event that additional referrals are needed.

Hiring I&R/A Specialists

- The AAAs/ADRCs are encouraged to hire regional I&R/A Specialists that have, at a minimum, a Bachelor's degree from an accredited college or university and/or three (3) years of experience in the field of public health or social services. I&R/A Specialists candidates without a Bachelor's degree should possess some background and/or practical experience in the areas of aging and/or disabilities.

- AAA/ADRC Directors shall hire regional I&R/A specialists who have the position qualifications as determined by the LGOA. The LGOA I&R/A Coordinator will be notified of all regional I&R/A hires and staff changes.

- The AAA/ADRC Directors shall ensure that all newly hired I&R/A Specialists meet with the LGOA I&R/A Program Manager for orientation within thirty (30) days of being hired.

- If the AAA/ADRC seeks to hire a specialist that does not have the required qualifications, an I&R/A Employment Waiver must be requested by the AAA/ADRC from the LGOA. I&R/A Employment Waiver forms can be obtained from the LGOA I&R/A Manager in the Program Services Division.

- When there has been a change in the I&R/A Specialist's employment status, the AAA/ADRC shall immediately notify the LGOA I&R/A Manager in writing, within three (3) working days.

SLAAA/ADRC staff is required to submit time and activity reports each month that reflect work activities performed and the appropriate account code to be charged. The SLRCOG's accounting system provides for a specific account code for I&R/A. The SLAAA/ADRC Director is responsible for reviewing the time and activity reports to ensure the appropriate funding is used. SLRCOG financial staff maintains a monthly report of all aging administrative and programmatic activities that compare budget to actual expenses. This report is shared monthly with the SLAAA/ADRC Director and reviewed monthly by the SLRCOG's Deputy and Finance Director.

Stewardship of Funds

The AAAs/ADRCs must be good stewards of OAA and LGOA funding and be accountable for programmatic budgeting, monitoring, and operation. The AAA/ADRC shall assure in writing, through its Area Plan, that I&R/A funding is not being used to fund other programs outside of the I&R/A program area. Should the LGOA determine the AAA/ADRC is in violation of using I&R/A funds for other activities, then funding for I&R/A services may be withheld in the future.

Currently, the SLAAA/ADRC has strong partnerships with nonprofit and for-profit groups, faith-based organizations, and other community groups that provide the most useful information and services to clients through the I&R/A Program. These partnerships have been established with our Aging and Disability Resource Center (ADRC) Advisory Committee and the Regional Aging Advisory Committee (RAAC). Both committees consist of knowledgeable consumers/professionals who reside within the SLAAA/ADRC region and support SLAAA/ADRC program functions. Over the next four (4) years the SLAAA/ADRC will continue its partnerships with existing partners and also look to add new partners to its existing committee.

While attending health fairs and outreach events at faith-based organizations and other community groups, the SLAAA/ADRC consistently come into contact with qualified individuals and knowledgeable consumers. These individuals become aware of SLAAA/ADRC functions and want to establish a partnership to close gaps of services. As a result, the SLAAA/ADRC is able to provide its clients with additional resources.

The SLAAA/ADRC will begin coordinating with Central Carolina Technical College and Shaw Air Force Base for interpretation services for the region's non-English speaking clients. A Memorandum of Agreement with interpretation services will be establish if the agreement is feasible to all parties. Once partnership/agreement is established, the interpretation services will allow the SLAAA/ADRC to facilitate and expedite the I&R/A process. In the event a non-English speaking client contacts the SLAAA/ADRC I&R/A Specialist, the interpretation service will be provided within 30 minutes.

The protocol for accurate and timely client intake and data input into OLSA in accordance to the SLAAA/ADRC Standard Operating Procedures follows. When a client contacts the SLAAA/ADRC, an intake form is completed; this includes all data needed for screening a client for services. A consent form is then explained and signed by the client in order for the SLAAA/ADRC to contact agencies on his/her behalf. The date, time spent, and referral codes are documented within each client's file on the client assistance log. After each encounter with a client, the file is provided to the data entry clerk to be inputted into OLSA. It is also the goal of the SLAAA/ADRC to input client contacts in real time.

Supervisory responsibilities for the I&R/A staff at the SLAAA/ADRC include ensuring that there is one full-time I&R/A Specialist. All new aging network I&R/A Specialists shall participate in the ABC's of Information and Referral classroom and on-line training provided by the LGOA. The I&R/A Specialist should also receive ten (10) hours of continuing I&R/A education every two (2) years to maintain AIRS certification. The SLAAA/ADRC will ensure that the I&R/A Specialist receives training in aging and disability programs, earn AIRS certification within fifteen (15) months of their hire date, and provide a copy of the current AIRS certificate to the LGOA I&R/A Manager. The SLAAA/ADRC Director shall meet monthly with their I/R&A staff to evaluate contact information in order to ensure that client follow-ups are being made according to the policies and procedures and that the established I&R/A goals are being met. A record of these follow-ups shall be kept by the SLAAA/ADRC in the event the LGOA requests to review it. The SLAAA/ADRC currently has the SHIP Coordinator in place as the I&R/A Specialist's back up. The SLAAA/ADRC ensures that the SHIP Coordinator receives training in aging and disability programs and completes at least four (4) hours of additional I&R/A training annually. The PSA Directors and AAA/ADRC Directors are responsible for cross-training all agency staff to be able to provide I&R/A Specialist services. As a result, all SLAAA/ADRC staff has been trained and is capable of assisting with I&R/A functions and services. If I&R/A staff is out of the office, the SLAAA/ADRC will ensure that I&R/A backup staff is available or other SLAAA/ADRC staff is available to assist as needed. I&R/A supervising staff is always available via phone, email or text.

Mandatory monthly meetings will be scheduled between the SLAAA/ADRC Director and I&R/A Specialist to determine how to best administer, amend, and/or improve the I&R/A program to achieve regional success. These mandatory meetings will review call volume, percentage of call by topic, and compare this data to the Area Plan and Geographical Information System (GIS) mapping data. The SLAAA/ADRC Director will also implement specific and individual program goals and objectives for the I&R/A Specialist and all SLAAA/ADRC staff.

The following policies and procedures are in place for crisis calls to the I&R/A program.

- All staff has been provided suicide prevention information. The suicide prevention information provides questions that should be asked in the event of a client contemplating suicide. In addition, the information provides the changes to watch for in adults and older persons.

- All staff has been provided a list of emergency shelters within the region. This information includes the mandatory and reserve shelters for clients in the event of a crisis.

- All staff has been provided additional suggested ways to speak with clients during a crisis.

- A detailed policies and procedures manual will be developed. See Appendix D (I&R/A Report)

D. Insurance Counseling and Senior Medicare Patrol (SMP)

The SLAAA/ADRC Senior Medicare Patrol/State Health Insurance Program (SMP/SHIP) Coordinator plans to increase awareness of the program and its benefits by establishing additional cooperative relationships with religious and community organizations throughout the region. Outreach events/presentations will be consistently scheduled within the region to educate clients on Medicare fraud, abuse, and waste and all SHIP functions the SLAAA/ADRC provides. Currently, there are eight (8) SHIP certified counselors at the SLAAA/ADRC. The SMP/SHIP Coordinator will gain two (2) SHIP certified counselors within a year to meet the requirement set by the LGOA of ten (10) SHIP certified counselors for the region. Eight (8) retired SMP volunteers will be obtained within six (6) months. SMP volunteers will be available in Clarendon, Lee, Kershaw, and Sumter County. All SHIP counselors will attend the necessary training to retain certification annually.

There are several weaknesses within the SMP/SHIP program which provide obstacles for reaching these goals. The first challenge will be the major influx of people (particularly Baby Boomers) who will be introduced into the aging network within the next ten (10) years. This increase will be a challenge with the current funding and staffing that is provided to the SLAAA/ADRC. Currently, rural areas are difficult to target with the amount of staff and funding available. The second challenge will be obtaining two (2) volunteer SHIP counselors within the SLAAA/ADRC region. Potential volunteer SHIP counselors are required to attend I-Care training, which takes place one (1) day a week for six (6) consecutive weeks. Training is typically located at a facility that requires a long commute, which causes volunteers to opt out of participating. This requirement would be more feasible and accepted by potential volunteers if I-CARE training could take place online. The SMP/SHIP Coordinator will also attempt to coordinate SHIP training at the SLAAA/ADRC next year. The third challenge is update training for all SHIP counselors annually. Training assistance/options are requested from the LGOA to ensure that all SHIP counselors obtain the necessary training to retain certification.

There are several strengths within the SHIP program's current configuration. The SLAAA/ADRC region currently has one (1) SMP/SHIP Coordinator who is SHIP certified. In addition, the SLAAA/ADRC has a total of (8) SHIP certified staff members. The SHIP Coordinator has set an interagency goal at the SLAAA/ADRC for the number of monthly SHIP contacts. Each staff member is encouraged to reach their personal goal in order to obtain the agency goal that has been set on a monthly basis. All SLAAA/ADRC staff is required to attend monthly SMP/SHIP staff meetings. The

SMP/SHIP Coordinator consistently monitors staff SMP/SHIP activity to ensure that training and monthly goals are met. There are several strengths within the SMP program's current configuration. The SMP/SHIP Coordinator requires staff to complete a SMP intake form when discussing SMP information with clients. This form is then provided to the SMP/SHIP Coordinator to enter all data into SMART FACTS in a timely manner. SMP articles are featured in the SLAAA/ADRC monthly newsletter, which is distributed to over 900 individuals throughout the region. New fraud trends are provided to all staff members on a monthly basis. Staff members are required to inform clients of the trends that are currently taking place within the state or region to increase awareness. Promotional items such as magnets, pens, and appointment journals/calendars are distributed at all health fairs and presentations.

Volunteer efforts that will be applied to the delivery of I-CARE services at the SLAAA/ADRC follow. Volunteer recruitment will take place with the Regional Aging Advisory Committee (RAAC) members, Council on Aging (COA) sites, senior centers, and faith based organizations. The SLAAA/ADRC goal is to increase the effectiveness of volunteer efforts. The effectiveness of volunteer's efforts will be increased through consistent training and management.

The SLAAA/ADRC current procedures for Part D open enrollment follow. Recruitment and training of additional SHIP volunteers will take place to assist staff with open enrollment within six (6) months. Currently, during the Part D open enrollment period the SLAAA/ADRC utilize all staff members to assist clients with plans. The SLAAA/ADRC begins the open enrollment process by sending out a form that must be sent back to the agency in order for plan comparisons to be run. The client will provide all of their current prescriptions, Medicare number, address, phone number, and date of birth. Once this form is sent back to the SLAAA/ADRC, forms are distributed evenly among all staff. Staff then begins entering the client's prescriptions into the system. An appointment is then scheduled with the client to share the plan comparisons, counsel, and enroll the client in the plan of his/her choice. Each SHIP counselor is responsible for logging each client (i.e. name, county, hours spent, and number of contacts, plan enrolled, and cost avoidance) for reporting purposes. Challenges during Part D open enrollment include clients not accepting services in Kershaw and Lee County. This challenge will be overcome by making the SLAAA/ADRC visible months in advance to the open enrollment period to gain trust from the individuals who reside in Kershaw and Lee County.

The SLAAA/ADRC's current protocol does not include direct entry into the State Health Insurance Program (SHIP) Talk system. Instead, all data is entered into SC ACCESS immediately after assisting clients. All SHIP contacts are then transferred from SC ACCESS to the SHIP Talk system. The SHIP Talk system is utilized by the SMP/SHIP Coordinator on a monthly basis to pull reports and monitor each counselor's monthly SHIP contact numbers.

The following process will be effective immediately for volunteers and staff to ensure twelve (12) hours of Medicare/Medicaid update training is completed annually. The SMP/SHIP Coordinator will obtain SHIP related webinars, conferences, etc., to ensure that training is provided to all volunteers and staff. These resources for training will be provided to all staff who will be required to attend. A rotation will take place among staff to attend quarterly SHIP meetings at the LGOA with the SMP/SHIP Coordinator. All staff hours, dates of training, and topic of training will be kept in a log to ensure update training hours are met annually.

Staff who is no longer conducting SHIP/SMP service will be identified in required meetings, which are scheduled each month. The SHIP Talk system is also utilized to ensure that all staff members are still active each month. If for any reason SLAAA/ADRC staff become inactive (i.e. termination, no longer conducting services etc.) the appropriate LGOA staff will be notified so they can be removed from the system.

When the SHIP program experiences high call volumes, additional staff is utilized to ensure that each client receives assistance or a call-back in a timely manner. The SLAAA/ADRC will also look into an automated system that directs people to the appropriate staff/service.

The SHIP marketing strategies to reach underserved consumers, such as dual eligible consumers with mental illness and consumers in underserved counties follow. The SLAAA/ADRC outreach events allow the SLAAA/ADRC to reach more beneficiaries who are dual eligible with mental illness and consumers in underserved areas. Health fairs and presentation are scheduled on a monthly basis and are attended by a variety of consumers. Clients who are under the age of 65 are being educated on Medicare and Medicaid before they become eligible. The SLAAA/ADRC will continue to schedule outreach events in underserved areas and where all ages are in attendance. With continuous education throughout the region, it is more likely for future beneficiaries and those in underserved areas to choose stable plans that will fit their health care and financial needs. The SLAAA/ADRC also contacts other regions to see what methods benefit their agency best. In addition, all staff screens every client they assist to match them with the appropriate services and programs. This strategy has allowed the SLAAA/ADRC to continue to find clients who are eligible for Medicaid and LIS, for example. As a result, the SLAAA/ADRC is able to assist with these applications. The SLAAA/ADRC will begin obtaining a partnership with the Department of Mental Health (DMH). A partnership with DMH would allow the agency to become more familiar with consumer with mental illnesses within the region. As a result, the SLAAA/ADRC will be able to assist clients with mental illnesses more frequently.

The timeframe for filling the position of a SHIP Coordinator is either immediate or within a 3 month timeframe. Since the SLAAA/ADRC is an ADRC in theory all staff are cross trained. If needed, a primary backup has been identified to support the program if a vacancy occurs.

The current protocol in place to ensure that SHIP and SMP funding is not being used to fund programs outside of SHIP and SMP areas include SLAAA/ADRC staff only charging work time to SHIP and SMP when functions are being performed in these programs. If SHIP and SMP functions are not taking place, these accounts are not being charged. In addition, the SLAAA/ADRC Director reviews all timesheets before submitting them to finance to ensure accuracy. The SLRCOG finance department then reviews timesheets to ensure that all the SLAAA/ADRC staff is correctly charging to the appropriate account(s). If time is charged to programs incorrectly, adjustments are then made.

The SLAAA/ADRC's current process for reviewing SHIP talk data for integrity and quality is completed by the SLAAA/ADRC SHIP Coordinator. The SHIP Coordinator periodically performs quality assurance reviews on random client files to ensure integrity and accurate client information. If issues are found, training takes place immediately to ensure mistakes do not continue. In addition, SC ACCESS update training is provided to ensure all SLAAA/ADRC staff on an annual basis to ensure data is being placed into the database in a timely and accurate manner.

Please see Appendix E (SHIP report)

Please see Appendix F (SMP report)

E. Family Caregiver Support Program

One of the SLAAA/ADRC FCSP long term goals is to have a caregiver support group within each of its four-county area. The FCSP Advocate will invite speakers from different community and state organizations, respite facilities, etc. These meetings will provide support to caregivers and grandparents/relatives raising children, as well as connect them with agencies and services. A weakness in attaining this goal is convincing the caregivers that they have within themselves the ability to facilitate these meetings. The goal is to have the caregivers manage the support group once it has been established. The FCSP Advocate should not always have to be in attendance.

Another goal of the FCSP is to improve the quality and availability of information and services to caregivers. A weakness in attaining this goal is a lack of self-confidence on the caregiver's part. Much of what they call the FCSP Advocate for can be done on their own.

A third goal is to ensure evacuation plans are in place in the home in the event of an emergency or other disaster. A weakness in attaining this goal is the lack of awareness on the caregiver's part of needing to have evacuation plans in place.

A major strength of the FCSP pertaining to the Grandparents/Relatives Raising Children is supplemental services. The FCSP addresses the needs of grandparents and children by

purchasing clothes, school supplies, tutoring, after school care, and summer camp for the children.

A major strength of the FCSP for caregivers is respite. Respite allows the caregiver to take a break from their daily routine to rejuvenate and strengthen themselves.

The SLAAA/ADRC FCSP procedures that are in place to effectively provide caregiver services within the region are as follows:

- receives request for assistance;
- FCSP Advocate telephones caregiver or grandparent/relatives raising children, explains the program, and sets up an appointment to conduct an in-home assessment; occasionally FCSP Advocate takes assessments over the telephone;
- in the home, FCSP Advocate explains the program again; describes respite and supplemental services; conducts risk assessment of the home; completes the FCSP Assessment form; obtains signatures on Income Statement and Permission and Release of Liability forms; and explains respite timesheets;
- Data Entry Clerk or FCSP Advocate enters the assessment information into Advanced Information Manager (AIM) and SC Access;
- A priority score is generated from AIM and the SLAAA/ADRC FCSP Aging Priority Risk Rating tool to determine eligibility (caregivers only);

- If the request is for respite services, the FCSP Advocate sends the caregiver a Respite Timesheet (with W-9) or Reimbursement Respite form;
- Once FCSP Advocate receives completed forms, FCSP Advocate completes a Request for Payment Respite Services form, obtains signature from AAA Director, and sends the form to the Finance Office for processing;
- If the request is for supplemental services and/or supplies, the FCSP Advocate completes a Purchase Order Request form, obtains signatures and a Purchase Order number, and provides a copy of the form to the vendor for processing;

- FCSP Advocate files all forms by county.

Family Caregiver Support Program Components

Budget, Timeline, Outcomes, Measures, Consumer Choice, Organizations

The SLAAA/ADRC FCSP budget for fiscal year 2012 -2013 is $172,968.00. This amount is divided into four service areas. These areas are Direct Services, Supplemental Services, Grandparent/Relatives Raising Children Services, and Respite Care. The FCSP attempts to spend the total budget by the end of the fiscal year. Outcomes of the FCSP are measured by the success stories and thank you notes the SLAAA/ADRC FCSP receives from caregivers and grandparents.

Consumer choice has always been a priority within the SLAAA/ADRC region. The primary caregiver chooses the respite worker and payment plan (hourly, daily, weekly or monthly). Caregivers choose the adult day care and grandparents choose the day care facility of their choice. The FCSP Advocate assists with information on these matters if asked. The final choice is made by the caregiver. The FCSP Advocate creates and maintains valuable working relationships with numerous organizations to assist and service caregivers. The FCSP Advocate negotiates lower facility rates for caregivers.

The FCSP Advocate collaborates with several community organizations during outreach events. These organizations include Alzheimer's Association, Councils on Aging, Departments of Social Services, Departments of Disabilities and Special Needs, and Community Long Term Care. Events are held at local churches, as well as in the community. They include health fairs, bazaars, senior centers, and senior resource days. The FCSP Advocate "spreads the word" about the FCSP on a daily basis in supermarkets, churches, Bible study groups, symposiums, transportation departments, and community businesses. Also, the FCSP Advocate attends interagency and community meetings. This includes sharing information about caregivers and grandparents/relatives raising children. Outreach proves to be a valuable asset to increase awareness about the FCSP.

Eligibility Policies and Procedures

The SLAAA/ADRC FCSP's eligibility policies and procedures follow.

- Caregivers must be 18 and older.
- Care recipients must be 60 or older who require assistance with at least 2 activities of daily living and/or some cognitive impairment. The care recipient can also be a non-sibling of the caregiver aged 19-59 who has a severe disability.
- Grandparents/relatives must be 55 or older and caring for children 18 and under.

Prioritization

The SLAAA/ADRC FCSP prioritization follows.

- Caregivers with the greatest social need who live in rural areas with limited access to services.
- Older individuals providing care to individuals with severe disabilities including children with severe disabilities.
- Family caregivers who provide care for individuals with Alzheimer's disease and related disorders.
- Grandparents/Relatives Raising Children who provide care for children with severe disabilities.
- Caregivers who are 65 or older.
- Care receivers who are 80 or older.

- Caregivers or care receivers who were recently hospitalized or scheduled for hospitalization.
- Care receivers who live alone.
- Caregivers stress level (assessed by the Zarit stress test).

Categories of Services (5)

1. Outreach and Information to Caregivers About Available Services

The FCSP Advocate collaborates with several community organizations during outreach events. These organizations include Alzheimer's Association, Councils on Aging, Departments of Social Services, Departments of Disabilities and Special Needs, and Community Long Term Care. Events are held at local churches, as well as in the community. They include health fairs, bazaars, senior centers, and senior resource days. The FCSP Advocate "spreads the word" about the FCSP on a daily basis in supermarkets, churches, Bible study groups, symposiums, transportation departments, and community businesses. Also, the FCSP Advocate attends interagency and community meetings. This includes sharing information about caregivers and grandparents/relatives raising children. Outreach proves to be a valuable asset to increase awareness about the FCSP.

2. Assistance to Caregivers in Gaining Access to Services

The SLAAA/ADRC FCSP is a "hands-on" program. Due to the accessibility to the FCSP Advocate, the SLAAA/ADRC FCSP is able to create a variety of innovative approaches tailored to the specific needs of the caregiver and her/his family. Assistance with prescribed medications, ramps, and minor housing repairs are some of the examples that have proven invaluable. The FCSP Advocate assists with minor home inspections and safety tips, fall prevention in the home, how to hire a respite worker, reducing stress, nutrition, and care giving. The SLAAA/ADRC FCSP maintains a lending library for caregivers and grandparents/relatives raising children. The FCSP Advocate also mails flyers to caregivers and grandparents/relatives raising children informing them of local events. In addition, the FCSP Advocate maintains a respite worker/sitter list for caregivers. Also, the FCSP Advocate frequently conducts home visits while in the area, especially for long-distance caregivers. Lastly, the FCSP Advocate provides assistance to caregivers, respite workers, social workers, nursing care facilities, adult day care centers, home health care services, hospices and suppliers over the telephone to better serve caregivers in the region.

3. Individual Counseling, Organization of Support Groups, and Caregiver Training

The SLAAA/ADRC FCSP currently has two support groups, one caregiver support group and one grandparents/relatives raising children support group. The SLAAA/ADRC FCSP

plans to establish a support group in each county in the region. The SLAAA/ADRC FCSP invites speakers from different community and state organizations, respite facilities, etc., to these meetings. Thus, the meetings provide support as well as connect caregivers and grandparents/relatives raising children with agencies and services. The goal is to have the caregivers manage the support group once it has been established. The FCSP Advocate should not always have to be in attendance.

The SLAAA/ADRC FCSP receives referrals from the schools, First Steps, Social Workers, Adult Education, the Parents as Teachers Program, and other grandparents. The FCSP partners with the Sumter School District and meets monthly during the school year. These meetings address issues on crime, bullying, grades, homework, cooking classes, arts and crafts, how to have your grandchild succeed, texting, etc. The FCSP has speakers from the police department, Clemson Extension, YMCA, Kool Smiles (dental care), tutors, and AARP. The FCSP gives grandparents a "Day of Respite" by taking the children bowling or roller skating. The FCSP provides grandparents with clothes, school supplies, tutoring, and summer camp for the children. The FCSP looks to expand the grandparents/relatives raising children program by partnering with local churches for summer programs. This partnership helps address the challenge of raising grandchildren.

The SLAAA/ADRC FCSP conducts both formal and informal training and education. The FCSP Advocate conducts trainings and provides educational materials in the comfort of the caregivers' home, over the telephone, or inside facilities. The FCSP Advocate conducts trainings on communication techniques, death and dying, stress, and Alzheimer's disease.

Each year in November (National Family Caregiver Month) the FCSP hosts a "Lunch and Learn" for caregivers and grandparents/relatives raising children. Guest speakers have been from the Federation of the Blind, Community Long Term Care, Hospices, durable supplies companies, respite facilities, adult day care centers, summer camps, Alzheimer's Association, social workers, hospitals, Medicare/Medicaid, nursing homes and assisted living facilities, Red Cross, Social Security, First Steps, Head Start, medical alert companies, Department of Social Services, Elementary and College school systems, Councils on Aging, Departments of Disabilities, and Special Needs, Adult Education, lawyers, funeral directors, AARP, and the SLAAA/ADRC LTC Ombudsman program. The FCSP also utilizes panel discussions at these "Lunch and Learns."

The SLAAA/ADRC FCSP Advocate is a certified Arthritis Exercise Instructor and teaches exercises to caregivers and grandparents/relatives raising children.

4. Respite Care

The SLAAA/ADRC FCSP provides caregivers respite relief from their responsibilities. Respite is an essential part of the overall support that families need when they are raising

grandchildren or taking care of someone with a chronic illness or dementia at home. The FCSP provides $500 for home respite, institutional respite, adult day care, emergency respite, child day care, and after school and summer programs to caregivers and grandparents/relatives raising children.

5. Supplemental Services

The SLAAA/ADRC FCSP purchases nutritional supplements, incontinence supplies, assistive technology devices, used washers and dryers, clothes, high rise commodes, and school supplies. Home modifications include air conditioners, ceiling fans, hand held showers, railings, and ramps. The FCSP also purchases Alzheimer's ID bracelets and door alarms. The FCSP obtains supplies that are identified by the caregiver to make it easier for them to assist and care for their loved one.

Gaps

The SLAAA/ADRC FCSP identifies the following gaps.

Funding for Respite

The FCSP Advocate intends to obtain approval from the FCSP Advisory Committee to increase respite from $500 to $700 per fiscal year.

Formalized Caregiver Training Program

The FCSP Advocate will ensure new caregivers receive training on transfer techniques, disease education management, range of motion, and supportive techniques for bed bound individuals.

Partnerships

The SLAAA/ADRC FCSP currently partners with the Sumter School District and First Steps. The FCSP looks to expand the grandparents/relative raising children program by partnering with local churches for summer programs. The FCSP Advocate collaborates with several community organizations during outreach events. These organizations include Alzheimer's Association, Councils on Aging, Departments of Social Services, Departments of Disabilities and Special Needs, and Community Long Term Care. The FCSP Advocate "spreads the word" about the FCSP on a daily basis in supermarkets, churches, Bible study groups, symposiums, transportation departments, and community businesses. Also, the FCSP Advocate attends interagency and community meetings. This includes sharing information about caregivers and grandparents/relatives raising children. Outreach proves to be a valuable asset to increase awareness about the FCSP.

New Ways for Caregivers to Access Information and Services

New ways caregivers can access information and services provided by the SLAAA/ADRC FCSP include the internet, hospitals, and faith based communities.

Reimbursement Model and Consumer Choice

The SLAAA/ADRC FCSP's current reimbursement model allows for consumer choice. Consumer choice has always been a priority within the SLAAA/ADRC region. The primary caregiver chooses the respite worker and payment plan (hourly, daily, weekly or monthly). Caregivers choose the adult day care and grandparents choose the day care facility of their choice. The FCSP Advocate assists with information on these matters if asked. The final choice is made by the caregiver. The FCSP Advocate creates and maintains valuable working relationships with numerous organizations to assist and service caregivers. The FCSP Advocate negotiates lower facility rates for caregivers.

Identify and Serve Higher Number of OAA Designated Priority Group Individuals

The SLAAA/ADRC FCSP will utilize census data to identify and serve more individuals in OAA designated priority groups.

How Basic Caregiver Services are Made Available

The SLAAA/ADRC FCSP Advocate places ads in the local newspapers; leaves brochures in senior housing complexes and doctors' offices; and provides information at community health fairs and faith based events.

See Appendix G (Family Caregiver Report)

See Appendix K (Family Caregiver Support Budget)

See Appendix I (Family Caregiver Goals and Objectives)

F. Disease Prevention/Health Promotion

The SLAAA/ADRC will assist in the coordination of Disease Prevention and Health Promotion Services with other community agencies and volunteer organizations with similar program goals throughout the four year duration of the Area Plan. The assistance will be in the form of promoting the program, assisting in providing prospective participants, advertisement and technical assistance.

The SLAAA/ADRC strives to build bridges over gap in services, and has built partnerships with other agencies that provide similar services to the same targeted population. With these partnerships, the SLAAA/ADRC will assist contractor/providers in coordinating disease prevention and health promotion (DP/HP). With the current partnerships, the SLAAA/ADRC has a deeper understanding of other agencies/organizations and the services they have to offer clients. The SLAAA/ADRC will continue to outreach to those agencies and organizations that may benefit our targeted population.

VII. Changing Demographic Impact on AAAs/ADRCs Efforts

A. Intervention vs. Prevention

The senior age group (retiree) in-migration is projected to be strong in the state and especially strong in the Santee-Lynches Region. The relocation of large numbers of retirees to South Carolina is basically an economic plus, especially in certain portions of the state. The Santee-Lynches Region can be a very attractive area for retirees. Kershaw County (Camden) is just minutes from the state capital of Columbia. Clarendon County has an attractive retirement community called Wyboo located on Lake Marion. Sumter County is home to Shaw Air Force Base, where a number of military retirees have, and will continue to, retire. Lee County is attractive for retires looking for a rural community in which to retire. It is projected that retirees will continue to retire in this region which will be an economic plus.

Projections indicate an additional 1.2 million seniors will either turn 60 in the next few years or migrate to South Carolina. Retirees, along with the indigenous population, will affect the demographics in the region immensely. Organizations and communities have to realize that funds at the federal level and State are considered seed money. Federal funding continues to decrease while state funding continues on an upward trend. Systems must be developed to create and generate additional resources to continue/maintain present levels of services. The SLAAA/ADRC will attempt to develop a fee-for-services/private option within its Service Delivery Area (SDA). These options can be targeted in the areas of the region where seniors can, and are willing to, pay for services. The funds obtained from this service will be placed back into the system to continue to support those seniors that are unable to pay for services.

The SLAAA/ADRC's role in intervention vs. prevention will be to assist in areas such as long-term care planning, pre-retirement education, community awareness and staff and contractor training. This is needed in order to redirect efforts toward raising awareness of available resources, choosing prevention, and reducing dependence on government funded services. All of the aforementioned areas can be addressed by taking a proactive vs. reactive role by the SLAAA/ADRC. Baby boomers are more educated than other recent generations of retirees. The SLAAA/ADRC will develop systems to address these areas through advocacy, advertisement and community involvement. It is with great hope that the SLAAA/ADRC can play a major role in assisting seniors (especially recent retirees) in this endeavor.

B. Senior Center Development and Increased Use

The SLAAA/ADRC nutrition program has continued the trend of declining participation in the Group Dining program since 2009-10. The decrease in meals can be attributed to the reduction of available resources and possibly the lack of group dining activities. Even though the senior population continues to increase there is not much attraction to group dining sites or multipurpose senior centers in the region. Again, many factors can be attributed to the declining participation. If trends continue there may not be a need for a multipurpose senior center in the region in the next ten (10) years. Senior centers must create activities and functions that attract the entire community, especially seniors. One of the major stigmas that have to be addressed to attract others is the perception that group dining sites and multipurpose senior centers are for the poor and minorities.

The SLAAA/ADRC will assist all senior centers in continuing to be focal points. The SLAAA/ADRC will promote the development of senior centers throughout the region as well as encouraging modernization of existing senior centers to make them more attractive to all seniors and a place where seniors want to go.

The SLAAA/ADRC will assist with focusing on senior centers and current aging operations in the region to improve the sustainability of the senior center as a community focal point. The agency will also assist with increasing access for more seniors. The SLAAA/ADRC will assist with locating and researching best practices in other areas of the state that run successful and marketable senior centers. The SLAAA/ADRC as a whole will encourage the change in the image of the traditional senior center as only a place for minorities and the poor. Today's seniors want more activities to participate in and they want choices and input into the programming. Senior Centers can enhance its role as a community focal point by promoting awareness, training, knowledge and resourcefulness. The SLAAA/ADRC will encourage the adoption of best practices base on the NCOA model to the provider/contractors by assisting in marketing the senior centers and their programs.

The SLAAA/ADRC will continue to provide assistance to its senior centers by assisting in the development of programs that are appropriate for seniors and by offering a choice of activities. The SLAAA/ADRC will continue visits to senior centers and nutrition sites to work directly with contractor's staff to encourage them to embrace the value of programming for their seniors. The SLAAA/ADRC will provide technical assistance to aging service contractor's providers in the Santee-Lynches region.

The SLAAA/ADRC encourages its providers/contractors to submit PIP applications to enhance the senior centers. Currently, Sumter Senior Services recently, completed upgrades to its senior center through a PIP grant. The SLAAA/ADRC reviews all

invoices and approves payment as it relates to PIP. Providers/contractors are aware that they have to be fully active senior center for the twenty years of the State reversionary period.

C. Alzheimer's Disease

The SLAAA/ADRC FCSP Advocate works closely with the Alzheimer's Association. The Advocate uses the Association as a referral and vice versa. The relationship is built on the premise of providing all possible resources for caregivers within the region.

The FCSP Advocate gives presentations on the FCSP at Alzheimer's Support Group meetings. The FCSP Advocate also provides trainings on communication, dementia dialogues, stress, arthritis exercises, and picking your battles. The trainings greatly improve the relationship between the two programs. The FCSP supports mainly the caregiver, and the Alzheimer's Association supports the care receiver.

Currently, the SLAAA/ADRC has no contract with service delivery agencies to address the need to offer service to those with Alzheimer's disease or their caregivers. It is with great hope that additional resources can be obtained through the Alzheimer's Association next fiscal year to assist with providing vouchers to caregivers who care for loved ones with Alzheimer's Association. This partnership would increase opportunities for respite for those caregivers.

Also, through the LGOA, the Alzheimer's Resource Coordination Center (ARCC) was created through state legislation in April of 1994. The center is housed in the Lieutenant Governor's Office on Aging and was created to provide statewide coordination, service system development, information and referral, and caregiver support services to individuals with Alzheimer's disease and related disorders, their families, and caregivers. Legislation directs the center to:

- Initiate the development of systems which coordinate the delivery of programs and services;

- Facilitate the coordination and integration of research, program development, planning and quality assurance;

- Identify potential users of services and gaps in the service delivery system and expand methods and resources to enhance statewide services;

- Serve as a resource for education, research and training and provide information and referral services;

- Provide technical assistance for the development of support groups and other local initiatives to serve individuals, families and caregivers;

- Recommend public policy concerning Alzheimer's disease and related disorders to state policymakers; and

- Submit an annual report to the Joint Legislative Committee on Aging and to the General Assembly.

The ARCC Advisory Council is composed of Governor appointed members and is comprised of persons from agencies and organizations that have a special interest in Alzheimer's disease and related dementias. The Advisory Council assists in reviewing grant applications and conducting site visits to the ARCC grantees.

To assist local communities in developing or strengthening programs or services to serve people with dementia and their caregivers, the ARCC awards seed grants to community organizations. In awarding grants, consideration is given to recommendations made by the advisory council to the center on priority needs and criteria for selecting grant recipients. As a condition to receiving a grant, the community or other entity must provide matching funds or in-kind contributions equal to the amount of funds awarded in the grant.

The center maintains resource materials, such as training videos and resource books on Alzheimer's disease and related dementias, which are available for use by entities serving persons with Alzheimer's disease and/or their caregivers. Technical assistance and training is provided through the center.

Grants awarded through the center assist local communities in developing programs to serve persons with dementia and their caregivers.

Lastly, the SLAAA/ADRC Director served on the Purple Ribbon Task Force. The AAA has been identified as the lead organization on several of the recommendations. The many functions of the AAA include: planning; program coordination; program development; and resource development. The function of the ADRC is a “one stop” resource center for the aging and disabilities community. For the AAA to address the needs of people with Alzheimer’s and their families there must be full support at the state and national level. Currently, the AAA, through Information and Referral and the FCSP, has the capacity to provide information about services and organizations. The following are the recommendations that involved all the AAA’s identified by the task force and how the SLAAA/ADRC addressed those recommendations:

Recommendation #1: Create a single point of entry for persons seeking assistance with Alzheimer's related needs utilizing a toll free number through the Lt. Governor's Office on Aging.

Plan: Recommendation #1 will be addressed through I&R/A and the ADRC. With additional resources, a staff will be assigned specifically to the Alzheimer's contact for information and services.

Recommendation #2: Provide appropriate referrals for hospice care for people with Alzheimer's disease and aftercare for the caregivers of persons with ADRD.

Plan: Recommendation #2 will be addressed by I&R/A/ADRC, giving all referrals to the FCSP Advocate.

Recommendation #9: Promote and support the use of home and community based services that enable families and caregivers to have the option to care for their loved ones with ADRD at home, allowing them to age in place for as long as practicable.

Plan: Recommendation #9 will be addressed by ensuring the "most in need" are being served. The AAA will also advocate for additional funding to help ensure people with Alzheimer's disease have the required resources.

Recommendation #10: Provide case management and person centered support services to persons with Alzheimer's disease and related disorders (ADRD) and their caregivers through a local/regional provider network.

Plan: Recommendation #10 will be addressed by providing a Case Manager at the AAA level.

Recommendation #13: Conduct focus groups across the state with professionals and consumers, to include caregivers, as well as those with early stage Alzheimer's disease, to determine service needs and recommend system changes.

Plan: Recommendation #13: The FCSP Advocate will develop and oversee an Alzheimer's support group so information about the disease can be shared.

The SLAAA/ADRC awaits further guidance and supports to address all other recommendations identified in the plan.

D. Legal Assistance

The SLAAA/ADRC region continues to have a need for legal assistance since it is one of the poorest and most rural regions statewide. The SLAAA/ADRC receives calls from seniors and people with disabilities as it pertains to its Title III B program. Because of age requirements, those individuals that are less than 60 are referred to other legal resources in the region/state by staff.

In the past, the SLAAA/ADRC sponsored legal forums in each of its four counties once a year. During these sessions individuals had access to a local attorney who provided information and answered questions. The majority of the forums were held at the local meal site where seniors congregate. Planned topics discussed included Last Will & Testament; Advanced Directives; Durable Power of Attorney; Probate Issues; Trusts; Medicaid Estate Recovery; Guardianship/Conservatorship; Medicare Part D; Fraud; and Reversed mortgage.

Currently, the Santee-Lynches AAA/ADRC utilizes a client-directed method in its usage of legal funding under III B. Clients identify and acquire the attorney used for their particular legal matter. The SLAAA/ADRC enters into a Memorandum of Understanding with the identified attorney, outlining parameters of the agreement, and awaits the client's call informing the SLAAA/ADRC of completion of the desired service. Once the service is completed, the SLAAA/ADRC pays the attorney.

Legal assistance is marketed in the region through both the Models Approached to Legal Services (MALS) and IIIB. The program is marketed with the use of flyers, newspapers, word of mouth and partnerships throughout the region/state.

The SLAAA/ADRC plans to enter into contract with the S.C. Legal Services, Incorporated (SCLS) to meet requirements for legal assistance in the region. Specifically, the SLAAA/ADRC will ensure that OAA Section 307(a) (11) (A to E) requirements are met as outlined below. In addition, the SLAAA/ADRC will require SCLS to provide documentation that shows priority was given to legal assistance as noted in OAA Section 307(a)(11)(E).

307(a) (11) (A) (i) and (ii)

SCLS is the South Carolina grantee of the U.S. Legal Services Corporation (USLSC) funding. As such, they must possess the experience and capacity to deliver legal assistance as required in the USLSC Act. In addition, as a grantee of USLSC funding, SCLS are held to USLSC restrictions and regulations.

307(a) (11) (A) (iii)

The SLAAA/ADRC works with, and plans to continue to work with, the S.C. Bar Association (Bar). The Bar is comprised of more than 14,000 lawyers throughout the State. These attorneys specialize in a variety of areas. The Bar sponsors free events that focus on the types of legal assistance about which SLAAA/ADRC clients inquire. These include landlord/tenant issues, wills, and probate issues. Additionally, the Bar has a pro bono aspect whereby attorneys provide legal assistance free of charge to individuals who cannot afford to pay.

307(a) (11) (B)

Utilizing SCLS (a grantee of USLSC) assures the SLAAA/ADRC that legal assistance will be provided to older individuals with social or economic need. One of the declarations in the USLSC Act stipulates "providing legal assistance to those who face an economic barrier to adequate counsel…"

307(a) (11) (C)

The SLAAA/ADRC will seek advice and technical assistance from the LGOA as needed. The SLAAA/ADRC staff will also attend legal assistance trainings as scheduled. In addition, the SLAAA/ADRC will keep the LGOA informed on legal service activity in the region and provide reports as requested.

307(a) (11) (D)

The SLAAA/ADRC will remain watchful for legal services funding sources other than that provided under the OAA. The SLAAA/ADRC will also remain accountable for the existing levels of legal assistance funding by maintaining up-to-date, accurate records. In addition, the SLAAA/ADRC will utilize Model Approaches to Legal Services (MALS) funding in a manner that allows III B legal services funds to do more. For example, the SLAAA/ADRC utilizes the S.C. Bar Association (Bar) to conduct legal "clinics" on such topics as wills, estate planning, and probate issues. Additionally, the Bar conducts clinics on "end of life issues" for the SLAAA/ADRC. The SLAAA/ADRC utilizes MALS funding to set up these clinics. The information seniors obtain from these clinics minimizes the amount of time spent with an attorney using III B funds. In addition, the SLAAA/ADRC utilized MALS funds to produce a comprehensive Elder Rights booklet. This booklet serves as a guide for seniors in the region. It not only contains a wealth of information on a wide variety of senior-related topics; but it also gives contact information for respective agencies. Again, arming seniors with this type of information and contacts minimizes the amount of time needed in an attorney's office utilizing III(B) funds.

307(a) (11) (E)

The SLAAA/ADRC will incorporate language into the contract with SCLS to ensure priority is given to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. The SLAAA/ADRC will also require SCLS to provide documentation that shows priority was given to same.

The SLAAA/ADRC uses OAA priorities to establish its objectives for targeting appropriate populations for legal assistance. These priorities include older individuals with the greatest economic and social needs (low-income older individuals, low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals at risk for institutional placement; and Indian populations.

The SLAAA/ADRC's plan to achieve established objectives includes utilizing agency (intra-agency as well as inter-agency) and community resources. SLAAA/ADRC staff promotes the legal assistance program, along with the agency's other programs, at community activities and events. In addition, SLAAA/ADRC staff attends monthly inter-agency meetings and promote the legal assistance program. The SLAAA/ADRC also utilizes local, county newspapers to promote the program. In addition, the SLAAA/ADRC uses its service providers to promote the legal assistance program—both by sending materials into the homes of clients, as well as posting flyers in the senior centers. Lastly, the SLAAA/ADRC utilizes its LTC Ombudsman to promote the legal assistance program within facility settings.

The SLAAA/ADRC maintains records of all activity with legal service clients. This provides a tangible mechanism by which objectives can be measured and by which reports can be produced and/or verified.

The SLAAA/ADRC works with, and plans to continue to work with, the S.C. Bar Association (Bar) to achieve established objectives. The Bar is comprised of more than 14,000 lawyers throughout the State. These attorneys specialize in a variety of areas. The Bar sponsors free events that focus on the types of legal assistance about which SLAAA/ADRC clients inquire. These include landlord/tenant issues, wills, and probate issues. Additionally, the Bar has a pro bono aspect whereby attorneys provide legal assistance free of charge to individuals who cannot afford to pay. The SLAAA/ADRC shall attempt to involve the private bar in legal assistance activities, including groups within the private bar who provide services to older individuals on a pro bono and reduced fee basis.

In the future, the SLAAA/ADRC shall enter into contracts with legal assistance providers who can demonstrate the experience or capacity to deliver legal assistance. Contracts

shall include provisions to assure that any recipient of funds will be subject to the same restrictions and regulations established under the Legal Services Corporation Act (with the exception of the restrictions and regulations regarding eligibility for legal assistance under the Legal Services Corporation Act and governing membership of local governing boards). This procedure cannot be implemented until the SLAAA/ADRC goes out on procurement. The SLAAA/ADRC will continue to use funds from MALS to leverage III B legal services in the region.

VIII. Region Specific Initiatives

The SLAAA/ADRC participates in several innovative events and partnerships to better serve the intended population within the region. Innovative events and partnerships include: Assisted Rides Program, Case Management, Central Carolina Technical College (CCTC), contractor resources, Family Caregiver Support Program, Friendly Visitors Program, media outlets, Managed Care, and the Veterans Directed Home Based Services program.

Assisted Rides Program (ARP)

The SLAAA/ADRC Assisted Rides Program (ARP) engages in community fundraising on a regular basis. All donations collected from each fundraising event are strictly used for the sustainability of the Assisted Rides Program. These events are designed to introduce the community to volunteer opportunities as well as program support. In 2012, the Assisted Rides Program coordinated a pancake breakfast through Applebee's restaurant. This event generated $1,074.08 to utilize for future driver incentives, mileage reimbursements, training, etc.

Case Management

The purpose of case management was to ensure that clients receive appropriate services through a process of comprehensive, ongoing assessment and coordination of resources. The SLAAA/ADRC started its care management system in July 2008 in Clarendon County. The philosophy surrounding this decision was based on an opportunity to provide the following at the AAA/ADRC level:

- Comprehensive face-to-face assessment of client needs;
- Development of care plans and periodic updates;
- Coordination of services received from multiple providers;
- Ongoing monitoring of client's condition; and
- Face-to-face reassessment and changes in services as warranted.

While case management is an authorized function of the OAA in South Carolina, it is not a practical activity due to budgetary restrictions (limited funding). Effective July 1, 2013 case management will no longer be a function of the SLAAA/ADRC. The SLAAA/ADRC has decided to allow its contractors to conduct the assessment and deliver the service. The SLAAA/ADRC will implement a process that allows for the selection of the client.

Central Carolina Technical College (CCTC)

SLAAA/ADRC's partnership with CCTC has enabled the agency to obtain knowledgeable students, who are majoring in Human Services and other related fields to complete their internship at the SLAAA/ADRC each semester. Interns assist staff with AAA/ADRC functions and attend outreach events/presentations to obtain in-depth experience, as well as an education of the actual work setting within the Human Services field.

Contractor Resources

Through the SLAAA/ADRC Consumer Directed Cost Sharing Pilot Program, the agency was able to obtain contractor relationships as an additional resource to utilize when other community resources are exhausted. Although the cost sharing program has ended, the partnerships gained with contractors throughout the region are still utilized to assist clients with their minor home repair needs at a reasonable cost.

Family Caregiver Support Program

The SLAAA/ADRC Family Caregiver Support program offers both caregivers and grandparents raising grandchildren educational and eventful group meetings. The SLAAA/ADRC caregiver support group meetings include the following organizational speakers, topics, and events:

- Police Department;
- Nutritionist;
- Alzheimer's Association;
- Long-term care Ombudsman;
- Arthritis exercise class;
- Dementia dialogue class;
- Class on end of life issues; and
- Lunch and learn annual event.

The SLAAA/ADRC grandparent's group meetings include the following organizational speakers, topics, and events:

- Police Department;
- Nutritionist;
- Clemson Extension Program;
- Arts and crafts;
- Texting 101;
- Games (i.e. brain teasers and bingo); and
- Brunches.

The SLAAA/ADRC Family Caregiver Support program also offers opportunities for arthritis exercise.

Managed Care

The South Carolina Dual Eligible Demonstration Project provides the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid to work in a single system. Through the shared savings, the State will be able to focus on preventative services and on delaying or eliminating the need for more costly institutional care. The SLAAA/ADRC, along with other AAA/ADRC's, has been approached by at least two (2) Managed Care Organizations as it relates to establishing a partnership for the delivery and collaboration of home and community based services through managed care. This is truly an opportunity for all AAA/ADR's to generate a revenue stream other than that which is provided by OAA and State funds.

Friendly Visitors Program

One of the major highlights of the SLAAA/ADRC's Friendly Visitor Program this fiscal year is the recruitment of a Volunteer Friendly Visitor Program Coordinator. Already, the Coordinator has taken two individuals through the certification process to the point of training. Another highlight of the SLAAA/ADRC Friendly Visitor Program is the partnering with one of the counties' Housing Authority for volunteer referrals. The SLAAA/ADRC looks forward to guiding many volunteers through the entire certification process and placed in facilities. This will greatly fill a social gap for residents. It will also increase the number of friendly visits to residents, thereby fulfilling a federal requirement.

Media Outlets

"Good Morning Sumter" is the ongoing Public Affairs Program on WDXY 1240 AM & 105.9 FM, hosted by Derek Burress. The SLAAA/ADRC's partnership with Derek Burress allows the agency to advertise programs and events that are taking place throughout the region. Broadcasting reaches Sumter, Lee, Clarendon, and parts of Kershaw County.

The SLAAA/ADRC Aging Director debuted on the popular television talk show "Senior Connections" to discuss all functions of the agency. This talk show is intended to improve the lives of seniors by discussing with their guests topics of importance to the senior community, their family members, and caregivers.

Veterans Directed Home Based Services (VDHBS) Program

As a component of the SLAAA/ADRC, the Veterans Directed Home and Community Based Services Program serves veterans who are able to self-direct and choose who they want as their employees. This program has been designed to help those veterans that are nursing home eligible remain in their homes independently, healthy and safe with the proper services/supports. The veteran or a designated representative would be able to hire, employ and supervise workers of their choice to provide those services such as attendant care, housekeeping, transportation and minor home modifications.

IX. Area Plan Appendices

A. PSA and AAA/ADRC Organizational Structure

B. Regional Needs Assessment

C. Long Term Care Ombudsman Service Report

D. Information and Referral/ Assistance (I&R/A) Report

E. Ship Midterm Report

F. SMP Report

G. Family Caregiver Report

H. All Required Documents

I. Goals and Objectives

J. Santee-Lynches Regional Aging Advisory Committee BY-LAWS

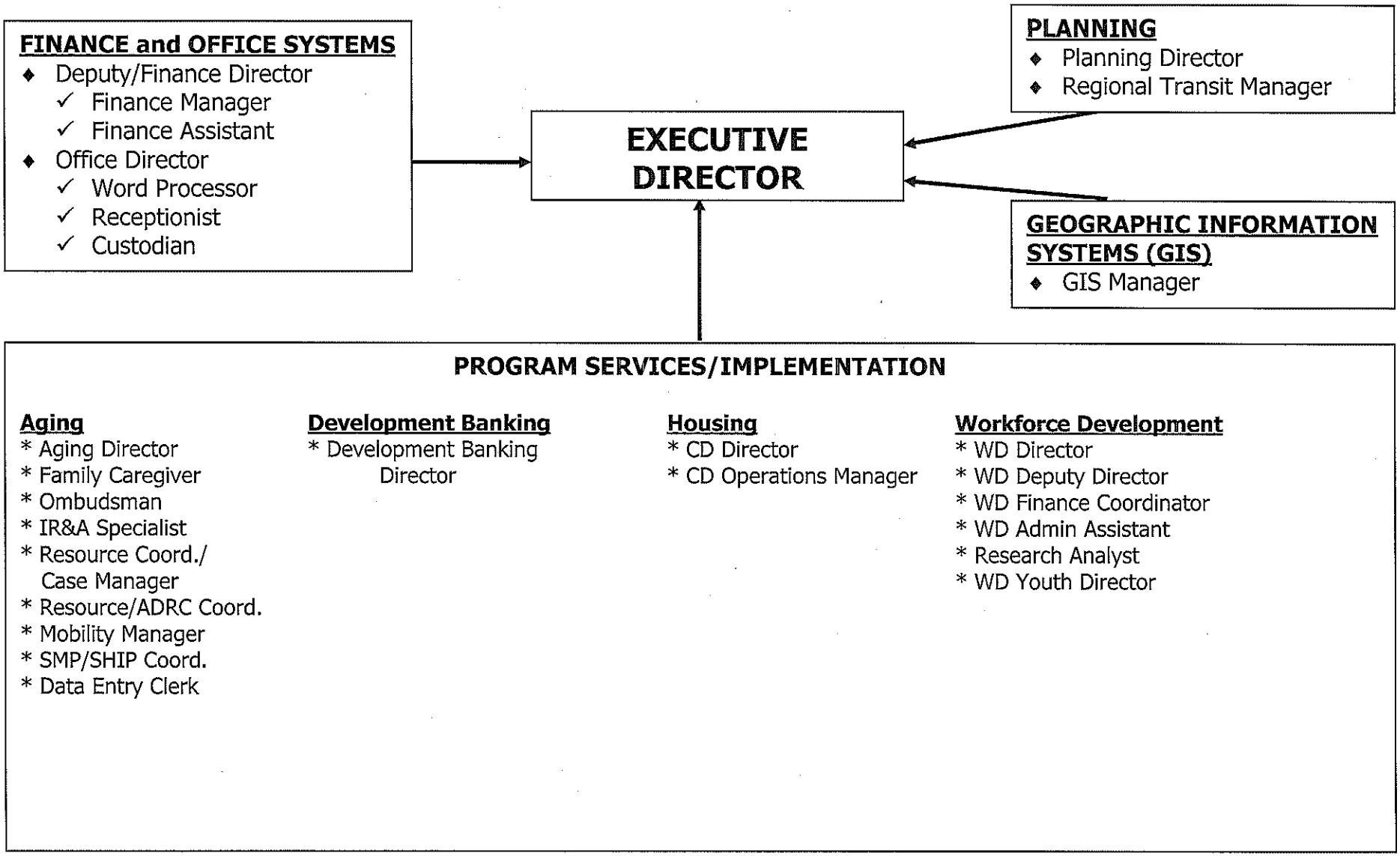
K. Santee-Lynches ADRC Newsletter

L. Santee-Lynches AAA/ADRC Policy and Procedures for Client Administration (Draft)

M. QA Monitoring Form

N. RFP Evaluation factors and Summary of Certifications and Organizational Info

SANTEE-LYNCHES RCOG STAFF POSITIONS
February 2013



FINDINGS: REGION 6 – SANTEE-LYNCHES

Representation of the Population

A total of 438 surveys were completed in Region 6. Respondents were asked a series of questions to determine if the respondent is a senior receiving services, a senior not receiving services, a caregiver, or an individual with a disability (the ARDC target population). These categories are not mutually exclusive and an individual could fall into more than one of these categories or none at all. Of the 438 surveys completed, 373 (85.2%) were categorized as a senior receiving services, 41 (9.4%) were categorized as a senior not receiving services, 121 (27.6%) were categorized as being a caregiver, and 316 (72.1%) were categorized as an individual with a disability.

For Region 6, the confidence interval for the sample of seniors receiving services is 4.96 points at a 95% confidence level assuming 50% agreement on the item in question. For items where there is greater agreement, the likelihood that the responses are representative of the population increases. Therefore, there is a relatively high probability that the findings represent the responses that can be expected from seniors receiving services (plus or minus 4.96 percentage points). The confidence interval for seniors not receiving services is higher (15.3 points at a 95% confidence level assuming 50% agreement), which indicates the sample of these seniors is not representative of the population of seniors not receiving services. The representation of caregivers is acceptable (7.2 points at a 95% confidence level assuming 50% agreement), and the representation of individuals with a disability who have received services through the ADRC is good (4.85 points at a 95% confidence level assuming 50% agreement). (See Table 6-1.)

TABLE 6-1: SAMPLE REPRESENTATION OF POPULATION

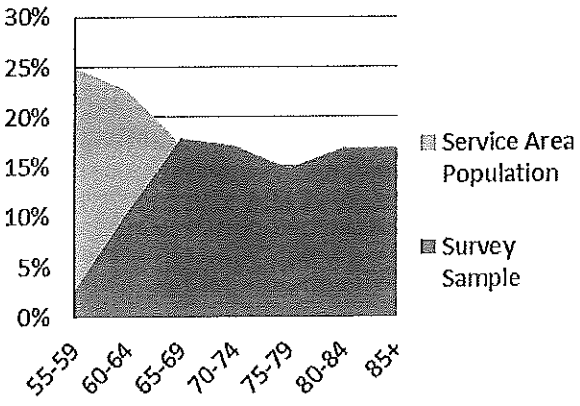
	Population Size	Sample Size	Representation
Seniors Receiving Services	8,255	373	4.96
Seniors Not Receiving Services	48,593	41	15.3
Caregivers	347	121	7.2
ADRC	1,400	316	4.85

Demographic Characteristics of Seniors

Compared to the service area senior population, the survey respondents are older. A small percentage of survey respondents are under 55 (n=13, 3.3%), 55 to 59 years old (n=10, 2.6%), or 60 to 64 years old (n=41, 10.5%), whereas 25% and 22.7% of the service area senior population is between these ages, respectively. The percentage of individuals between 65 to 69 years are similar (n=70, 17.9% of the sample and 17.3% of the population). The survey sample has higher percentages in older age groups compared to the population (ages 70 and older: n=257, 65.7% of the sample and 35.1% of the population). (See Figure 6-2.) For this reason, further population figures only include seniors ages 65 and older.

FIGURE 6-2: AGE GROUP

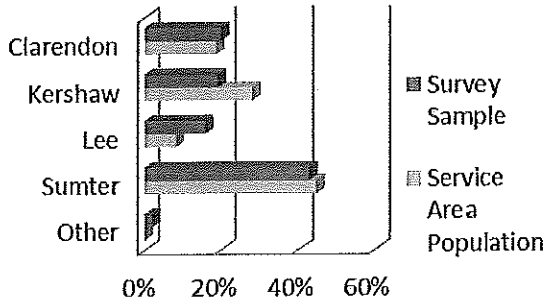
	Survey Sample	Service Area Population
Total	391	59,562
Under 55 years	3.3%	--
55 to 59 years	2.6%	25.0%
60 to 64 years	10.5%	22.7%
65 to 69 years	17.9%	17.3%
70 to 74 years	17.1%	13.1%
75 to 79 years	14.8%	9.8%
80 to 84 years	16.9%	6.4%
85 years and over	16.9%	5.9%



The proportion of the sample residing in each county is very similar to that of the population with a slightly smaller percentage of the sample residing in Kershaw (n=75, 19.2% compared to 28.2% of the service area senior population) and a slightly larger percentage of the sample residing in Lee (n=62, 15.9% compared to 8.3% of the service area senior population). (See Figure 6-3.)

FIGURE 6-3: COUNTY OF RESIDENCE

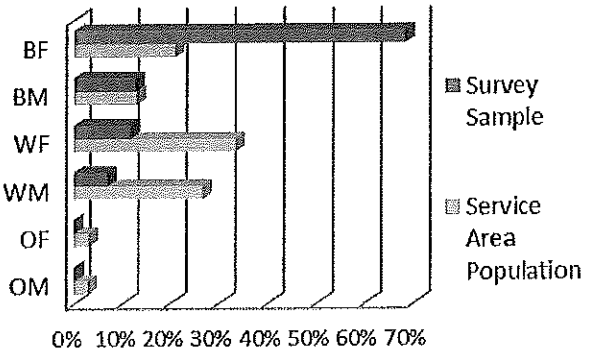
	Survey Sample	Service Area Population
Total	**390**	31,181
Clarendon	20.0%	18.8%
Kershaw	19.2%	28.2%
Lee	15.9%	8.3%
Sumter	42.8%	44.6%
Other	2.1%	---



A much larger percentage of the survey sample are African American female (n=272, 68.2%) than in the service area senior population (21%). Conversely, a smaller percentage of the survey sample are Caucasian female (n=47, 11.8%) or Caucasian male (n=28, 7%) compared to the service area senior population (33.4% and 26.6%, respectively). Approximately the same percentage of respondents are African American male (n=51, 12.8%) as the population (13%). Very few respondents were of other races (females: n=0, males: n=1, 0.3%). These populations are also relatively small in the service area senior population (other females: 3%; other males: 2.9%). (See Figure 6-4.)

FIGURE 6-4: RACE AND GENDER OF SENIORS

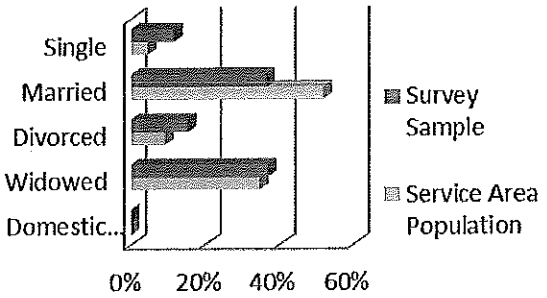
	Survey Sample	Service Area Population
Total	**399**	**31,181**
African American Female	68.2%	21.0%
African American Male	12.8%	13.0%
White Female	11.8%	33.4%
White Male	7.0%	26.6%
Other Female	0.0%	3.0%
Other Male	0.3%	2.9%



The survey sample has a slightly larger percentage of individuals who are single (n=28, 11.6%) or divorced (n=37, 15.3%) than exist in the service area senior population (4.6% and 9.2%, respectively). Conversely, there is a much smaller percentage of individuals who are married (n=88, 36.4% of the sample compared to 51.6% of the service area senior population). A fairly similar percentage of respondents are widowed (n=89, 36.8%) as are in the service area senior population (34.5%). (See Figure 6-5.)

FIGURE 6-5: MARITAL STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**242**	**29,208**
Single	11.6%	4.6%
Married*	36.4%	51.6%
Divorced*	15.3%	9.2%
Widowed	36.8%	34.5%
Domestic Partner**	0.0%	--

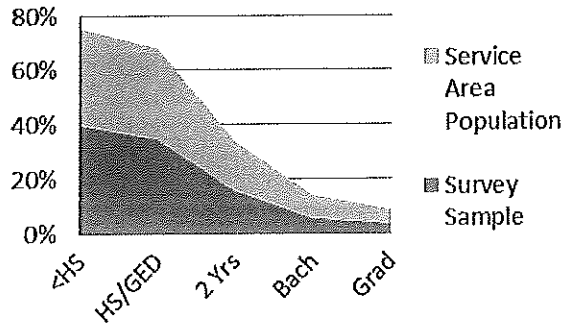


*Individuals in the service area population categorized as "Married, spouse absent, not separated" were excluded from the counts.
**Individuals who are in a domestic partnership were not included in the population counts as the Census does not include this category in the marital status calculation. Inclusion of this category in the population counts could lead to a duplication of individuals currently classified as single ("never married").

The level of educational attainment of the survey sample is very similar to the educational attainment of the service area senior population. The majority of respondents completed less than high school (n=163, 40%) or received a high school diploma or GED (n=142, 34.8%), compared to 35.2% and 33.4% of the service area senior population, respectively. Approximately the same percentage of the respondents (n=65, 15.9%) attended some college or earned as Associate's degree than the service area senior population (18.1%). The percentage of respondents who earned a Bachelor's degree (n=23, 5.6%) or an Advanced/Graduate degree (n=15, 3.7%) are similar to the percentage in the service area senior population (8.4% and 4.9%, respectively). (See Figure 6-6.)

FIGURE 6-6: EDUCATIONAL ATTAINMENT OF SENIORS

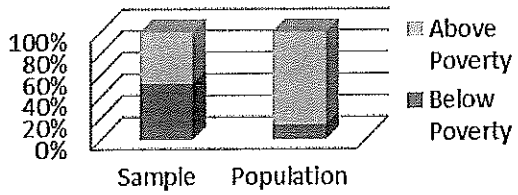
	Survey Sample	Service Area Population
Total	**408**	**29,749**
Less than high school	40.0%	35.2%
High school diploma/GED	34.8%	33.4%
Some college/Associate's	15.9%	18.1%
Bachelor's degree	5.6%	8.4%
Advanced/Graduate degree	3.7%	4.9%



In comparison to the service area senior population, respondents to the survey are estimated to more likely be below the poverty line (n=200, 52.4% compared to 13.8% of the service area senior population). (See Figure 6-7.)

FIGURE 6-7: POVERTY STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**382**	**29,074**
Below Poverty Line	52.4%	13.8%
Above Poverty Line	47.6%	86.2%



Overall, the demographic characteristics of the survey sample are not representative of the general population of seniors residing in the areas served by the AAA's. Rather, the survey sample tends to be older, single or divorced, and below the poverty line, as well as more likely to be African American and female.

Demographic Characteristics of Individuals Who Have a Disability

Only 14 survey respondents from this region are considered to have a disability and also be under the age of 65. Therefore, the characteristics of these individuals are not compared to the service area population.

Reclassification into Mutually Exclusive Categories

For purposes of analysis, the respondents were re-classified into mutually exclusive categories of each type of targeted population in order to compare responses by targeted group. Seniors receiving services are now those who are over the age of 55, reported that they were receiving services, are not caring for another individual, and most often were answering the survey for themselves. This group comprises 64.6% (n=283) of the sample. Seniors not receiving services are those who are over the age of 55, did not report that they were receiving services, are not caring for another individual, and most often were answering the survey for themselves. This group comprises 5.7% (n=25) of the sample. Caregivers are caring for another individual

(senior, person with disability, or child under 18), and may or may not be over the age of 55. This group comprises 26% (n=114) of the sample. Persons with disabilities are the smallest group (n=14, 3.2%) and represents those who have a disability, are between the ages of 18 and 64, and are not caring for another individual.

Four clusters of individuals were identified previously and are described under the statewide analysis. Cluster 1 is comprised of 52 respondents (11.9% of the sample and 28.6% of those classified). Cluster 2 is comprised of 51 respondents (11.6% of the sample and 28% of those classified). Cluster 3 is comprised of 49 respondents (11.2% of the sample and 26.9% of those classified). Cluster 4 is comprised of 30 respondents (6.8% of the sample and 16.5% of those classified). The remaining 256 (58.4%) of respondents did not report one or more demographic variables and could not be included in the cluster analysis.

Service Needs by Targeted Group

A principle components factor analysis was conducted previously to determine if respondents responded similarly to certain groups of items. The solution identified five components that explained most of the variance among the variables. The five components are classified as: Personal and Home Care, Senior Center Activities, Maintaining Independence, Information Referral and Assistance, and Monetary Assistance.

Personal and Home Care

The Personal and Home Care component is comprised of the following nine items: Transportation to the grocery store, doctor's office, pharmacy, or other errands; Having someone bring a meal to me in my home every day; Help keeping my home clean; Help with repairs and maintenance of my home or yard; Help with personal care or bathing; Help with washing and drying my laundry; Having someone help me with my prescription medicine; Keeping warm or cool as the weather changes; and Modifications to my home so that I can get around safely. Scores for items are approximately 92% consistent among cases. The composite was calculated by averaging each individual's responses to the nine items.

On average, seniors receiving services view personal and home care needs to be quite a bit important (*mean=3.06, median=4.0, n=282, sd=1.12*). The most important of these needs are transportation for errands (*mean=3.21, median=4.0, n=277, sd=1.2*) and home repairs and maintenance (*mean=3.32, median=4.0, n=275, sd=1.12*). The least important services to seniors who are already receiving services are personal care (*mean=2.79, median=4.0, n=276, sd=1.4*) and housekeeping (specifically laundry) (*mean=2.83, median=4.0, n=276, sd=1.38*). (See Figure 6-8.)

Seniors who have not received services view personal and home care needs to slightly less than quite a bit important (*mean=2.78, median=2.87, n=25, sd=1.05*). The most important of these needs are transportation for errands (*mean=3.0, median=3.5, n=20, sd=1.21*) and household chores (specifically keeping the house clean) (*mean=3.13, median=3.0, n=23, sd=1.06*). The least

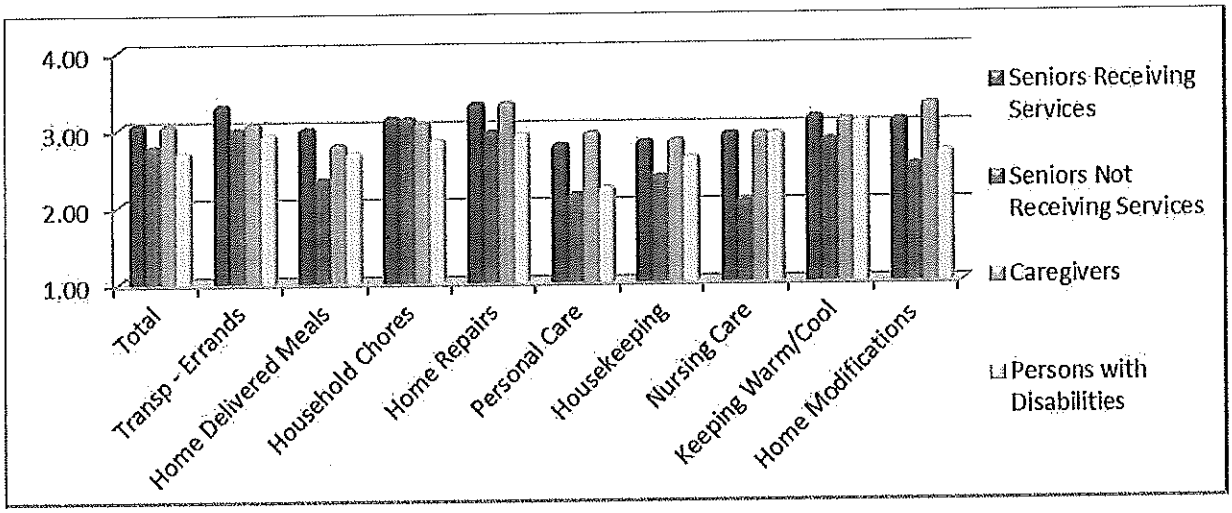
important services to seniors who are already receiving services are personal care (*mean=2.15, median=1.5, n=20, sd=1.35*) and nursing care/prescription assistance (*mean=2.05, median=1.0, n=20, sd=1.36*). (See Figure 6-8.)

Caregivers view personal and home care needs to be quite a bit important (*mean=3.05, median=3.25, n=111, sd=0.91*). All of the services are quite a bit important (*mean=2.83-3.31, median score = 3.0-4.0, sd=1.05-1.4*). (See Figure 6-8.)

Persons with disabilities view personal and home care needs to be quite a bit important (*mean=2.7, median=2.78, n=14, sd=0.83*). The most important services to persons with disabilities are transportation for errands (*mean=2.93, median=3.5, n=14, sd=1.27*), home repairs and maintenance (*mean=2.93, median=3.0, n=14, sd=1.07*), and keeping warm or cool (*mean=3.08, median=4.0, n=13, sd=1.26*). (See Figure 6-8.)

FIGURE 6-8: PERSONAL AND HOME CARE NEEDS BY TARGETED GROUP

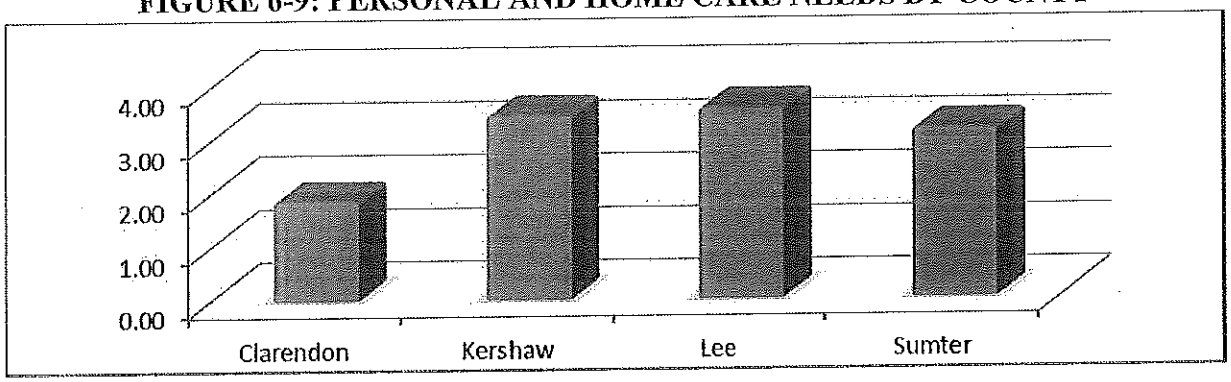
	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Personal and Home Care Composite	**3.06**	**2.78**	**3.05**	**2.70**
Transportation for Errands	3.31	3.00	3.07	2.93
Home Delivered Meals	3.00	2.35	2.79	2.69
Household Chores	3.14	3.13	3.06	2.85
Home Repairs/Maintenance	3.32	2.96	3.33	2.93
Personal Care	2.79	2.15	2.94	2.23
In-Home Housekeeping	2.83	2.38	2.84	2.62
Nursing Care/Prescription Assistance	2.93	2.05	2.93	2.92
Keeping Warm/Cool	3.14	2.85	3.11	3.08
Home Modifications	3.10	2.52	3.31	2.69



The difference in the personal and home care needs composite is not significantly different between the targeted groups (*F=1.02, df=3, p=0.384, r^2=0.007*). African Americans, those who are married, and individuals below the poverty line also rated these services as being of greater importance to them (*F=13.49, df=1, p<0.001; F=2.98, df=3, p=0.032; and F=12.73, df=1, p<0.001, respectively*). Individuals residing in Kershaw and Lee County expressed significantly greater need than individuals residing in Clarendon County (*F=22.39, df=3, p<0.001*).

Individuals classified as being part of Cluster 3 (Black females, widowed, with less than high school education, who are below the poverty line) expressed significantly greater need than any other demographic cluster (*F=2.66, df=3, p=0.050*).

FIGURE 6-9: PERSONAL AND HOME CARE NEEDS BY COUNTY



Senior Center Activities

The Senior Center Activities component is comprised of the following eight items: transportation to the senior center; group dining; recreation/social events; getting exercise; exercising with others; counseling (specifically having someone to talk to when feeling lonely); nutrition counseling; and having a senior center close to home. The scores for items are approximately 90% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items.

On average, seniors receiving services view senior center activities to be quite a bit important (*mean=3.11, median=3.38, n=247, sd=0.87*). All of the items have a median value of very important. The most important of these needs are getting exercise (*mean=3.59, median=4.0, n=278, sd=0.79*) and having a senior center nearby (*mean=3.58, median=4.0, n=271, sd=0.9*). The least important, but still quite a bit important, service to seniors who are already receiving services is transportation to the senior center (*mean=3.17, median=4.0, n=272, sd=1.26*). (See Figure 6-10.)

Seniors who have not received services view senior center activities to be quite a bit important (*mean=2.77, median=2.8, n=14, sd=0.85*). The most important of these needs is getting exercise (*mean=3.29, median=4.0, n=14, sd=0.99*). The least important services to seniors who are not already receiving services are transportation to the senior center (*mean=2.42, median=2.0, n=19, sd=1.35*) and having a senior center close to home (*mean=2.45, median=2.0, n=20, sd=1.23*). (See Figure 6-10.)

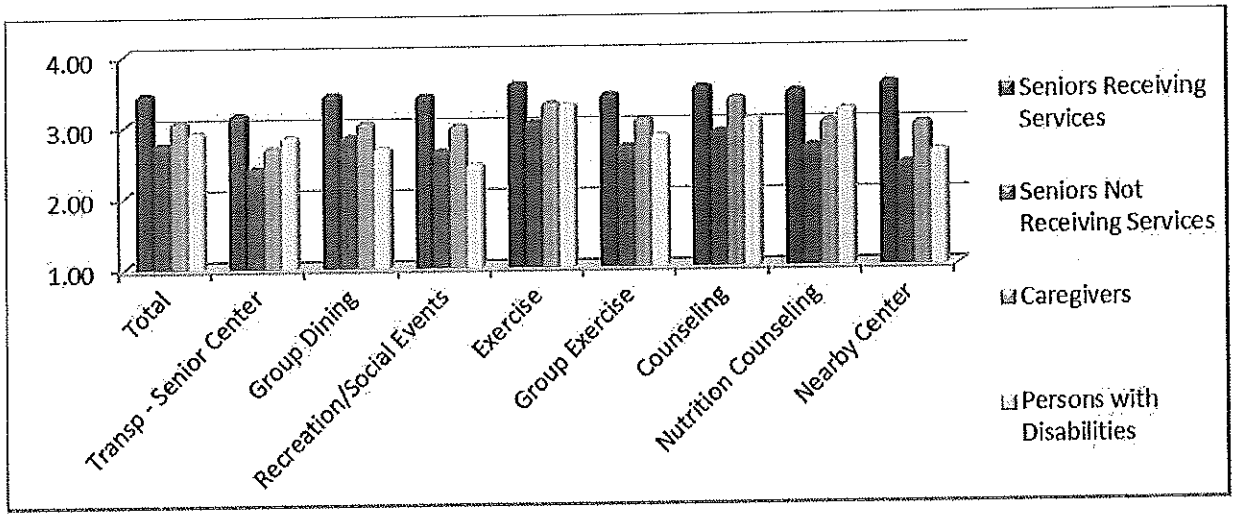
Caregivers view senior center activities to be quite a bit important (*mean=2.77, median=2.8, n=22, sd=0.95*). The most important of these needs are getting exercise (*mean=3.31, median=4.0, n=107, sd=0.97*) and counseling (having someone to talk to) (*mean=3.37, median=4.0, n=108, sd=0.93*). The least important service to caregivers is transportation to the senior center (*mean=2.7, median=3.5, n=106, sd=1.41*). (See Figure 6-10.)

Persons with disabilities view senior center activities to be quite a bit important (*mean=2.92, median=3.13, n=14, sd=0.85*). The most important services to persons with disabilities are getting exercise (*mean=3.29, median=4.0, n=14, sd=0.99*) and nutrition counseling (*mean=3.21, median=3.0, n=14, sd=0.89*). The least important service to persons with disabilities is recreation and social events (*mean=2.46, median=2.0, n=13, sd=1.27*). (See Figure 6-10.)

Transportation to the senior center is the least important of all the senior center activities seniors receiving services, seniors not receiving services and caregivers. Getting exercise is the most important to all of the target groups.

FIGURE 6-10: SENIOR CENTER ACTIVITIES BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Senior Center Activities Composite	**3.46**	**2.77**	**3.07**	**2.92**
Transportation to the Senior Center	3.17	2.42	2.70	2.85
Group Dining	3.45	2.86	3.05	2.69
Recreation/Social Events	3.43	2.65	3.00	2.46
Exercise	3.59	3.05	3.31	3.29
Group Exercise	3.43	2.71	3.08	2.85
Counseling (someone to talk to)	3.53	2.91	3.37	3.08
Nutrition Counseling	3.47	2.70	3.04	3.21
Nearby Senior Center	3.58	2.45	3.01	2.62

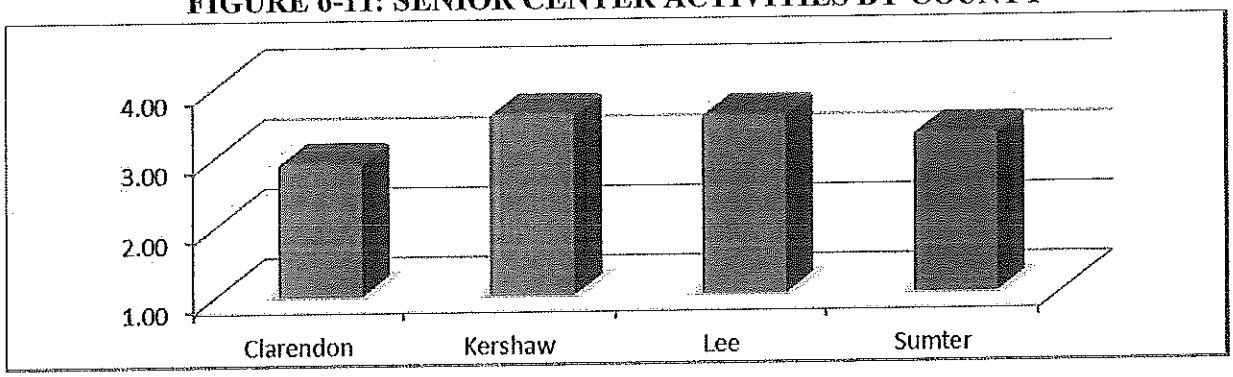


The difference in the senior center activities composite is significantly different between the targeted groups (*F=10.11, df=3, p<0.001*). Therefore, seniors receiving services view senior center activities to be more important than any other group. However, the target group categorization only accounts for 6.7% of the variability in this composite (r^2*=0.067*).

African Americans, females, individuals with less than a high school education, and those below the poverty line rated these services as being of greater importance to them (*F=30.01, df=1, p<0.001; F=8.7, df=1, p=0.003; F=2.85, df=4, p=0.024; and F=8.38, df=1, p=0.004, respectively*). Individuals who reside in Kershaw or Lee counties reported a greater need for senior center activities than did individuals residing in Clarendon county (*F=4.89, df=8, p<0.001*).

Overall, the demographic cluster of respondents who reported that these services are of greatest importance to them is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line) (*F=3.6, df=3, p=0.015*). The second group to whom these services are important are individuals in Cluster 2 (white females, widowed, with a high school diploma or GED, who are above the poverty line).

FIGURE 6-11: SENIOR CENTER ACTIVITIES BY COUNTY



Maintaining Independence

The Maintaining Independence component is comprised of the following four items: preventing falls and other accidents; help making choices about future medical care and end of life decisions (Healthcare Directives); someone to protect my rights, safety, property or dignity (Ombudsman – Protection); and someone to call when I feel threatened or taken advantage of (Ombudsman – Complaint). The scores for items are approximately 88% consistent among cases. The composite was calculated by averaging each individual's responses to the four items.

On average, seniors receiving services view services to help in maintaining independence to be quite a bit important (*mean=3.22, median=4.0, n=283, sd=1.11*). All of the needs are considered to be quite a bit important (preventing falls: *mean=3.22, median=4.0, n=278, sd=1.21*; healthcare directives: *mean=3.13, median=4.0, n=276, sd=1.26*; protection of rights: *mean=3.23, median=4.0, n=273, sd=1.22*; having someone to call if feeling threatened or taken advantage of: *mean=3.24, median=4.0, n=277, sd=1.2*). (See Figure 6-12.)

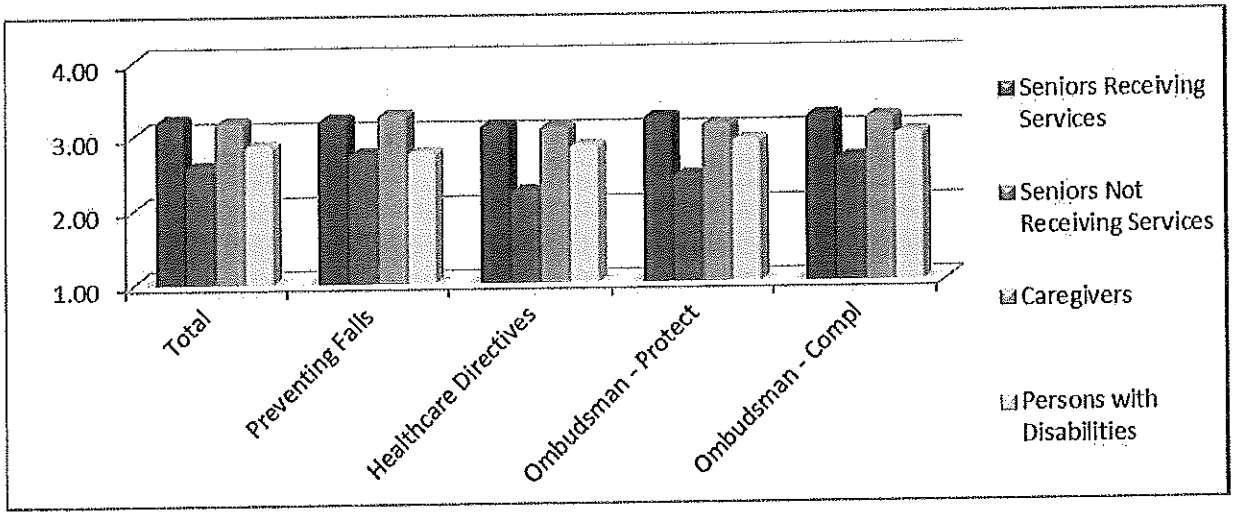
Seniors who have not received services view services to help in maintaining independence to be between a little a quite a bit important (*mean=2.61, median=2.63, n=22, sd=1.15*). All of the services were deemed to be a little or quite a bit important (preventing falls: *mean=2.76, median=3.0, n=21, sd=1.3*; healthcare directives: *mean=2.25, median=2.0, n=20, sd=1.25*; protection of rights: *mean=2.45, median=3.0, n=20, sd=1.23*; having someone to call if feeling threatened or taken advantage of: *mean=2.67, median=3.0, n=21, sd=1.2*). (See Figure 6-12.)

Caregivers view services to help in maintaining independence to be quite a bit important (*mean=3.19, median=3.75, n=110, sd=0.98*). All of the needs are considered to be quite a bit important (preventing falls: *mean=3.28, median=4.0, n=107, sd=1.09*; healthcare directives: *mean=3.1, median=4.0, n=107, sd=1.18*; protection of rights: *mean=3.13, median=4.0, n=108, sd=1.1*; having someone to call if feeling threatened or taken advantage of: *mean=3.22, median=4.0, n=110, sd=1.11*). (See Figure 6-12.)

Persons with disabilities view services to help in maintaining independence to be quite a bit important (*mean=2.87, median=3.25, n=13, sd=0.97*). The most important service is having someone to call if feeling threatened or taken advantage of: *mean=3.0, median=3.5, n=12, sd=1.21*). (See Figure 6-12.)

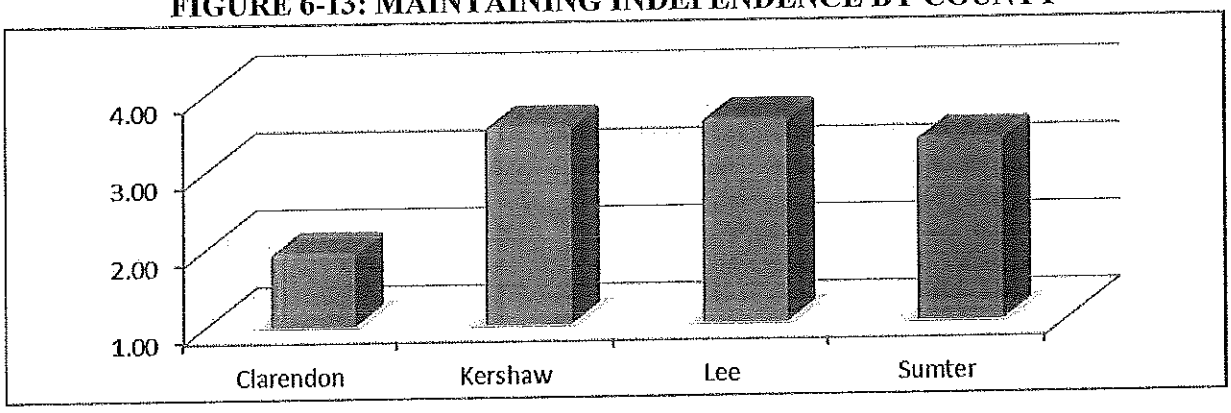
FIGURE 6-12: MAINTAINING INDEPENDENCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Maintaining Independence Composite	**3.22**	**2.60**	**3.19**	**2.87**
Preventing Falls	3.22	2.76	3.28	2.77
Healthcare Directives	3.13	2.25	3.10	2.85
Ombudsman - Protection	3.23	2.45	3.13	2.92
Ombudsman - Complaints	3.24	2.67	3.22	3.00



The difference in the maintaining independence composite is not significantly different between the targeted groups (*F=2.54, df=3, p=0.056, r^2=0.018*). African Americans and individuals below the poverty line also rated these services as being of greater importance to them (*F=4.16, df=1, p=0.042 and F=8.1, df=1, p=0.005, respectively*). Individuals who reside in Kershaw and Lee counties expressed a significantly greater need for these services than those residing in Clarendon County (*F=22.65, df=8, p<0.001*). There are no differences in service need by demographic cluster (*F=0.98, df=3, p=0.405*).

FIGURE 6-13: MAINTAINING INDEPENDENCE BY COUNTY



Information, Referral & Assistance and I-CARE

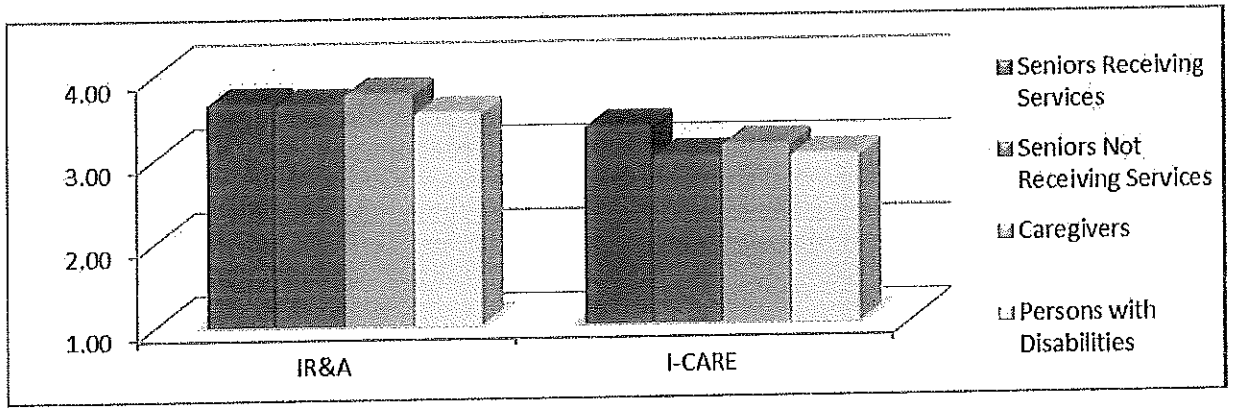
This section is comprised of the following two items: Knowing what services are available and how to get them (IR&A); and information or help applying for health insurance or prescription coverage (I-CARE). A reliability analysis determined that these two items have only fair internal reliability. Therefore, a composite is not created and these two variables are considered separately.

Of the 438 respondents, 412 reported on how important information, referral and assistance services are to keeping them where they are now. All of the targeted groups view IR&A to be very important (*mean=3.54-3.78, median=4.0*). The results of the Kruskal Wallis test indicate that there are no significant differences between the target groups ($X^2_{K\text{-}W}$*=2.43, df=3, p=0.488*). (See Figure 6-14.)

Of the 438 respondents, 402 reported on how important information or help applying for health insurance or prescription coverage (I-CARE) is to keeping them where they are now. All of the targeted groups view I-CARE to be quite a bit important (*mean=3.0-3.36, median=3.5-4.0*). The results of the Kruskal Wallis test indicate that there are no significant differences between the target groups ($X^2_{K\text{-}W}$*=7.78, df=3, p=0.051*); however, seniors who are receiving services have the greatest need of all the groups (*mean=3.36, median=4.0, n=264, sd=1.1*). (See Figure 6-14.)

FIGURE 6-14: IR&A AND I-CARE BY TARGETED GROUP

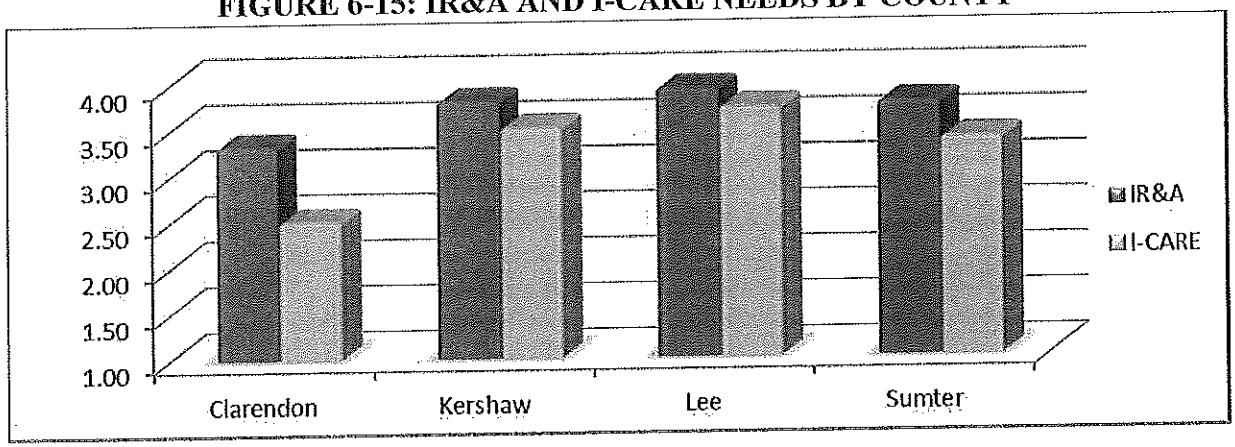
	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Information, Referral & Assistance	3.67	3.65	3.78	3.54
Insurance Counseling (I-CARE)	3.36	3.00	3.13	3.00



Individuals who are divorced have a greater perceived need for IR&A ($t=8.07$, $df=3$, $p=0.045$). Individuals residing in Lee, Kershaw, and Sumter counties expressed significantly greater need for this service ($X^2_{K\text{-}W}=55.16$, $df=3$, $p<0.001$). Since most of the respondents viewed this service to be quite a bit to very important, there are no other significant differences by demographics.

African Americans and individuals below the poverty line also rated these services as being of greater importance to them ($t=9.2$, $df=1$, $p=0.002$ *and* $t=12.08$, $df=1$, $p<0.001$, *respectively*). Individuals residing in Lee and Kershaw counties expressed significantly greater need for this service ($X^2_{K\text{-}W}=63.43$, $df=3$, $p<0.001$).

FIGURE 6-15: IR&A AND I-CARE NEEDS BY COUNTY



Monetary Assistance

The Monetary Assistance component is comprised of the following eight items: help paying for utilities or an unexpected bill; dental care and/or dentures; hearing exam and/or hearing aids; paying for an eye exam and/or eyeglasses; health insurance; help paying for healthy food; medical care; prescriptions or prescription drug coverage. The scores for items are approximately 93% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items.

On average, seniors receiving services view monetary assistance to be quite a bit important (*mean=3.15, median=3.88, n=283, sd=1.05*). All of these needs were reportedly quite a bit important (*mean=3.0-3.33, median=4.0, sd=1.08-1.32*). (See Figure 6-16.)

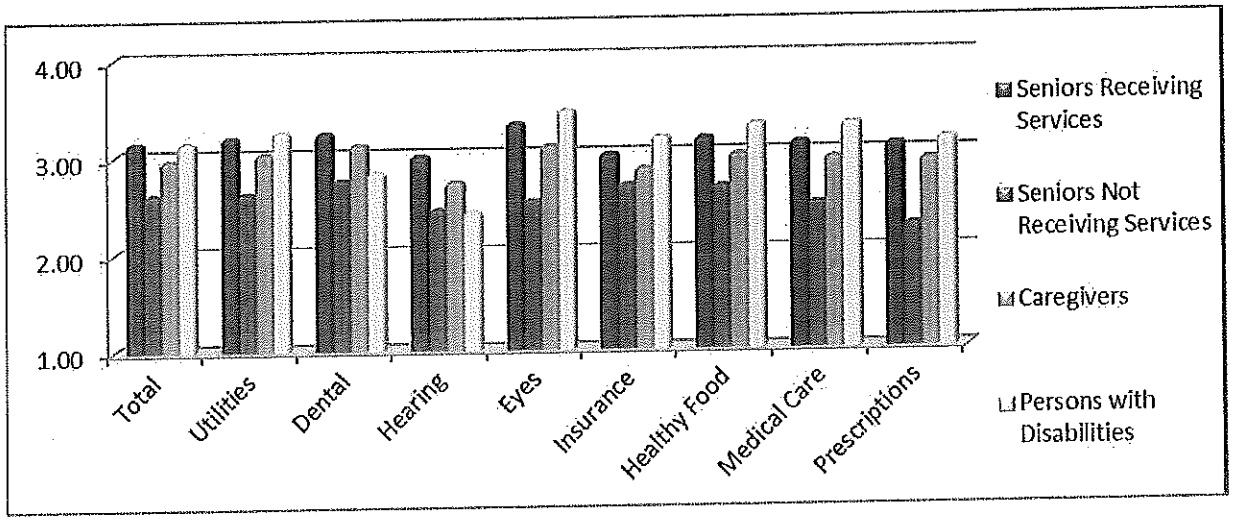
Seniors who have not received services view monetary assistance to be between a little and quite a bit important (*mean=2.62, median=2.83, n=25, sd=1.05*). The most important of these needs are help paying for dental care and/or dentures (*mean=2.76, median=3.0, n=19, sd=1.34*). The least important service to seniors who have not received services is help paying prescriptions or prescription coverage (*mean=2.27, median=2.0, n=22, sd=1.2*). (See Figure 6-16.)

Caregivers view monetary assistance to be quite a bit important (*mean=2.97, median=3.25, n=112, sd=1.02*). The most important of these needs are help paying for dental care and/or dentures (*mean=2.76, median=3.0, n=19, sd=1.34*). The least important service to caregivers is help paying prescriptions or prescription coverage (*mean=2.27, median=2.0, n=22, sd=1.2*). (See Figure 6-16.)

Persons with disabilities view monetary assistance to be a little important (*mean=2.25, median=2.13, n=18, sd=1.0*). The most important of these needs is help paying for utilities or an unexpected bill (*mean=3.25, median=3.5, n=12, sd=0.97*). The least important service to persons with disabilities is help paying for hearing exam and/or hearing aids (*mean=2.42, median=2.0, n=12, sd=1.24*). (See Figure 6-16.)

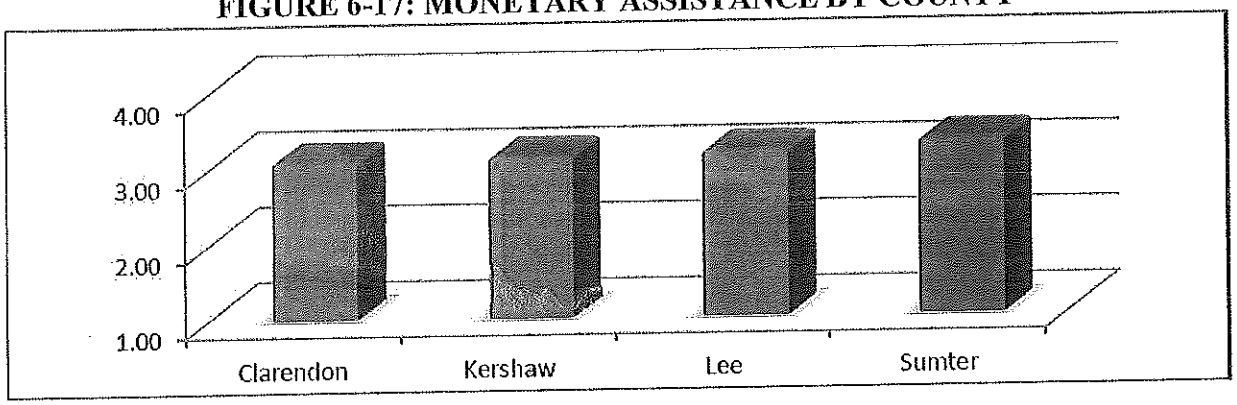
FIGURE 6-16: MONETARY ASSISTANCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Monetary Assistance Composite	**3.15**	**2.62**	**2.97**	**3.15**
Utilities or an unexpected bill	3.20	2.63	3.03	3.25
Dental Care and/or Dentures	3.24	2.76	3.12	2.83
Hearing Exam and/or Hearing Aids	3.00	2.45	2.73	2.42
Eye Exam and/or Eyeglasses	3.33	2.54	3.10	3.46
Health Insurance	3.01	2.70	2.86	3.18
Healthy Food	3.17	2.68	3.00	3.31
Medical Care	3.12	2.50	2.96	3.31
Prescriptions or Prescription Drug Coverage	3.10	2.27	2.94	3.15



The difference in the monetary assistance composite is not significantly different between the targeted groups (*F=2.54, df=3, p=0.056, r^2=0.017*). African Americans, individuals who are married or divorced, those who have received an Associate's degree or less, and individuals below the poverty line also rated these services as being of greater importance to them (*F=15.82, df=1, p<0.001; F=3.25, df=3, p=0.022; F=9.78, df=3, p<0.001; and F=15.04, df=1, p<0.001, respectively*). Individuals who are single rated these services as being of greater importance to them than individuals who are widowed, married, or divorced (*F=3.01, df=1, p<0.001*). Individuals residing in Kershaw and Lee counties expressed a greater need for monetary assistance than did individuals who reside in Clarendon (*F=8.29, df=8, p<0.001*).

FIGURE 6-17: MONETARY ASSISTANCE BY COUNTY



Caregiver Needs

The Caregiver Needs component is comprised of the following five items: monetary assistance for services; information and referral; training on caring for someone at home; Adult Day Care; Respite. The scores for items are approximately 84% consistent among cases. The composite was calculated by averaging each individual's responses to the eight items. Doing so also allows for an individual to have a composite score even if they did not respond to any one of the items.

Caregivers were asked to report the number of seniors, persons with disabilities, seniors with disabilities, and children for whom they care. These responses were used to categorize caregivers into four types: caregivers of seniors (*n=24, 38.1%*), caregivers of seniors with disabilities (*n=30, 47.6%*), caregivers of persons with disabilities (*n=5, 7.9%*), and caregivers of children (*n=4, 6.3%*). It must be noted that these items on the survey were not mutually exclusive, and as such, respondents may have selected more than one response for the same individual. Furthermore, approximately half of the caregivers of children are also the caregiver for a senior or senior with a disability, and approximately half of the caregivers of persons with disabilities are also the caregiver for a senior or a senior with a disability.

Caregivers of seniors (who do not have a disability) agree that caregiver services are necessary to help them care for the individual(s) (*mean=3.48, median=4.0, n=39, sd=0.73*). All services are equally important (*mean=3.29-3.61, median=4.0, sd=0.73*). (See Figure 6-18.)

Caregivers of seniors who do have a disability agree that caregiver services are necessary to help them care for the individual(s) (*mean=3.33, median=3.4, n=50, sd=0.55*). The most important of these needs is for assistance in paying for services (*mean=3.69, median=4.0, n=45, sd=0.56*) and respite (*mean=3.6, median=4.0, n=47, sd=0.68*). (See Figure 6-18.)

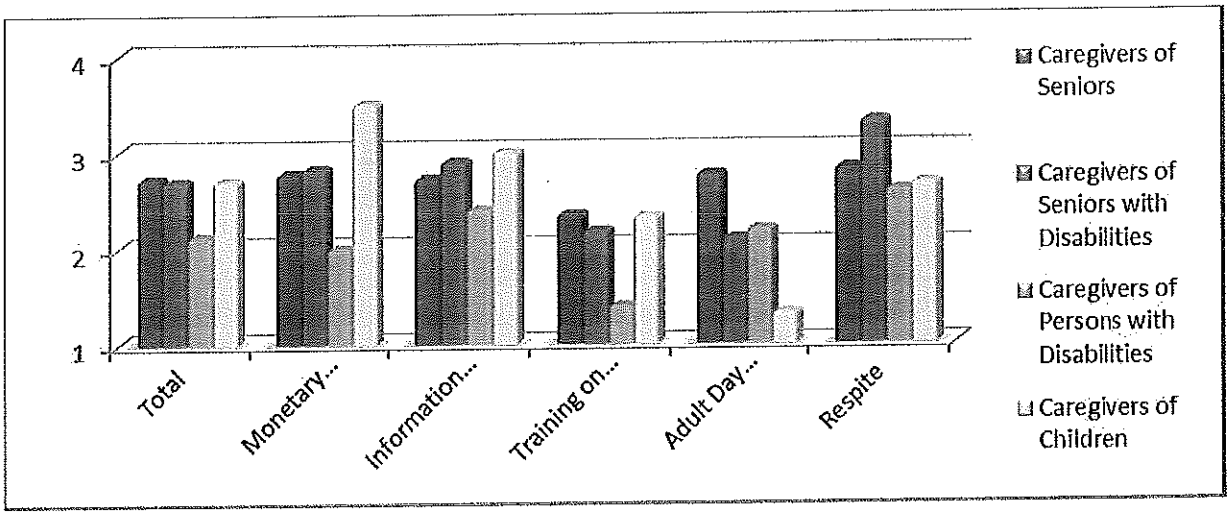
Caregivers of persons who have a disability (and are under 60 years of age) agree that caregiver services are necessary to help them care for the individual(s) (*mean=3.41, median=3.65, n=8, sd=0.71*). The most important needs are for assistance in paying for services (*mean=3.41, median=3.65, n=8, sd=0.71*) and respite (*mean=3.6, median=4.0, n=5, sd=0.89*). (See Figure 6-18.)

Seniors who are also caregivers of children agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.67, median=2.7, n=6, sd=0.64*). The most important needs are for information and referral for services (*mean=3.0, median=4.0, n=3, sd=1.7*) and monetary assistance in acquiring services (*mean=3.5, median=3.5, n=4, sd=0.58*). Note that some of these senior caregivers of children also care for other seniors. (See Figure 6-18.)

The difference in the caregiver needs composite is significantly different between the type of person being cared for (*F=2.83, df=3, p=0.043*), most likely due to the small number of persons caring for a person with a disability who is under 60 and seniors caring for a child under 18. Monetary assistance, information and referral, and respite are the services most needed by all types of caregivers. There are no differences in the needs of caregivers based on demographics.

FIGURE 6-18: CAREGIVER NEEDS BY WHO CARE IS PROVIDED TO

	Caregivers of Seniors	Caregivers of Seniors with Disabilities	Caregivers of Persons with Disabilities	Caregivers of Children
Caregiver Needs Composite	**3.48**	**3.33**	**3.41**	**2.67**
Monetary Assistance	3.61	3.69	4.00	3.83
Information & Referral	3.57	3.47	3.20	3.33
Training on Caregiving	3.29	2.71	3.25	1.17
Adult Day Care	3.31	2.95	3.00	2.33
Respite	3.47	3.60	3.60	2.67



Partner/Professional Survey

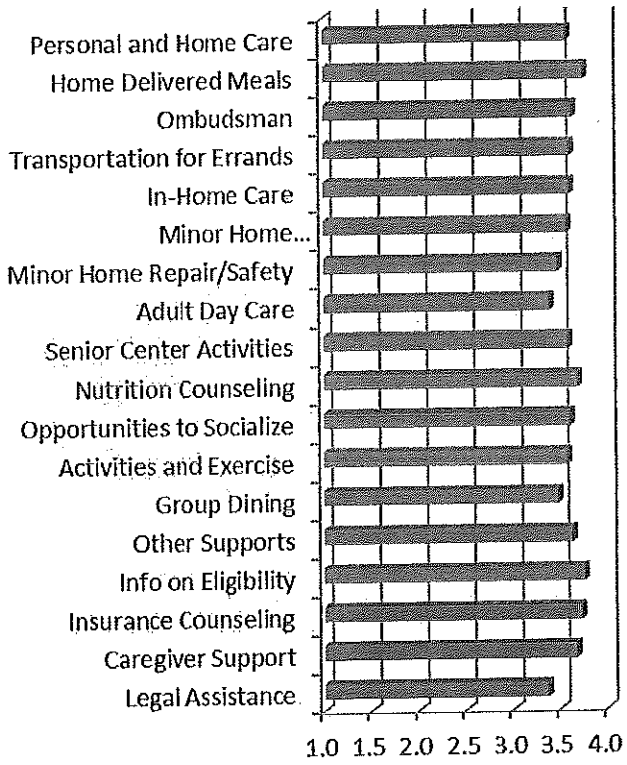
Three composites were created from the questions on the partner survey related to preserving services. These three composites are: Personal and Home Care (which consists of items related to home delivered meals, in-home care, minor home repairs/property upkeep, transportation for errands, adult day care, ombudsman, and minor home repair/maintenance/home safety), Senior Center Activities (which consists of items related to group dining services, activities and exercise, nutrition counseling, and opportunities to socialize), and Other Supports (which consists of items related to insurance counseling, information on service eligibility, legal assistance, and caregiver supports).

Overall, Personal and Home Care services (*mean=3.58, median=3.86, n=33, sd=0.55*), senior center activities supports (*mean=3.59, median=3.75, n=33, sd=0.58*), and other supports (*mean=3.63, median=3.75, n=33, sd=0.46*) are all viewed to be essential services to helping seniors and those with disabilities in Region 6 to remain independent. The most essential services are home delivered meals (*mean=3.76, median=4.0, n=33, sd=0.5*), information on eligibility for services (ADRC) (*mean=3.76, median=4.0, n=33, sd=0.44*) and Insurance

Counseling/Medicare Counseling services (*mean=3.73, median=4.0, n=33, sd=0.52*). (See Figure 6-19.)

FIGURE 6-19: PARTNER PERCEPTION OF ESSENTIAL SERVICES

	Mean Response
Personal and Home Care	**3.58**
Home Delivered Meals	3.76
Ombudsman	3.64
Transportation for Errands	3.61
In-Home Care	3.61
Minor Home Repairs/Upkeep	3.58
Minor Home Repair/Safety	3.48
Adult Day Care	3.39
Senior Center Activities	**3.59**
Nutrition Counseling	3.69
Opportunities to Socialize	3.61
Activities and Exercise	3.58
Group Dining	3.48
Other Supports	**3.63**
Info on Eligibility	3.76
Insurance Counseling	3.73
Caregiver Support	3.67
Legal Assistance	3.36



Overall, partners' perceptions of how their organization interacts with the AAA are positive. The majority are knowledgeable of the services offered (n=28, 87.5%), are aware of the AAA's strategic plan (n=28, 87.5%), understand how the AAA/ADRC sets priorities for which clients receive services (n=28, 87.5%), believe that the AAA is a critical partner for their organization (n=29, 93.5%), refer clients to the AAA/ADRC (n=26, 83.9%), and believe that the services of the AAA are easily accessible to clients (n=28, 87.5%). Of concern is that 56.3% of partners (n=18) stated that they do not understand which clients are eligible to receive services. Furthermore, 37.5% (n=20) stated that there are unmet needs for caregivers, 40.6% (n=13) stated that there are unmet needs for seniors, and 40.6% (n=13) stated that there are unmet needs for persons with disabilities. Only 37.5% of partners (n=12) stated that the clients are able to pay part of the cost of their services, and 80% (n=24) agreed that the AAA/ADRC should offer providers the opportunity to contract for fixed reimbursement rates. (See Figure 6-20.)

FIGURE 6-20: PARTNER PERCEPTIONS OF INTERACTIONS WITH AAA

	Agree	Disagree	Total Responses
Knowledgeable of Services	87.5%	12.5%	32
Aware of Strategic Plan	87.5%	12.5%	32
Know who is Eligible	43.8%	56.3%	32
Understand Priorities for Services	87.5%	12.5%	32
Critical Partner	93.5%	6.5%	31
Refer to AAA	83.9%	16.1%	31
Services Easily Accessible	87.5%	12.5%	32
Clients able to Pay	37.5%	62.5%	32
Unmet Needs for Caregivers	37.5%	62.5%	32
Unmet Needs for Seniors	40.6%	59.4%	32
Unmet Needs for PWD	40.6%	59.4%	32
Fixed Reimbursement	80.0%	20.0%	30

For seniors, the geographic areas that are most underserved are, in order of prominence:

- Lee County
- Rural
- Sumter County
- Clarendon County
- Also all areas and rural Kershaw

The services most needed by seniors in the underserved areas are, in order of prominence:

- Transportation
- In home meals
- Healthcare
- Also, caregiver support, home repairs, food bank and help with paying utilities

The services most needed by persons with disabilities in the underserved areas are, in order of prominence:

- Transportation
- Healthcare
- Caregiver support

Quotes:

There are problems placing seniors who has a mental health diagnoses and many seniors are facing with leaving their home due to poor caregivers support

Seniors are living a lot longer so more services will be needed to keep clients in their homes.

To reduce the cost of services, allow providers to contract for a financial review rather than an audit. Both performed by an independent CPA. 2. Eliminate the requirement for a 3

hour delivery window for meals. Four hours meets both federal and SCDHEC guidelines. This would reduce the cost of meals in many regions of the state.

There are never enough funds to provide needed services, also more Public Service announcements and Seminars should be held to keep the public more aware of what is available and the process to apply. Also more information need to be distributed on how to tap into needed resources. Technology is a problem for the seniors due to lack of computer skills and lack of assessing computers. A lot of information is now distributed on line and our seniors and disable population may not always ha...

The Seniors are in need of services for minor home repairs and help with Utilities.

Mostly the disabled seniors.

Long Term Care Nursing Facility Resident Interviews

Nineteen individuals were interviewed in nine different facilities. The fewest interviewed in any facility was one and the most interviewed in a single facility was six.

County of Residence	
Clarendon	1 (5%)
Kershaw	5 (26%)
Lee	7 (37%)
Sumter	6 (32%)
Total	**19 (100%)**

Age Groups	
18-59	4 (21%)
60-74	4 (21%)
75-84	6 (32%)
85+	4(21%)
Unk	1 (5%)
Total	**19 (100%)**

Marital Status	
Single	6 (32%)
Married	4 ((21%)
Divorced	1 (5%)
Widowed	8 (42%)
Total	**19 (100%)**

Education	
Less than High School	11 (59%)
High School	5 (26%)
Some College	2 (10%)
Unk	1 (5%)
Total	**19 (100%)**

Race	
Black	6 (32%)
White	13 (68%)
Total	**19 (100%)**

Length of Years in Facility	
One	3(16%)
Two	7 (37%)
Three	2 (10%)
Four	1 (5%)
Five	3 (16%)
Six	2 (11%)
Seven	0
Eight	1 (5%)
Total	**19 (100%)**

Gender	
Male	7 (37%)
Female	12 (63%)
Total	19 (100%)

Discussion of Demographics

The members of the sample interviewed are relatively diverse. There are representatives from all four counties in the region. About half of the respondents are over 75 and half are 74 or younger. Twelve are married or widowed and seven are single or divorced. The education level is relatively low, with almost 60% having less than a high school education, which is fairly typical of this age group in South Carolina. Not quite seventy percent are white with the remainder African-American. About two-thirds are female and one-third male, also fairly typical in this population.

Over half the respondents have been in the facility for one or two years. The remaining respondents are pretty evenly distributed across three, four, five and six years, with one outlier at eight years.

Participant Views

a. This facility is the right place for me to get the care I need right now	Definitely No	Probably No	Maybe Yes, Maybe No	Probably Yes	Definitely Yes
	1	1		2	15

b. My rights as a resident have been explained to me	Definitely No 1	Probably No 1	Maybe Yes, Maybe No 1	Probably Yes 2	Definitely Yes 14
c. The staff here know about client rights	Definitely No 1	Probably No 1	Maybe Yes, Maybe No 1	Probably Yes 2	Definitely Yes 14
d. I know who to talk to if I believe that my rights have been violated	Definitely No 3	Probably No 2	Maybe Yes, Maybe No 1	Probably Yes 1	Definitely Yes 12
e. The staff here follow my choices and preferences	Definitely No	Probably No 1	Maybe Yes, Maybe No	Probably Yes 3	Definitely Yes 15
f. I have concerns about my safety and dignity	Definitely No 14	Probably No	Maybe Yes, Maybe No	Probably Yes	Definitely Yes 5
g. I am entirely satisfied with the services I receive at this facility	Definitely No 1	Probably No 2	Maybe Yes, Maybe No 1	Probably Yes 3	Definitely Yes 12

h. The Area Agency on Aging has services that would help me here	Definitely No 10	Probably No 4	Maybe Yes, Maybe No	Probably Yes 1	Definitely Yes 1
i. I want to be discharged from this facility	Definitely No 10	Probably No 1	Maybe Yes, Maybe No 1	Probably Yes 1	Definitely Yes 6
j. I would need additional supports to be able to live at home	Definitely No 4	Probably No 3	Maybe Yes, Maybe No	Probably Yes	Definitely Yes 11

Discussion of Participant Views

Most of the respondents appear to believe they are in the right place and are receiving the care they need. A large number, given the small size of the sample, have concerns about their rights (b, c, and d) and about their safety (f).

While many would like to be discharged from the facility, most appear to realize (as supported by the comments in the next section) that they cannot live at home and that the AAA has little to offer that could help them to do so. This knowledge may confound the answers to h, i and j, which on the whole indicate a desire to be elsewhere, but the knowledge that, for most, this is not possible.

Participant Responses to Open-Ended Questions

1. What services that AAA provides would help you in this facility?

Most of the respondents (14 out of 19, or 74%), said none. One other said unknown. The remaining three said help with going home, help with getting up in the morning and support from home care.

2. If you were able to be discharged, what kind of help or support would you need to stay at home?

Of the 19 respondents, nine, or almost 50%, indicated they could not live outside the facility, and therefore the question did not apply to them. Six of the remaining ten, or sixty percent of those

who believed they could return home, said they needed family help. The remaining four asked for help in the home similar to the help they got in the facility.

Discussion of Participant Responses to Open-Ended Questions

As in the previous section, the respondents indicate that they do not believe they can go home. The surprising result, however, was that six believed they could return home if they had support from their family. This may explain some of the ambivalence found in the responses elsewhere in the interview.

The difficulty for many of the participants in returning home seems to be, at least from their viewpoint, lack of family support. A closer look at the data shows no particular age pattern for the respondents who feel this way. Two are 18-59, two are 75-84, one is 85 +, and one's age is unknown. However, their marital pattern may hold some clues. One is widowed, three are single and two are married. The widowed and single persons would, certainly, not have as much support as persons with a spouse might have. And one of the married persons is in the 75-84 age group and the health of his spouse may be poor.

In short, the respondents did not believe the AAA could give them much support in the facility, and four (21%) felt the AAA might be able to help them leave the facility. However, the fact that a relatively large proportion of the respondents are concerned about their safety in the facility indicates a role for the AAA in the facility that the respondents would not perhaps think of.

Service Priorities Recommended To Address the Needs Identified and a Timeline for Implementation

Using a principle components factor analysis, SWS identified five components that classify the service needs of the target groups it was asked to conduct a needs assessment with. What was found was that the priorities placed on service needs vary among the target groups served by Region 6. Furthermore, priorities vary within the target groups in many instances depending upon demographic variables. Given this variation, service priorities need to follow priorities established by the staff and board of Region 1 following the needs identified as most important within each of the five components. This, in part will depend on where the planners wish to place their emphasis. The needs assessment for the Region provides a great deal of evidence of what is important to each target group and to the demographic groups presently being served. It would be presumptuous of SWS to make recommendations to those responsible for the planning in the Region of which services and target populations should be emphasized. However, what the target groups believe is important is presented in the report.

Timelines for implementation are dependent upon the planning process, oversight of those conducting that process and availability of funds. SWS proposes the following timeline.

1. SWS prepare a 15-20 minute PowerPoint presentation of the findings for the Region's needs assessment after completion of the report.

2. The regional director notify SWS by October 26 if the Region would like to have a Webinar presentation of the PowerPoint.
3. The presentation be scheduled.

Discussion and Summary

As might be expected, the population in need is more poor, more African-American, more female, less likely to have a spouse, and older than the general senior population in the region. These demographic characteristics are often connected.

Overall, respondents viewed all of the services to be quite a bit important. Information, Referral, and Assistance is the service most important to helping them stay where they are, followed by caregiver services, senior center activities, I-CARE (Insurance Counseling), services to help them maintain independence, and monetary assistance. The most important service to caregivers is respite care, followed by monetary assistance in obtaining services. Within senior center activities, respondents viewed exercise to be the most valuable. Services to help in maintaining independence came in fifth, with the most important services being those of the Ombudsman. Monetary assistance is only slightly less than quite a bit important, with the most important being help with payments for dental care and/or dentures and eye exams and/or eyeglasses. Personal and home care is viewed to be the least important overall, but still quite a bit important for seniors receiving services and caregivers, with the most important of these being transportation for errands, keeping warm or cool, and home repairs and modifications (for both upkeep and for safety).

However, these are generalizations. There is a great deal of variation within categories. For example, service needs of caregivers vary depending upon whom they are caring for and whether they are caring for children. Personal and home care, which is viewed as the least important to persons with disabilities is is viewed as very important to caregivers and seniors already receiving services. Mean scores, therefore, for the sample as a whole, are not necessarily a good guide for planning. Rather, the needs perceived by each group should be examined separately and in detail. This is a segmented market and should be approached as one, as Region 6 is doing. It is strongly recommended that the Service Needs by Targeted Group sections of this report be carefully reviewed by the staff and policy makers of Region 6 rather than an attempt be made to produce a single list of needs in order of priority.

In this report, SWS presents the needs as reported by the respondents to the needs assessment survey by target group, demographic clusters and the two combined. It has further divided the needs by the types of services provided and has provided an additional breakdown for caregivers. This information is provided in written and in graphic form. This information can be utilized as a rich source for in-depth planning for services in the Region.

Appendix C
Long Term Care Ombudsman Service Report
FY 2012

Case/Complaints opened

185 cases with 392 complaints

Cases/Complaints closed

157 cases with 326 complaints

Friendly visits conducted

25

Consultations

660

Trainings provided

20

Community Education Events

20

Resident Council Trainings

4

Advanced Directives Witnessed

11

Friendly Visitor's Program

The SLAAA/ADRC is working with a volunteer to coordinate its Friendly Visitor's Program. Currently, there are no volunteers in the Program. However, recruitment efforts include word-of-mouth, brochures, training sessions, and community events. In addition, the SLAAA/ADRC has begun to receive referrals from one of its local Housing Authority for potential volunteers in need of community service. The amount of time needed to get the Program fully operational presents a challenge. The Volunteer Coordinator can only dedicate one day a week to Program activities.

ADRC National Evaluation Survey

Report for South Carolina.

Local Report for Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments)

Section A. Baseline Characteristics

1. Has your organization realized an improvement in ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community) since the start of the ADRC grant?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

2. Which have had the most positive impact on your organization's ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community)? (Select up to two)

- ☒ Partnerships developed/expanded
- ☐ Staffing changes
- ☐ Shared data
- ☐ Focus on providing person-centered, self-directed services
- ☒ Other, please specify

Specify Other:
Outreach

3. Which of the following best describes the reason your site became an ADRC?

To better integrate service provision systems	To develop or strengthen agency/organizational partnerships	To improve data or IT infrastructure	To improve marketing or awareness efforts related to Long Term Care Services and Supports (LTSS)	To expand services to additional populations	To expand services to additional geographic locations	Other, please specify
○	○	○	○	◎	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

4. Please indicate the extent to which Federal (AoA/CMS) grants have enabled your ADRC to realize any of the following outcomes... (Select all that apply)

	Very much	Somewhat	Very little
...increase the skills of existing staff	◎	○	○
... recruit or attract more experienced staff	○	◎	○
... increase/expand populations served	○	◎	○
... increase the number of consumers served	◎	○	○
... increase the number of partnerships	◎	○	○
... increase range of services offered	◎	○	○
... make other changes (please specify)	○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

5. How has the ADRC grant(s) affected the resources or resource allocation at your organization or within your state? [IF THERE IS MORE THAN ONE ADRC IN THE STATE CHECK THE BOX IF THE ITEM IS TRUE OF AT LEAST ONE ADRC] (Check all that apply)

	At the Site or Local Level	At the State Level
Helped us leverage other funds	☒	☐
Improved staff training opportunities	☒	☐
Increased service efficiency	☒	☐

Contributed to the development of a statewide database of LTSS services and/or consumers	☐	☒
Promoted the development of standard operating procedures	☒	☐
Increased the level of coordination between organizations serving older individuals and individuals with disabilities	☒	☐
Improved awareness/marketing campaigns/activities	☒	☐

Section B. Populations Served

For the following items, please indicate the demographic composition of your service area. (This question applies to the community that Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) serves)

6. Latino/Hispanic Origin

3.2 Yes %

96.8 No %

7. Race

53.1 Caucasian/White %

42.7 Black or African American %

.2 American Indian or Alaska Native %

.7 Asian %

.1 Nation Hawaiian or Other Pacific Islander %

8. If you have one or more significant racial/ethnic sub-populations in your service area please list it here:

n/a

9. What percentage of your service area is living at or below the poverty line?

At or below the poverty line %	Not sure, but a significant population lives under the poverty line	Not sure, but the population is small or negligible
◉	○	○

Specify Percentage:

19.1

Click here to clear all radio buttons in the question above.

10. What percentage of your service area is uninsured/does not have health insurance coverage?

Uninsured %	Not sure, but a significant population is uninsured	Not sure, but the population is small or negligible
○	◉	○

Specify Percentage:
☐

Click here to clear all radio buttons in the question above.

11. Within the last 12 months, has a community LTSS needs assessment been conducted?

Yes	No, but we did complete a community needs assessment within the past three years	No, a community needs assessment was not completed within the past three years
◉	○	○

Click here to clear all radio buttons in the question above.

This next set of questions is designed to gather information about the conditions in your service area.

12. Community Needs

Barriers to receiving Long Term Supports and Services

To what extent is each of the following a barrier for individuals seeking Long Term Supports and Services both prior to receiving an ADRC grant and currently?

	Prior	Currently
Lack of Long Term Supports and Services--Needed services are not offered	Often a Barrier ▼	Often a Barrier ▼
Lack of available Long Term Supports and Service slots--(e.g., There are long waitlists)	Often a Barrier ▼	Often a Barrier ▼
Poor service quality	Not a Barrier ▼	Not a Barrier ▼
Lack of health insurance	Often a Barrier ▼	Often a Barrier ▼
Providers not accepting consumers with Medicaid	Sometimes a Barrier ▼	Often a Barrier ▼
Barriers based on consumer disabilities	Sometimes a Barrier ▼	Often a Barrier ▼
Language barriers	Not a Barrier ▼	Not a Barrier ▼
Cultural barriers	Not a Barrier ▼	Not a Barrier ▼

Religious barriers	Not a Barrier	Not a Barrier
Sexual orientation barriers	Not a Barrier	Not a Barrier
People needing services do not have a permanent address	Not a Barrier	Often a Barrier
Consumers lack transportation	Often a Barrier	Often a Barrier
Stigma, discrimination and prejudice against older adults	Sometimes a Barrier	Often a Barrier
Stigma, discrimination and prejudice against persons with disabilities	Sometimes a Barrier	Often a Barrier
Providers have high staff turnover	Sometimes a Barrier	Often a Barrier
Providers lack appropriately trained staff	Often a Barrier	Often a Barrier
Service provider hours/locations are hard to access	Not a Barrier	Not a Barrier
Other Please specify:	Please Select	Please Select

Specify Other:
☐

Section B. Populations Served, Continued

13. Service Availability/Choice

	Please indicate the Current availability of the following services within your service area	**For the following services, to what extent is there provider choice? (Approximately 8 years ago or if you do not have information that goes back that far, as far back as you do have information)**	**For the following services, to what extent is there provider choice? (Currently)**
Safe and affordable housing options	Not available	Limited	Limited
Peer support services/groups	Not available	No	No
HCBS Medicaid Waiver Programs	Adequate availability	Limited	Limited

Caregiver Support (i.e. respite programs, support groups, or counseling)	Available but inadequate to meet need	Limited	Limited
Nutrition Programs	Available but inadequate to meet need	Limited	Limited
Employment services	Available but inadequate to meet need	Limited	Limited
Education services	Available but inadequate to meet need	Limited	Limited
Opportunities to develop advanced directives	Available but inadequate to meet need	Limited	Limited
Transportation services	Available but inadequate to meet need	Limited	Limited
Opportunities for socialization/recreation	Not available	No	No
Mental health services	Adequate availability	Limited	Limited
Ombudsman services	Adequate availability	Limited	Limited
Health prevention and screening services	Available but inadequate to meet need	Limited	Limited
Services for emergent cases/Crisis intervention	Available but inadequate to meet need	Limited	Limited
Transition programs (from hospitals, nursing homes etc.)	Available but inadequate to meet need	Limited	Limited
Nursing home (institutional) diversion programs	Available but inadequate to meet need	Limited	Limited
Nursing home/residential beds	Available but inadequate to meet need	Limited	Limited
Income assistance	Not available	No	No
Energy assistance	Available but inadequate to meet need	Limited	Limited
Personal care services	Available but inadequate to meet need	Limited	Limited
Medicaid waivers	Available but inadequate to meet need	Limited	Limited
Independent Living services (e.g., skills training, peer support)	Not available	No	No
Other, please specify	Please Select	Please Select	Please Select

Specify Other:
☐

Section B. Populations Served, Continued

14. How many consumers of each type were served in the most recent 6 month period (October 2012-March 2013) NOTE: This question is specific to the consumers who access Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) services such as I&R/I&A, benefits or options counseling, Information and referral services, services to support transitions from residential or institutional facilities to the community.

Number of Older Adults (60+) Total [982]

15. How many consumers of each type were served in the most recent 6 month period (October 2012-March 2013) NOTE: This question is specific to the consumers who access Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) services such as I&R/I&A, benefits or options counseling, Information and referral services, services to support transitions from residential or institutional facilities to the community.

	Consumers under 60 (Currently)	Consumers 60 and over (Currently)
Individuals with Disabilities		
Physical disabilities	[11]	[67]
Cognitive impairment	☐	[3]
Intellectual disabilities	☐	☐
Developmental disabilities	☐	☐
Mental Illness	[3]	[2]
Multiple disabilities	[13]	[87]
Caregivers		
Informal/family caregiver	[16]	[13]
Paid Caregiver	☐	☐
Health & Human Service Professional (e.g., physician, hospital discharge planner, nursing home staff)	[2]	[2]
Special Subpopulations		
Traumatic Brain Injury (TBI)	☐	☐
Emergent/Emergency Cases	☐	☐
Low income	[101]	[455]
Limited English proficiency	[3]	[4]
Is the Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) making any special efforts to target a particular population not listed above? If yes, please specify.		
Other (Please specify)	☐	☐

Specify Other:
☐

Other (Please specify) ☐ ☐

Specify Other:
☐

16. Since the start of the ADRC grant, the number of clients under 60 served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

17. Since the start of the ADRC grant, the number of consumers 60 and over served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

18. Since the start of the ADRC grant, the number of consumers with physical disabilities served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

19. Since the start of the ADRC grant, the number of consumers with mental/emotional disabilities served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

20. Since the start of the ADRC grant, the number of consumers with multiple disabilities served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

21. Since the start of the ADRC grant, the number of caregivers served by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

Section C. Service Provision

These questions are about the services provided by your organization/network

22. How frequently do consumers ask about the following? For each, indicate "frequently," "sometimes," "infrequently", or "never."

Topic	Frequency of consumer inquiry:
Advanced directives	Frequently
Advocacy	Frequently
Caregiver support	Frequently
Respite services	Sometimes
Chronic health conditions	Sometimes
Education	Never
Employment	Infrequently
Energy assistance	Frequently
Home modification	Frequently
Affordable housing	Frequently
Income assistance	Frequently
Medicaid eligibility and services	Sometimes
Medicare eligibility and services	Frequently
Mental/behavioral health services	Infrequently
Nutrition services	Frequently
Ombudsman/abuse or neglect issues	Frequently
Independent living services	Sometimes
Personal care/attendant care services	Frequently
Preventative health services	Infrequently
Recreation opportunities	Infrequently
Services for emergent care/crisis intervention	Sometimes

Support groups	Never
Transition services	Sometimes
Transportation	Frequently
Other, please specify	Please Select

Specify Other:
☐

23. Does Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) engage in advocacy activities for older adults?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

24. Does Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) engage in advocacy activities for persons with disabilities?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

25. Is diversion from nursing homes or other institutional residential facilities an outcome sought to be achieved?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

26. How is Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) measuring and tracking this?

Staff track using a standard electronic system	Staff track using a standard hardcopy/paper system	An external group (e.g., an evaluator, auditor) tracks using a standard system	Staff track using an informal system	Other, please specify
◉	○	○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

CARE COORDINATION/TRANSITION ASSISTANCE PROGRAMS

27. Does your organization provide transition services to consumers discharged from an acute care setting?

Yes	No
○	◉

Click here to clear all radio buttons in the question above.

28. Care Coordination/Transition Assistance

	Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Provided Care Coordination/Transition Assistance
Number individuals assisted with transition from hospital ONLY through formal care transitions program (evidence-based CT intervention or innovative model)	☐
Number of participants carried over from last 6 months (October 2012-March 2013) (started program within last 6 months and continued with the intervention)	☐
Number of participants whose cases were closed during the last 6 months (October 2012-March 2013) (i.e., participants whose transition services were ended either bacause of a readmission or new admission to a care facility or because the transition period ended)	☐
Number of participants that readmitted within 30 days of discharge	☐
Number of participants that readmitted within 30 days and re-entered the care transition program	☐

29. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program in this Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) program service area in the past 6 months (October 2012-March 2013) by participating hospital?

☐ Name of Hospital 1
☐ No. of Individuals for Hospital 1
☐ Name of Hospital 2
☐ No. of Individuals for Hospital 2
☐ Name of Hospital 3
☐ No. of Individuals for Hospital 3

30. What is the number of individuals who were assisted with transitioning from the

hospital through a formal care transition intervention program across all participating hospitals in this Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) program service area in the past 6 months (October 2012-March 2013) by age group?

☐ Aged 60 and Over
☐ Under Age 60
☐ Age Unknown

31. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) program service area in the past 6 months (October 2012-March 2013) by health insurance source?

☐ Medicare
☐ Medicaid
☐ Dual-Eligible
☐ No insurance
☐ Private insurance
☐ Veterans Administration Services
☐ Other

32. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) program service area in in the past 6 months (October 2012-March 2013) who were referred to one or more health/prevention programs?

☐ Chronic Disease Self Management Program
☐ Diabetes Self Management Program
☐ Exercise Program
☐ Mental Health and Substance Misuse
☐ Falls Management and Prevention
☐ Alzheimer's Programs
☐ Medication Management
☐ Home Injury/Risk Screenings
☐ Other

33. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) program service area in the past 6 months (October 2012-March 2013) that were referred to one or more of the following long term services or supports?

☐ Additional Options Counseling
☐ Home delivered meals

☐ Nutrition services or nutrition counseling
☐ Care giver support
☐ Personal care/homemaker/choremaker services
☐ Transportation

34. Do you have a marketing plan?

Yes, our marketing plan is operational	Yes, we have a plan but it is not yet operational	No, we do not have a plan at this time
◎	○	○

Click here to clear all radio buttons in the question above.

35. Does Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) utilize a standard operating procedure to assess consumer need?

Always	Sometimes	Never
◎	○	○

Click here to clear all radio buttons in the question above.

36. Is the consumer assessment tool and/or basic consumer needs assessment process common across partner organizations?

Yes, common across all partners	Yes, common across some partners	No, each partner organization uses their own assessment tool/process
○	○	◎

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

OPTIONS COUNSELING OR OTHER ONE ON ONE COUNSELING

37. Does your organization/network provide "Options Counseling" or other one-on-one counseling designed to support consumers' ability to make informed decisions about their long-term care?

Yes	No
◎	○

Click here to clear all radio buttons in the question above.

38. Referrals to Public and Private Services in the past 6 months (October 2012-March

2013)

	Referrals to Public and Private Services this Reporting Period
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) clients referred to or given an application for a public program, including Older Americans Act; Medicare; Medicaid; Food Stamps; TANF; Social Security (SSI or SSDI); LI-HEAP; VDHCBS; Other State-funded and county-funded programs for Medicaid; Other?	1205
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) clients referred to some other type of service (non-public services, resources or program)?	21
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) clients that were not referred to any type of service?	21
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Unknown Clients (remainder of all Clients)?	☐
Total	1228

39. Clients Provided Options Counseling in the past 6 months (October 2012-March 2013)

Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Provided Options Counseling By Age	
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Aged 60 and Over	902
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Under Age 60	177
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Age Unknown	31
Total	1110
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Provided Options Counseling by Method	
In person	466
By phone	463
Electronic Communication (e.g. email or website chat)	54
Total	1110
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients Provided Options Counseling by Setting	
Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments)	1110
Hospital	☐
Nursing facility/Institution	☐

At the client's community residence	☐
Other	☐
Total	1110

Client Feedback About Options Counseling

What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients who report that options counseling enabled them to make well informed decisions about their long term support services?	☐
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients surveyed this reporting period?	☐

40. Does Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) or network have a standardized tool or process to provide options counseling?

Yes	No	Do not know	Not applicable
○	○	◎	○

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

PUBLIC PROGRAMS

41. Average Monthly Public LTSS Program Enrollment in WHOLE Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) SERVICE AREA

This set of questions is asking about all current enrollment levels in these programs in the Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) service area. Enrollment fluctuates from month to month, so please calculate the average enrollment per month during the last 6 months.

	Average Monthly Public LTSS Program Enrollment in WHOLE Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) SERVICE AREA
What is the average number of individuals enrolled in Medicaid HCBS Waivers in Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Service Area each month (should include Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients and might include Non-Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients)?	☐

What is the average number of individuals enrolled in Medicaid residing in institutions in Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Service Area each month (should include Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients and might include Non-Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients)? ☐

What is the average number of individuals enrolled in other public LTSS programs in Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Service Area each month (should include Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients and might include Non-Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients)? ☐

42. Please list LTSS programs and HCBS waivers (e.g. aged and disabled, MR/DD) that individuals are enrolled in.

☐

43. Total New Enrollment among Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) CLIENTS ONLY in Public LTSS Programs

This set of questions is asking about the absolute number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) clients who were newly enrolled into these programs during the past 6 months (October 2012-March 2013).

	Total New Enrollment among Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) CLIENTS ONLY in Public LTSS Programs
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients who are newly enrolled into a Medicaid HCBS Waiver (including individuals enrolled by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) staff and individuals referred for assessment/application by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) staff)?	☐
What is the number of Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients who are newly enrolled into Medicaid institutional services (including individuals enrolled by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) staff and individuals referred for assessment/application by Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) staff)?	☐

What is the total number of clients newly enrolled in other public LTSS programs in Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Service Area each month (should include Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients and might include Non-Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) Clients)? ☐

44. Please list LTSS programs and HCBS waivers (e.g. aged and disabled, MR/DD) that individuals are enrolled in.

☐

45. For data collected on consumers, are staff required to follow the Alliance of Information and Referral Systems (AIRS) standards (Standard 13: Inquirer Data Collection)?

Yes with all consumers	Yes, with specific groups of consumers--Please specify:	Never
○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

46. Does Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) have a database/MIS that does any of the following (Select all that apply)?

- ☒ Track consumer requests for information and referrals
- ☒ Track referrals made to consumers
- ☒ Maintain records on individual consumers
- ☒ Maintain a list of services/service providers
- ☐ Links to other databases (e.g., Medicaid waiver tracking systems, Money Follows the Person tracking system). If yes, specify:

Specify Other:
☐

- ☐ Other, please specify

Specify Other:
☐

47. Do operational partners have access to data they need for their operations such as data about your consumers/services? If yes, for what purpose? (review client information, input

client demographic information, input referrals, input service utilization information, review client service utilization, obtain summary reports on clients and/or services)

Yes	No, but there are plans to develop that capacity	No, and there are no current plans to do this
○	○	◉

Specify Purpose:
☐

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

48. Do service providers have access to data about your consumers? If yes, for what purpose? (review client information, input client demographic information, input referrals, input service utilization information, review client service utilization, obtain summary reports on clients and/or services)

Yes (Specify)	No, but there are plans to develop that capacity	No, and there are no current plans to do this
○	○	◉

Specify Purpose:
☐

Click here to clear all radio buttons in the question above.

49. Do staff follow up with consumers after their initial contact with your organization?

Always	Sometimes--Under what circumstances:	Never
○	◉	○

Specify Circumstances:

Follow up with consumers varies per case. If follow up is needed then it will be completed by staff members.

Click here to clear all radio buttons in the question above.

50. How many times does staff follow up with consumers after their initial contact with

your organization?

Once	Multiple times
○	◉

Click here to clear all radio buttons in the question above.

51. What is the approximate timing of the first follow up with consumers after their initial contact with your organization?

One to two weeks after service	Three weeks after service	One to two months after service	Three to five months after service	Six months after service	One year or longer after service
◉	○	○	○	○	○

Click here to clear all radio buttons in the question above.

52. What is the approximate timing of the last follow up with consumers after their initial contact with your organization?

One week after service	Two weeks after service	Three weeks after service	One to two months after service	Three to five months after service	Six months after service	One year or longer after service
○	◉	○	○	○	○	○

Click here to clear all radio buttons in the question above.

53. When consumers are referred to other agencies or organizations, are those providers contacted as part of the follow up procedure?

Always	Sometimes-Under what circumstances:	Never
○	◉	○

Specify Circumstances:

Depending on the capabilities of the client. For instance, if they do not have transportation or a telephone then our agency would assist.

Click here to clear all radio buttons in the question above.

54. Approximately what percentage of consumers who are referred to other organizations receive a "warm transfer" (e.g., Simultaneous transfer of a telephone call and its associated data from one agent to another agent or supervisor)?

80

55. Does your organization routinely collect quantitative performance data about its services and consumers?

Yes	No
○	◉

Click here to clear all radio buttons in the question above.

56. Indicate any of the ways that your organization uses performance data: [check all that apply]

- ☐ To justify funding requests
- ☐ To improve consumer service
- ☐ To administer service provider contracts
- ☐ To provide information to stakeholders (governing board, advocacy organizations, local government, etc.)
- ☐ For program planning
- ☐ Do not use performance data

57. On which topics, if any, would you like to receive additional assistance from the technical assistance provider?

How to pull accurate reports.

Section C. Service Provision, Continued

Eligibility Screening Module: Initial Screening of ADRC Clients

58. When a client contacts the ADRC about long-term services and supports (LTSS), do ADRC staff administer a screening questionnaire to make a preliminary determination of eligibility and need for publicly-funded LTSS?

Yes	No	Other, please describe
○	◉	○

Specify
Other:
☐

Click here to clear all radio buttons in the question above.

59. If yes, to which of the following populations is the eligibility screening instrument administered ? Check all that apply.

- ☐ Aged 65 and older
- ☐ Physical disability

- ☐ Intellectual Disability/Developmental Disability
- ☐ Brain injury
- ☐ HIV/AIDS
- ☐ Medically fragile
- ☐ Autism
- ☐ Mental illness
- ☐ Other (specify ________)

Specify Other:
☐

60. What kind of information is collected? Check all that apply.

- ☒ Demographic information (i.e., age, gender, ethnicity, marital status)
- ☒ Living arrangements
- ☒ Caregivers
- ☒ Health status
- ☒ Activities of daily living (ADL)
- ☒ Instrumental activities of daily living(IADL)
- ☒ Cognitive functions
- ☒ Troublesome behaviors
- ☐ LTSS currently received
- ☒ Income
- ☒ Assets
- ☐ Other, please list ______________

Specify Other:
☐

Eligibility Screening Module: Financial Eligibility Determination

61. How do clients in your state/site complete and file applications for financial eligibility for Medicaid or publicly-funded LTSS? Check all that apply.

- ☒ Applications are accessed on-line, printed, completed by hand, and returned to a state or county office.
- ☒ Applications are accessed on-line, completed on-line, printed, and returned to a state or county office.
- ☒ Applications are accessed on-line, completed on-line, and submitted to the state or county electronically.

☒ Paper copy applications are obtained at various locations including ____ [SPECIFY LOCATIONS], completed by hand, and returned either in person or by mail to a state or county office.

Specify Locations:
Medicaid yearly reviews.

☐ Other

Specify Other:
☐

62. In what ways do ADRC staff assist clients with financial eligibility applications for Medicaid LTSS Programs? Check all that apply.

☒ We do not assist clients with financial eligibility applications
☐ Advise the client where s/he can obtain an application
☐ Assist the client in completing the application
☐ Assist the client in collecting the required financial documentation
☐ Check on the status of the client's application
☐ Notify the client when the application has been approved/disapproved
☐ Manage appeals by clients whose applications were not approved
☐ Other

Specify Other:
☐

63. In what ways do ADRC staff assist clients with financial eligibility applications for publicly-funded LTSS other than Medicaid LTSS? Check all that apply.

☐ We do not assist clients with financial eligibility applications
☐ Advise the client where s/he can obtain an application
☐ Assist the client in completing the application
☐ Assist the client in collecting the required financial documentation
☐ Check on the status of the client's application
☐ Notify the client when the application has been approved/disapproved
☐ Manage appeals by clients whose applications were not approved
☐ Other

Specify Other:
☐

64. Please describe the publicly funded LTSS services in your state. This includes LTSS

programs funded solely by state or county

CLTC

65. Does your state/site permit presumptive financial eligibility in order to expedite the provision of LTSS to clients while their financial eligibility applications are being processed?

Yes	No	In Progress
○	◉	○

Click here to clear all radio buttons in the question above.

Eligibility Screening Module: Functional Assessment

66. Does your state/site use a universal, comprehensive assessment instrument for functional (level of care) eligibility determinations for LTSS?

Yes	No	No, but in development
◉	○	○

Click here to clear all radio buttons in the question above.

67. If yes, what best describes the kind of instrument your state/site is using? Check one.

A custom-designed instrument developed by state staff	A custom-designed instrument developed by a vendor specifically for our state	An instrument developed by a vendor that is also used by other states	Other, please list:
○	◉	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

68. What best describes the process for how the assessor completes the instrument? Check all that apply.

- ☐ The assessor completes a paper form while interviewing the client; there is no electronic data entry.
- ☒ The assessor completes a paper form while interviewing the client and later inputs the data on an electronic form at the office.
- ☐ The assessor completes an electronic form while interviewing the client, which is later downloaded into an electronic database.

☐ The assessor completes a web-based form while interviewing the client and the client's data is entered "real time" into an electronic database.

69. Do you work with consumers to develop a care plan?

Yes, with all consumers	Yes under certain circumstances (Please specify)	No, that is not part of this service
○	◉	○

Specify Other:
Case Management

Click here to clear all radio buttons in the question above.

70. For which of the following populations is the functional assessment used? Check all that apply.

☒	Aged 65 and older
☒	Physical disability
☐	ID/DD
☐	Brain injury
☐	HIV/AIDS
☐	Medically fragile
☐	Autism
☐	Mental illness
☒	Other

Specify Other:
Alzheimer's dementia

The Affordable Care Act requires states to implement Health Insurance Exchanges effective January 1, 2014. States are required to provide a single electronic portal for "real time" financial eligibility determinations for Medicaid and Qualified Health Plans offered through the Exchange.

71. Is your organization involved in planning for your state's Exchange?

Yes	No	Not sure
○	○	◉

If Yes, please describe your organization's role:
☐

Click here to clear all radio buttons in the question above.

72. Is your state/site examining ways to align functional eligibility determination for publicly-funded LTSS with Medicaid financial eligibility determination carried out through the Exchange website?

Yes	No	Not Sure
○	○	○

If Yes, please describe:
☐

Click here to clear all radio buttons in the question above.

73. Are any of your organization's functions reimbursed under Federal financial participation (FFP) or Federal medical assistance percentage (FMAP)? If so please specify the functions.

☒ No, none of our functions are reimbursed under FFP or FMAP
☐ Yes, the following functions are reimbursed under FFP

Specify Functions:
☐
☐ Yes, the following functions are reimbursed under FMAP

Specify Functions:
☐

Section D. Organizational Characteristics

74. For the current Fiscal Year, what is the approximate amount of funding from each of the following sources? (In $ amounts)

"Amount of funding during the current Fiscal Year" refers to the FY13 share of a grant awarded in FY13 (not the total grant) and if an existing grant, the funds allotted in FY13.

Check if you have received funding in prior Fiscal Years	Amount of funding during the current Fiscal Year	Funding source
☐	☐	Administration on Aging Title IV ADRC Grant

☐	☐	Administration of Aging Title II Grant
☐	☐	CMS Real Choice Systems Change Grants
☐	☐	CMS Person-Centered Hospital Discharge Planning Grant
☐	☐	Patient protection and Affordable Care Act Grant
☒	29340	Veteran's Administration
☐	☐	Money Follows the Person Demonstration
☐	☐	State Transformation Grant
☐	☐	Alzheimer's Disease Demonstration Grant
☐	☐	Evidence-Based Disease Prevention Grant
☐	☐	Program of All-Inclusive Care for the Elderly (PACE)
☒	10077	Medicare Improvement for Patients and Providers Act (MIPPA)
☐	☐	Respite Care Act funds
☐	☐	Rehabilitation Services Administration (RSA)
☐	☐	Substance Abuse and Mental Health Services Administration (SAMHSA) - Mental Health Transformation Grant
☐	☐	Agency for Health Care Research and Policy - Chronic Disease Self-Management Grant
☐	☐	Administration for Children and Families, Office of Community Services - Low Income Home Energy Assistance Program (LIHEAP)
☐	☐	Health Resources and Services Administration HIV/AIDS Bureau - Ryan White Fund
☒	547655	State Unit on Aging
☒	36687	State General Revenue
☒	80726	County of local government
☐	☐	Private entities/grants - Hospitals or other businesses
☐	☐	Medicaid for Direct Services (state and federal)
☐	☐	Medicaid for Federal Financial Participation
☐	☐	Care Transitions Income
☐	☐	Consumer Fees or Cost Sharing
☐	☐	Charitable Donations
☐	☐	Other, please specify

Specify Other for funding received in prior Fiscal Years:
☐

Specify Other:
☐

☐	☐	Total Budget for FY 2013

75. What best characterizes the operation of your agency?

Single-point of entry: one agency maintains a knowledgebase on LTSS options and assists consumers in making decisions about the best and most feasible options for LTSS	No wrong door: multiple agencies are knowledgeable about LTSS options and cooperate to assist consumers regardless of which agency the consumer first contacts.
○	○

Click here to clear all radio buttons in the question above.

76. Do you identify your structure as any of the following:

Independent, non-profit	Part of city government	Part of county government	Part of COG or RPDA	Other. Specify:
○	○	○	◎	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

77. What organizations comprise the core operating organizations?

Organization	Core Operating Organization?
AAA	Yes
State Unit on Aging	Yes
Veterans Organization	No
Alzheimer's Association	No
Other Aging Services Organization	No
Centers for Independent Living	No
Vocational Rehabilitation Departments	No
Other Disability Services Organization	Yes
Community Mental Health	No
County or Regional Council of Governments	Yes
County Government Office or Agency	No
Local Housing Authority	No
State or Local Medicaid Agency	No
211	No
Other Human Services of Social Service Provider (please specify)	Please Select

Specify Other:
☐

78. [FOR EACH OF THE CORE OPERATING ORGANIZATIONS]: Please describe your relationship with other core operating organizations at your site and the functionality of the site in meeting the objective of improving and streamlining access to information, assistance, and long-term services and supports for older adults, persons with disabilities, and their families. Would you describe the current status as having a solid working relationship? Please provide as much detail as possible.

- Our ADRC Advisory members consists of a variety of professionals within our region. Professionals from the following our region nclude; Sumter County DSS, CareSouth, Community Long Term Care, DDSN, The Shepherds Center, American Cancer Society, Vocational Rehab, and Habitat for Humanity. These professionals advise the ADRC staff on ways to better assist our region. - RAAC Advisory members consists of consumers who provide all staff members with advise on how to better assist the disabled and elderly individuals within our region. - The ADRC has a wonderful relationship with SSA which makes our day to day functions much easier.

Section D. Organizational Characteristics, Continued

79. With which organizations do Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) have a partnership? What is the strength of the relationship, as well as the type of partnership agreement and shared resources?

	Partner	Functionality of Partnership	Partnership Agreement	Shared Resources
State Departments (with cabinet-level secretaries):				
Health	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Human Services	☒	Highly functional	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Specify Other:
☐
State Agencies (located within state departments):

Aging	☒	Highly functional	☒Funding Relationship ☒Formal MOU ☒Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☒Shared monetary resource ☒Information sharing ☒Joint training ☒Joint sponsorship of programs ☒Shared non-monetary resources (i.e. office space) ☒Shared data ☐No shared resources
Developmental Disabilities	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Acquired or Late-Onset Disabilities	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Mental Health	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Medicaid	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Housing	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Education	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Specify Other:
☐
Local Government Agencies

Area Agency on Aging	☒	Highly functional ▼	☒Funding Relationship ☐Formal MOU ☐Contract ☒ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☒ Co-located staff ☒Shared monetary resource ☒Information sharing ☒Joint training ☒Joint sponsorship of programs ☒Shared non-monetary resources (i.e. office space) ☒Shared data ☐No shared resources
County Health Department	☒	Moderately functional/functional in some areas ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

County Medicaid office	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
County Department on Aging	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

County Department on Disability	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
County Housing Office	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Library	☒	Highly functional	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐
Federal Agencies:

Local Veterans Administration	☒	Highly functional	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☒Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Local Indian Health Service	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Other (specify):	☐	Please Select	☐ Funding Relationship ☐ Formal MOU ☐ Contract ☐ Cooperative ☐ Informal Working Relationship ☐ Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐ Shared monetary resource ☐ Information sharing ☐ Joint training ☐ Joint sponsorship of programs ☐ Shared non-monetary resources (i.e. office space) ☐ Shared data ☐ No shared resources

Specify Other:
☐

Organizations Providing Direct Services:

211 or other call center	☐	Please Select	☐ Funding Relationship ☐ Formal MOU ☐ Contract ☐ Cooperative ☐ Informal Working Relationship ☐ Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐ Shared monetary resource ☐ Information sharing ☐ Joint training ☐ Joint sponsorship of programs ☐ Shared non-monetary resources (i.e. office space) ☐ Shared data ☒ No shared resources

Community Health Clinic	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Community Mental Health Clinic	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Deaf Service Center	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Hospital/Medical Center	☒	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

School for the Blind	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
School for the Deaf	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

The ARC	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
United Way	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Vocational/Rehabilitation Services	☒	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐

Advocacy/Referral Organizations:

AIDS Coalition	☒	Moderately functional/functional in some areas ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☒Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Alzheimer's Association	☒	Highly functional ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☒Shared monetary resource ☒Information sharing ☒Joint training ☒Joint sponsorship of programs ☒Shared non-monetary resources (i.e. office space) ☒Shared data ☐No shared resources

American Council of the Blind	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Autism Society state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Brain Injury Association state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Centers for Independent Living	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Easter Seals	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Epilepsy Foundation state/regional chapter	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

National Association of Mental Illness state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
National Autism Association state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

National Multiple Sclerosis Society state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
State Association for the Deaf	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐
			☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

United Cerebral Palsy	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐

Section D. Organizational Characteristics, Continued

80. Approximately how many FTEs (Full-time equivalents) perform each of the following functions?

8 I&R/I&A

5 Options counseling/counseling to provide in-depth person centered decision support

[5] Benefits counseling/eligibility determination

[2] Care transition services

[5] Crisis intervention services

[2] Independent Living services

[8] Advocacy services

[8] Providing administrative or other support for the above functions

81. How many front line staff are Alliance of Information and Referral Systems (AIRS) certified?

[4] Number of AIRS certified staff

[9] Total number of front line staff

82. Is your organization paid on a fee-for-service or per-unit basis for performing any of the following services for a client? (Please check all that apply)

☐ Information/referral
☐ Options counseling
☐ Screening
☐ Assessment
☐ Application assistance
☐ Transition support
☒ Other, please specify

Specify Other:
[N/A]

83. What is the source of the fee-for-service or per-unit payments?

☐ Medicare
☐ Medicaid waiver
☐ Medicaid state plan
☐ Medicaid managed care organization
☐ State-funded program other than Medicaid
☐ Private health plan
☐ Provider
☒ Other, please specify

Specify Other:
[N/A]

Section E. LTSS Environment

84. Since Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) started serving consumers, has there been an impact on the LTSS or Home and Community-Based (HCBS) system in your community?

There has been an increase in the number of LTSS providers.	There has been a decrease in the number of LTSS providers.
○	◎

Click here to clear all radio buttons in the question above.

85. Since Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) started serving consumers, has there been an impact on the LTSS or Home and Community-Based (HCBS) system in your community?

There has been an increase in the quality of LTSS services.	There has been a decrease in the quality of LTSS services.
○	◎

Click here to clear all radio buttons in the question above.

86. Please add any final thoughts about Santee Lynches Aging and Disability Resource Center (Santee Lynches AAA/Council of Governments) and either its operations and/or its results

□

RESOURCE REPORT

Complete Only One RR Form for the Entire State. Do Not Submit Sponsoring-Agency-Level or Within-State-Regional Resource Reports. All Person Counts Should Reflect Active Counselors, Coordinators, Other Staff as of the End of Each Grant Year (31 March).

12 Month Period for This Report	State Code	State Grantee Name
From: 2012 To: 2013	45	

Person Completing Report	Title	Telephone Number
Janae Allumba	SMP/SHIP Coo	(803) 775-738

Section 1
Number of Active Counselors And Hours As of 31 March

	State Office	All Other Local and Field Sites	Total
A. Number of Volunteer Counselors		0	
B. Number of SHIP-Paid Counselors		8	
C. Number of In-Kind-Paid Counselors		0	
Total Number of Counselors - A+B+C		8	
D. Volunteer Counselor Hours		0	
E. SHIP-Paid Counselor Hours		2,262.50	
F. In-Kind-Paid Counselors Hours		0	
Total Counselors Hours - D+E+F		2,262.50	

Section 2
Number of Local Coordinators / Sponsors and Hours As of 31 March

	Total
A. Number of Volunteer (Unpaid) Coordinators	0
B. Number of SHIP-Paid Coordinators	1
C. Number of In-Kind-Paid Coordinators	0
Total Number of Coordinators - A+B+C	1
D. Volunteer (Unpaid) Coordinator Hours	0
E. SHIP-Paid Coordinator Hours	574
F. In-Kind-Paid Coordinator Hours	0

Total Coordinator Hours - D+E+F	574

Section 3
Number of Other Paid and Volunteer Staff And Hours As of 31 March

	State Office	All Other Local and Field Sites	Total
A. Number of Volunteer Other Staff		7	
B. Number of SHIP-Paid Other Staff		0	
C. Number of In-Kind-Paid Other Staff		0	
Total Number of Other Staff - A+B+C		7	
D. Volunteer Other Staff Hours		608	
E. SHIP-Paid Other Staff Hours		0	
F. In-Kind-Paid Other Staff Hours		0	
Total Other Staff Hours - D+E+F		608	

Section 4
Counselor Trainings

	Total
A. Number of Initial Trainings for New SHIP Counselors	2
B. Number of New SHIP Counselors Attending Initial Trainings	0
C. Total Number of Counselor Hours in Initial Trainings	44
D. Number of Update Trainings for SHIP Counselors	6
E. Number of SHIP Counselors Attending Update Trainings	8
F. Total Number of Counselor Hours in Update Trainings	58.50

Section 5

Number of Total Active Counselors (SHIP-Paid, In-Kind-Paid and Volunteer Counselors) with the Following Characteristics

Years of SHIP Service		**Counselor Race - Ethnicity**		**Counselor Disability**	
Less Than 1 Year	2	Hispanic, Latino, or Spanish Origin	0	Disabled	0
1 Year Up to 3 Years	2			Not Disabled	8
3 Years Up to 5 Years	1			Not Collected	0
		White, Non-	5	**Counselor Speaks Another Language**	

More Than 5 Years	3
Not Collected	0

Counselor Age

Less Than 65 Years of Age	7
65 Years or Older	1
Not Collected	0

Counselor Gender

Female	7
Male	1
Not Collected	0

Hispanic	
Black, African American	3
American Indian or Alaska Native	0
Asian Indian	0
Chinese	0
Filipino	0
Japanese	0
Korean	0
Vietnamese	0
Native Hawaiian	0
Guamanian or Chamorro	0
Samoan	0
Other Asian	0
Other Pacific Islander	0
Some Other Race - Ethnicity	0
More Than One Race - Ethnicity	0
Not Collected	0

Language Other than English	0
English Speaker Only	8
Not Collected	0

FY 2012 SHIP Year End Progress Report

Region

The purpose of this report is for sub-grantees to indicate SHIP activates performed during **September 1, 2012 through December 31, 2012** and state proposed activities for 2013.

I. What actions did your region take in FY 2012 to expand your outreach and counseling efforts?

Prior to the reporting period Santee-Lynches ADRC (SLADRC) used a RV/mobile unit weekly to perform outreach and outreach events in the underserved communities in the region. Santee-Lynches ADRC (SL ADRC) decided that it could no longer afford the use of the mobile unit due to funding. However, SL ADRC has implemented an outreach calendar to schedule events, which still allows for our agency to be mobile in each county. Health Fairs and presentations are scheduled on a monthly basis. This calendar is distributed to 900 individuals each month. Each staff member contributes equally by attending these events. Two more staff members were SHIP certified this year, which means all staff members are now certified to counsel clients. At every outreach and presentation counseling is available and offered on the spot. Promotional items are consistently distributed to ensure that clients always have our agencies contact information handy. SLADRC Aging Director made his debut on Senior Connections which reached a large amount of our region and future clients. After the taping was aired many callers contacted our office for assistance.

A. What changes will your region make in 2013 to enhance these efforts?

Our current efforts have been enhanced since implementing the outreach calendar. Our state goal has been exceeded each month. SLADRC monthly average is currently at 478 contacts. Each staff member has contributed to this effort and as a team we continue to strive for success. We will continue to schedule more outreach events and presentations, which will allow faith based organizations, senior seniors, and facilities within our region to become more familiar with our agency and the services we provide. Our agency also has proposed the implementation of a Facebook page for our region. This media outlet will enhance our efforts by reaching more clients and their family members. Retraining will also be provided to volunteers and staff members to ensure our efforts stay consistent.

II. What actions did your region take to reach more consumers through presentations and health fairs?

Presentations/health fairs from Sep-Dec 2012 are represented in the table below.

	Sumter	Lee	Kershaw	Clarendon	Total
Total Events Scheduled	8	1	4	4	17
Total Clients Reached	295	33	255	69	652

FY 2012 SHIP Year End Progress Report

Region

- *Our outreach calendar is mailed/email to all that receive an SL ADRC newsletter.*
- *The Shepherd's Center of Sumter distributes our event calendar to all of their organizations members every month.*
- *The state is notified of our events so they can be posted on the calendar of events on the following web page for the community to view: https://scaccess.communityos.org/cms/*
- *Provide promotional items and counseling on the spot at all events.*
- *Inform partners such as the Senior Life Improvement Center, board members, and faith based organizations, and senior centers of the location, time, and date of presentation/outreach events.*

A. What changes will your region make in 2013?

Changes that will be made include building more partnerships with faith based organizations in the region. These partnerships will allow our agency to fill the gaps for clients. With our current efforts we continue to see the gaps close. Clients are becoming more educated on Medicare, Medicare fraud, Medicaid and other related issues due to health fairs and presentations at faith based organizations.

III. What actions did you take to increase the number of consumers reaching your office through direct contact such as in-person, telephone calls and home visits?

- *Our Clarendon County Case Manager contacts clients in-person, by telephone, and will visit clients homes for those who are unable to commute to our office or do not have transportation. SLADRC Case Manager assists clients with any Medicare/Medicaid needs in Clarendon County.*

- *Our Ombudsman consistently briefs all clients that she comes in to contact with on Medicare fraud, abuse, and waste.*

- *During each outreach event staff provides SMP magnets, pens, and calendars with contact information on them. Clients are encouraged to contact our office with any Medicare or Medicaid concerns.*

- *Technical assistance with Catawba AAA for SHIP best practices took place on May 31, 2012. Staff that attended this training briefed Aging Director on meeting. Next, all aging staff members were trained on new practices, which included all staff members consistently assisting clients with SHIP related functions. Each staff member was assigned an individual goal, which is required to be met each month. Bi-weekly meeting are required to take place and all staff members must attend to discuss the team's effort throughout the month. New SHIP practices were successfully implemented at Santee-Lynches ADRC.*

Region

A. What changes will your region make to increase direct contacts in 2013?

"Insurance Counseling" promotional items include pill boxes, bandage dispensers, and bag clips will increase the number of direct contact by being dispersed at every presentation, health fair, and home visit. "Stop Medicare Fraud" promotional items include ice scrappers and pens. These items will also be dispersed to increase contact to our agency.

IV. What actions did you region take to reach more beneficiaries under age 65?

The SLADRC outreach calendar was our agencies action to reach more beneficiaries under the age of 65. Health fairs and presentation are attended by individuals who are of all ages. Client that we come in contact with who are under the age of 65 are becoming more educated on Medicare and Medicaid before they become eligible.

A. What are your 2013 strategies to reach more consumers under age 65?

SLADRC will continue to schedule outreach events where all ages are in attendance. With continuous education throughout our region it is more likely for future beneficiaries to choose stable plans that will fit their health care needs. SLADRC will also contact other regions to see how they are reaching consumers that are under the age of 65.

V. What was your region's strategy for reaching LIS eligibles?

Our regions strategy for reaching those who are eligible for LIS include all staff members screening all clients that our agency assists. In the month of September our agency submitted seven LIS applications. In the month of October our agency submitted seven LIS applications. In the month of November our agency submitted 18 LIS applications. In December our agency submitted three LIS applications. A total of 35 LIS applications were submitted between the months of September and December.

A. What are your strategies for 2013?

Our strategy for 2013 includes reaching out to areas in our region that have not been visited often. Many of our clients are already receiving Extra Help, which means we need to target new areas, obtain new clients, educate them, and then screen for LIS.

VI. What was your strategy or process for enrolling consumers into Part D plans?

Outline for Medicare Part D Open Enrollment for 2012.

Medicare Letters

- *Prepared and mailed out on August 20, 2012 to all clients from the SC Access mailing list for FY11-12.*

FY 2012 SHIP Year End Progress Report

_____

Region

Volunteers

- *Schedule for Open Enrollment completed by August 30, 2012 (SMP, Interns and recruited Medicare Volunteers)*
- *Volunteer/Intern Training week of August 27*
- *Will contact client to verify that medication information provided is correct to be entered into the system.*

Staff

- *Toni Brew and Janice Coney devote one day a week to enter medication into the plan finder on the Medicare website.*

Once medication has been enter into the system the clients will be divided between Yolonda Russell, Shalyse Edgar, Janae Lang, and Kristy Pritchard. Gena Kiber will continue to assist her clients in Clarendon County.

Total # Clients Served

County	Numbers Served	Numbers Served	Numbers Served	Numbers Served
	2009	2010	2011	2012
Clarendon	77	217	109	169
Kershaw	28	17	13	21
Lee	36	12	43	17
Sumter	230	265	184	242
TOTALS	371	511	349	449

Cost Benefits ($ Savings/Cost Avoidance)

Enrollment Year	Cost Benefit	Average Cost Savings per Client Served

FY 2012 SHIP Year End Progress Report

_____

Region

2009	$326,186	$1424
2010	$ 84,756	$657
2011	$ 94,644	$763
2012	$278,586	$1272

Total # Contacts made with Clients

County	Contacts 2009	Contacts 2010	Contacts 2011	Contacts 2012
Clarendon	300	501	338	460
Kershaw	134	78	78	69
Lee	91	36	88	61
Sumter	1035	767	648	821
TOTAL	1560	1382	1152	1411
Average Contacts per Client	4.2	2.7	3.3	3.1

Total # Hours Expended

County	Hours 2009	Hours 2010	Hours 2011	Hours 2012
Clarendon	325.75	465.0	221.0	326.47
Kershaw	111.0	54.0	43.75	42.50

FY 2012 SHIP Year End Progress Report

Region

Lee	68.25	36.75	50.92	31.75
Sumter	793.0	500.5	391.42	501.25
TOTAL	1296.0	1056.25	707.09	901.97
Average Hours per Client	3.5	2.1	2.03	2.0

A. What is your strategy for increasing Part D enrollment in 2013?

We will continue to see the serving population increase in the coming years. There for additional outreach in our region will take place, especially in Lee and Kershaw County. Additional staff and volunteer training for SHIP counselors will take place. We will also increase volunteer recruiting efforts and train earlier.

CMS Compiled data response:

Since working with and then obtaining the position of SMP/SHIP coordinator at SLADRC the outreach calendar was implemented. Since implementation of the calendar our numbers in both Lee and Kershaw County reveal an increase from pervious reporting periods. Through the months of June2012 through August 2012 our agency averaged approximately 45 contacts in Kershaw County and averaged approximately 42 contacts in Lee County. Through the months of September2012 to December 2012 we averaged approximately 44 contacts in Kershaw County and averaged approximately 28 contacts in Lee County. Efforts in Kershaw and Lee County are continuous. I continue to see individuals in Kershaw County becoming more comfortable working with our agency and contacting us for Medicare, Medicaid, and other assistance they are in need of. Lee County continues to be one of our agencies challenges. Attempts are made to provide services to this area. In return we receive little or no response.

SMP Progress Report Guidelines for Grant No. 90AM2706
Report Period
1/1/2012 thru 6/30/2012

1. **What did you do to promote the National and Regional SMP Program?**

Our agency has been promoting National and Regional SMP programs through several sources: our Mobile Unit program, Case Management Program, facilities/organizations, and partners of the agency.

Our Mobile Unit program which services Clarendon, Kershaw, Lee, and Sumter gave us the opportunity to take our office mobile and interact with beneficiaries face to face. For many of these clients, this method is the only way which they may be able to seek help with any Medicare issues they may encountered during the year. Through our Mobile Unit, we were able to provide information and help with Medicare issues. While in all four counties flyers and SMP information was dispersed to facilities. In Clarendon County, SMP information was provided to the Clarendon County Library. Also, our Clarendon Case Manager has assisted in giving clients the general information on Senior Medicare Patrol. In Kershaw County, SMP information was provided to the Kershaw Public Library. In Lee County, SMP information was provided to the DSS office and to the Lee County Mental Health facility. In Sumter, The Shepherd's Center (agency partner) was provided with SMP materials for the members of their organizations.

What were your regional marketing activities?

Our agency created SMP flyers and obtained materials from the smpresource.org website to disperse at our regions senior centers, health fairs (Sumter Seniors Games), community events, and places of faith (Radiant Life Community Field Day. Our agency is partnered with Derek Burgess who hosts Good Morning Sumter, a radio show that reaches out to audiences in Clarendon, Kershaw, Lee, and Sumter County. This partner offers our agency slots to promote ADRC programs such as Senior Medicare Patrol.

Describe all efforts with the National SMP program such as webinars, ordering materials, etc. *(see attached materials-did not order-downloaded and printed for handouts):*

Our agency participated in technical training meetings. Talvin Herbert gave training at the ADRC and at Central Midlands AAA. Mark Jordan gave technical training on the SMP program. Information on how to recruit volunteers and order promotional items was administered.

Our agency used the SMP Resource and US Administration on Aging to download or request information and articles pertaining to Medicare fraud to share with our beneficiaries. Our agency also ordered specialized promotional materials to distribute at regional SMP presentations. These materials included; pens, calendars, and magnets that displayed "Senior Medicare Patrol" and contacts information.

2. **What did you do to improve beneficiary education and Inquiry resolution?**

Education: Our agency continued to promote beneficiary education and inquiry resolution through our ADRC Advisory Committee and our monthly newsletter. By producing our monthly ADRC newsletters and distributing them to our partner agencies and the local COA's in our region, we work to give the most recent information to all who are receiving or in other ways coming in contact with Medicare.

Also, the Shepherd's Center (agency partner) runs a monthly SMP article in their newsletter that is distributed to all members.

Inquiry resolution: (include follow-ups, resolution process and intake process.)

Our agency provides one on one counseling to resolve errors or misunderstandings of services that were provided in at the ADRC office, over the phone, or at outreach events.

For example, a client contacted the ADRC expressing their concern with a medical bill that was received in the mail. This client was instructed to complete an intake form. Then the client was asked how they may be helped and what concerns she was encountering. The charges were for this client's husband who had passed in 2003. However, the charges for services were administered in 2011. The organization was attempted to be contacted but no resolution was able to be made. This organization was clearly committing Medicare fraud. After the organization would not respond to our agency the client's information was submitted to Talvin Herbert for further investigation. This clients' case is still under review.

3. **How did you foster the National SMP Program Visibility?**

Our agency fosters national SMP program visibility through our monthly ADRC newsletter. Going through the Medicare website for information on programs and other items of interest, we are able to gather information which we use to inform our partner agencies and beneficiaries. We have at least on article per month dedicated to SMP fraud in which we encourage our beneficiaries to contact any of the agencies for assistance. We give this information to our attendees at any presentation or meeting in which we are asked to participate in. We also provide promotional materials at each presentation and/or training which prominently displays the national SMP program logo and disclaimer.

Do you have a link to the national SMP?

Our agency has a link to the National SMP through our reporting to the SMP SMARTFACTS program. We use the SMP resource website to gather information and materials which we can use to promote fraud protection in our region.

How do you market the national SMP (newspaper, promotional items, etc)?

Our agency markets the National SMP through our monthly agency newsletter, our promotional items (pens, calendars, magnets, etc.) The Shepherd's Center (agency partner) was provided with an SMP article to run continuously in their organizations newsletter, which is mailed out to all members. We also have our agency-produced handouts promoting fraud prevention to share with beneficiaries.

4. **How did you improve your efficiency?**

Define efficiency in terms of what worked and what areas needing improvements.

We were able to work with our target population and ask them specifically if there were any issues related to Medicare fraud or questionable tactic from people cold-calling them about services or items for which did not ask. We had more beneficiaries tell us they did receive unwanted calls or visits at their home from agents and immediately told them they did not wish to speak with the. These individuals also alerted others in their neighborhood and through their local or faith based organizations about the calls and visits from high pressure salespeople. As a result, clients are safeguarding their Medicare and other personal identification better through our constant reminders.

Clients continue to struggle with been exploited or defrauded and are still unsure on who to contact when the situations arise. Many of our clients/beneficiaries have no relatives who can help them navigate the system to get the relief they need. Our agency is also struggling with a lack of education on the SMARTFAX database. The system is limited to one user which makes data entry difficult when all employees advocate for Senior Medicare Patrol.

How will you improve outreach and contacts for the next report period?

Our agency is in the process of working with several organizations to provide information on the SMP program. We are attempting to schedule these presentations and outreach events so that the information can be shared with as many beneficiaries at once. We will work to ensure that every person who contacts our agency for any service (particularly the Family Caregiver, Care Management, I-CARE/SHIP, Assisted Rides and VA programs) is continuously reminded to be aware of potential fraud.

What were the prevalent fraud trends in your area and what were your strategies for reducing the incidences?

We are continuing to see a number of questionable marketing tactics related to Medicare beneficiaries. Those tactics include cold calls to client who did not request any service or visits from agents, as well as questionable promises from sales agents who are making promises regarding services which are untrue or misleading. Up coding is also a prevalent act taking place in health care organizations primarily by physicians.

5. **How did you target populations for your training? Volunteers**

Target populations for training took place at Central Carolina Technical College. This partnership enabled us to recruit and train eight SMP volunteers. All eight of these volunteers received technical training at the ADRC by Talvin Herbert. Once training was completed, volunteers were given an option to complete an exam which would make them SMP certified. Four volunteers completed the examination and were successful.

6. **Who were your targeted populations?**

Target populations were in areas where beneficiaries were most prevalent. Areas such as senior centers, health fairs, Senior Life Improvement Center partnership, will be targeted

7. **Do you have partners helping to reach populations?** Yes

Who are they?

Partners include eight SMP's and our ADRC Advisory Committee which consists of 24 partners.

What did you accomplish since last report period and what will you do different for the current period?

What were your challenges and what are your plans to be successful in spite of obstacles.

8. **Include any events scheduled for the rest of the year including Media Events.**

9. **Please send an electronic or hard copy of all materials used in your program.**

10. **Confidentional items**
    Lock cabinet, all volunteers signed a confidentially waivers.

SMP Progress Report Guidelines
for
7/1/2012 thru 12/31/2012

Region VI

The SMP Grant is to support regions in achieving the following AOA outcomes. Please list your goals and describe activities to implement key requirements of the program.

1. **What did you do to promote the National and Regional SMP Program?**

Our agency has been promoting National and Regional SMP programs through: our outreach calendar, Aging and disability Resource Center programs, and agency partners. Our outreach calendar is distributed with our monthly newsletter, which is distributed to over 900 individuals on a monthly basis. The outreach calendar allows our agency to be mobile within the region and interact with beneficiaries face-to-face in remote areas. For many of these clients, this method is the only way which they may be able to seek help with any Medicare or Medicaid issues they may have encountered during the year. Through our outreach calendar, we were able to provide information to educate the residents to. Below is a chart showing the number of outreach events that took place in each county from 7/1/12 through 12/31/12.

County	Outreach/Education	Total Number Reached
Clarendon	5	118
Kershaw	8	128
Lee	4	82
Sumter	13	291
Richland	1	5

Our Aging and Disability Resource Center programs were utilized to continuously provide information to a variety of clients/beneficiaries and their families. In Sumter, The Shepherd's Center and Senior Life Improvement Center (agency partner) was provided with SMP materials for the members of their organizations.

What were your regional marketing activities?

Our agency created SMP flyers and obtained information materials from the smpresource.org website to disperse in all four counties. Material was dispersed at senior centers, health fairs, community events, and places of faith. Our agency participated in television broadcasting on Senior Connection which was taped October 26, 2012 and aired November 13, 2012. This television debut reached many viewers in our region. As a result, our agency received a flood of calls.

Describe all efforts with the National SMP program such as webinars, ordering materials, etc.

Our agency participated in a series of webinars. SMART FACTS 101 was attended, which included the following topics; Introduction to SMART FACTS, Outreach and Education, Volunteer Tracking and Management, and Editing Data. Complex Issues, Reporting Basics, OIG Reporting was also attended.

Our agency used the SMP Resource and US Administration on Aging to download or request information and articles pertaining to Medicare fraud to share with our beneficiaries. Our agency also ordered specialized promotional materials to distribute at regional SMP presentations. These materials included; pens and ice-scrapers that displayed "Stop Medicare Fraud" and contact information. Our agency now has flyers, tip sheets, magnets, pens, and ice-scrapers as SMP promotional items. These items are dispersed at all outreach events, presentations, and with one-on-one encounters.

2. ***What did you do to improve beneficiary education and Inquiry resolution?***

Education: Our agency continued to promote beneficiary education and inquiry resolution through our ADRC Advisory Committee and our monthly newsletter. By producing our monthly ADRC newsletters and distributing them to our partner agencies and the local COA's in our region, we work to give the most recent information to all who are receiving or in other ways coming in contact with Medicare. Beneficiaries' education was also improved by continuously attending outreach throughout the region on a monthly basis.
Simple Inquiries: Beneficiary education was improved by a collective effort from the SLADRC staff. Staff members have continuously made an effort to educate beneficiaries on fraud, waste, and abuse, which lead to more simply inquiries.
Complex Inquiries: Our agency did not encounter any complex issue this reporting period. However, our agency will provide one-on-one counseling to resolve errors or misunderstandings of services in the ADRC office, over the phone, or at outreach events when needed.

Include numbers served through Simple, Complex, Media and Group Education. List follow-ups, resolution process and intake process.

Are inquiries entered into SMART-Facts bi-weekly _____? If not, why?

Inquires are entered into the SMART-Facts on a monthly basis. The reason for information not being entered in to the system bi-weekly is due to the fact that it is easier to enter the whole month at once. Also, SHIP numbers are due into the system on the 5th of each month along with most programs reports. I find it more reasonable for staff members to have all inquiries turned in to me on the 15th of each month.

3. ***How did you foster the National SMP Program Visibility?***

Our agency fosters national SMP program visibility through our monthly ADRC newsletter. Going through the Medicare website for information on programs and other items of interest, we are able to gather information which we use to inform our partner agencies and beneficiaries. We have at least on article per month dedicated to SMP fraud in which we encourage our beneficiaries to contact any of the agencies for assistance. We give this information to our attendees at any presentation or meeting in which we are asked to participate in. We also provide promotional materials at each presentation and/or training which prominently displays the national SMP program logo and disclaimer.

Do you have a link to the national SMP?

Our agency has a link to the National SMP through our reporting to the SMP SMARTFACTS program. We use the SMP resource website to gather information and materials which we can use to promote fraud protection in our region.

How do you market the national SMP (newspaper, promotional items, etc)?

Our agency markets the National SMP through our monthly agency newsletter; our promotional items (tip sheets, pens, magnets, ice-scrapers etc.) The Shepherd's Center (agency partner) was provided with an SMP article to run continuously in their organizations newsletter, which is mailed out to all members. We also have our agency-produced handouts promoting fraud prevention to share with beneficiaries.

Number of group presentations conducted 31. What were your outreach goals? Did you meet or exceed your goals? What is your improvement plans?

Our interagency outreach goal is to teach Medicare beneficiaries how to protect their personal identity, identify and report errors on their health care bills, and identify deceptive health care practices. During this reporting period our agency did meet our interagency outreach goal by providing 5 outreach/education sessions in Clarendon County (Clarendon County has a case management entity that is readily available for all services including but not limited to SMP, I-Care, IR&A, etc.) 8 in Kershaw County, 4 in Lee County, 13 in Sumter County and 1 in Richland County. All outreach/education events are scheduled on a monthly basis to ensure that beneficiaries are provided with information on how to prevent, detect and report health fraud, errors, and abuse. Our agency will continue these practices for the next reporting period and increase our efforts in Lee County.

4. ***How did you improve efficiency*?**

How many SMP volunteers do you have? 8

Did contacts or inquiries increased or decreased? WHY?

What are your strategies to improve contacts for the next report period?

Our agencies strategy to improve contacts for the next report period include; more volunteer recruitment, training, and to continue with our frequent outreach. Our agency is in the process of working with several organizations to provide information on the SMP program. We are attempting to schedule these presentations and outreach events so that the information can be shared with as many beneficiaries at once. We will work to ensure that every person who contacts our agency for any service

(particularly the Family Caregiver, Care Management, I-CARE/SHIP, Assisted Rides and VA programs) is continuously reminded to be aware of potential fraud.

What were the prevalent fraud trends in your area and what did you do to inform or help consumers?

We are continuing to see a number of questionable marketing tactics related to Medicare beneficiaries. Those tactics include cold calls to client who did not request any service or visits from agents, as well as questionable promises from sales agents who are making promises regarding services which are untrue or misleading. Up coding is also a prevalent act taking place in health care organizations primarily by physicians. As a result of these trends these topics are visited at each outreach event and presentation to ensure that residents are aware of these tactics.

5. ***In addition to reaching all populations, how did you target underserved populations?***

Our agency targeted underserved populations by scheduling outreach in rural areas. Also, our agency uses partners, which include our ADRC Advisory Committee consisting of 40 partners. These members advise and help the program when asked. The SMP and Family Caregiver Support Program needs to work more closely to educate the caregivers within our region.

6. ***Who were your targeted underserved populations?***

Are primary target populations are seniors 60 and older, any adult with a disability, and their caregivers (adult children, neighbors, and others who care for them). We also target our training to the staff of other organizations that come in contact with Medicare beneficiaries so they can either give direct support to those who need help or refer their clients to our organization for the assistance. The underserved targeted population would be caregivers in our region. I believe as an agency we could better educate the caregivers that receive services from the Family Caregiver Support Program.

7. ***Who are your <u>new partners</u> since last report period?***

A new partnership that was gained from last reporting period is Safe Credit Union. Safe Credit Union is willing to provide Seminars to the public at no cost. Seminars include Identity Theft and Senior Financial Scams: How to protect Family and Friends. This partnership will be extremely in providing education to beneficiaries with in the region.

8. ***What new approaches did you implement since last report period and what will you do different for the current period? What are you goals for the upcoming period?***

Last year the outreach calendar was implemented which proved to be successful for our agency. SMP volunteers and Central Carolina Technical College (CCTC) interns assisted staff with health fairs and presentations when scheduled.

For the upcoming period an SMP intake form has been constructed and implemented within the agency. The SMP intake form will allow our agency to capture all data that is relevant to the SMP program to ensure that it is entered into the system. All aging staff has this form and is now responsible for using it to capture all dissemination activities, community outreach, simply inquiries, group education, and media airings.

The scheduling of seminars with Safe Credit Union is currently in the process of being implemented. This partnership will lead to more education with in the community which is our agencies goal. Other goals for the upcoming period include; obtaining Lee County SMPs and scheduling more training for all SMP volunteers.

9. Please list all events and trainings for the upcoming period.

See attached calendars for the month of February 2013 and March 2013.

- Identity Theft Seminars.
- Senior Financial Scams: How to protect Family and Friends.
- Presentations at faith based organizations, senior centers, community centers, libraries, etc.

  * These events are scheduled on a month by month basis.

- More volunteer recruitment.
- Consistent volunteer training will be scheduled for the upcoming period.

10. Please list your process for maintaining the confidentiality of client's records and SMP information.

Santee-Lynches ADRC has implemented a privacy and confidentiality agreement that all employees are required to sign. File cabinets have been moved into once centralized location where the door is locked at all times. Also, all file cabinets are required to be locked. If files are need to be taken out of the office they will only be taken out of the office if they are signed out and placed into a locked case, which will be placed in the trunk of the vehicle while traveling. Currently, all volunteers and temporary employees are required to sign a confidentially statement. The front desk is always manned when the office is open and visitors must sign in and be monitored while in the building.

Appendix G

Family Caregiver Support Program

July 2, 2011 – June 30, 2012

Program Accomplishments by Category

Information and Outreach

1. The Family Caregiver Advocate does in - home assessments.
2. The FCA gives FCSP presentations in the region.
3. The FCA provides information on Three Wishes.
4. The FCA participates in Community Events & Health Fairs in the region.
5. Provides information/updates to Santee-Lynches Regional Aging Advisory Committee.
6. Provides information during the Annual Lunch & Learn.
7. Maintains a working relationship with Community Long Term Care, Hospice, Hospital Social Workers, Home Care Providers, and, Nursing Homes.
8. Maintains working relationship with Long Term Care Ombudsman, Information & Referral Specialist/ ADRC Resource Coordinator, Case workers, & Adult Day Care's.
9. Member of the Parents as Teachers Program/Sumter School District
10. Partners with School District 17/Grandparents Support Group
11. Partnered with United Ministries with ramp building.
12. Partnered with Clemson Extension/4-H Program.
13. Medication Assistance Program
14. Participates in events with the Councils on Aging
15. On the Board of Sumter First Steps.
16. Partners with Dementia Doctor in Sumter & Respite Providers.
17. Speaks regularly at the Alzheimer's Support Group meetings.
18. Provides information on Alzheimer's and other dementias.

Major Resource Development Accomplishments

1. Preparation & Planning for the Annual Lunch & Learn
2. FCA teaches Arthritis Exercise classes.
3. Conducts Wii Physical Fitness classes.
4. Sends out bids for procurement

Assistance

1. The FCA does in home assessments.
2. The FCA frequently does home visits.
3. The FCA orders supplemental services supplies.
4. The FCA does personal shopping for caregivers & grandparents.
5. Prescription Assistance Program.
6. Provides information for the Legal Assistance Program.

Counseling, Support Groups, and Training

1. The FCA does Grief Counseling.
2. Dementia Dialogues training.
3. The FCA provides caregiver stress and communication trainings.
4. The FCA provides caregiver/grandparent consultations in home and on the telephone.
5. The FCA partners with Sumter School District by co-facilitating Grandparents Support Group meetings.
6. The FCA facilitates a Support Group for caregivers in Kershaw County.
7. Provides vendors, entertainment, and speakers for Lunch & Learn.

Respite

1. Provided in home, Adult Day Care's, and nursing facilities.
2. Provided to Grandparents/Relatives.
3. Provided for attendance at Annual Lunch & Learn.
4. Provided for caregiver trainings.

Supplemental Services

1. Purchases of air conditioners, washers, dryers, clothing, and household items.
2. Purchases of nutritional supplements, incontinence supplies, assistive technology devices, and emergency response monitors.
3. Purchases of materials to build ramps, chain link for a fence, skirting for a mobile home, and minor home repair/supplies.
4. Purchases of clothing, school supplies, and Christmas items for Grandparents Raising Children.

Caregiver Activity Group - All Undup

Santee-Lynches Region COG Caregiver

From: 07/01/2011
To: 06/30/2012

Unduplicated Count - Total Units

Activity Group / Activity	Funding Source	Clients	$ Amount	QTY Units
Santee-Lynches Region COG Caregiver				
Caregiver Supplemental Services		**7**	**245.00**	**217**
SS Nutrition -Meals CG IIIE	Title III E	7	245.00	217
Caregiver Supplemental Services		**19**	**4,682.58**	**646**
SS Home Modification CG IIIE	Title III E	19	4,682.58	646
Caregiver Supplemental Services		**1**	**0.00**	**1**
SS Volunteer Services CG IIIE	Title III E	1	0.00	1
Caregiver Supplemental Services		**15**	**1,431.09**	**22**
SS Assistive Technology CG IIIE	Title III E	15	1,431.09	22
Caregiver Supplemental Services		**59**	**10,441.08**	**427**
SS Incontinence Supplies CG IIIE	Title III E	59	10,441.08	427
Caregiver Supplemental Services		**29**	**3,833.66**	**3,513**
SS Nutrition -Supplements CG IIIE	Title III E	29	3,833.66	3,513
regiver Supplemental Services		**1**	**225.00**	**240**
SS Emerg Response Install/Monitor CG IIIE	Title III E	1	225.00	240
Caregiver Supplemental Services		**2**	**520.00**	**16**
SS Other Support Linked to CG Role CG IIIE	Title III E	2	520.00	16
Caregiver Access Assistance		**52**	**0.00**	**76**
A Assess/Screen CG IIIE	Title III E	52	0.00	76
Caregiver Access Assistance		**150**	**0.00**	**240**
A Care Coordination CG IIIE	Title III E	150	0.00	240
Caregiver Access Assistance		**143**	**0.00**	**210**
A Assess/Screen -Home CG IIIE	Title III E	143	0.00	210
Caregiver Access Assistance		**53**	**0.00**	**62**
A Follow-up/Evaluation CG IIIE	Title III E	53	0.00	62
Caregiver Access Assistance		**13**	**0.00**	**14**
A Information & Assistance CG IIIE	Title III E	13	0.00	14
Caregiver Counseling/Support Groups/Caregiver Training		**7**	**0.00**	**10**
C Individual Counseling CG IIIE	Title III E	7	0.00	10

Caregiver Activity Group - All Undup

Santee-Lynches Region COG Caregiver

Unduplicated Count - Total Units

From: 07/01/2011
To: 06/30/2012

Activity Group / Activity	Funding Source	Clients	$ Amount	QTY Units
Santee-Lynches Region COG Caregiver				
Caregiver Counseling/Support Groups/Caregiver Training		**1**	**0.00**	**1**
S Individual Support -Home CG IIIE	Title III E	1	0.00	1
Caregiver Respite		**167**	**77,605.42**	**10,565**
R In-Home Respite CG IIIE	Title III E	167	77,605.42	10,565
Caregiver Respite		**3**	**1,450.00**	**296**
R Facility Respite CG IIIE	Title III E	3	1,450.00	296
Caregiver Respite		**2**	**1,000.00**	**192**
R Emergency Respite CG IIIE	Title III E	2	1,000.00	192
Caregiver Respite		**5**	**2,265.00**	**265**
R Adult Day/Child Day Care CG IIIE	Title III E	5	2,265.00	265
Caregiver Supplemental Services		**25**	**3,917.95**	**452**
SS Shopping CG IIIe	Title III E	25	3,917.95	452
olicated Count, Sum of Units for Santee-Lynches Regior		754	107,616.78	17,464
Caregiver Unduplicated Count		**292**		

SRC Activity Group - All Undup

Santee-Lynches Region COG Caregiver

Unduplicated Count - Total Units

From: 07/01/2011
To: 06/30/2012

Activity Group / Activity	Funding Source	Clients	$ Amount	QTY Units
Santee-Lynches Region COG Caregiver				
SRC Access assistance		**48**	**0.00**	**62**
A Care Coordination SRC IIIE	Title III E	48	0.00	62
SRC Access assistance		**17**	**0.00**	**24**
A Assess/Screen -Home SRC IIIE	Title III E	17	0.00	24
SRC Access assistance		**32**	**0.00**	**34**
A Follow-up/Evaluation SRC IIIE	Title III E	32	0.00	34
SRC Access assistance		**1**	**0.00**	**1**
A Information & Assistance SRC IIIE	Title III E	1	0.00	1
SRC Counseling/Support Groups/Training		**1**	**0.00**	**1**
S Group Support SRC IIIE	Title III E	1	0.00	1
SRC Respite		**9**	**4,120.00**	**1,162**
R In-Home Respite SRC IIIE	Title III E	9	4,120.00	1,162
SRC Respite		**1**	**380.00**	**120**
R Adult Day/Child Day Care SRC IIIE	Title III E	1	380.00	120
SRC Respite		**2**	**600.00**	**222**
R After School/Summer Programs SRC IIIE	Title III E	2	600.00	222
SRC Supplemental Services		**46**	**13,254.67**	**1,375**
SS Shopping SRC IIIE	Title III E	46	13,254.67	1,375
SRC Supplemental Services		**2**	**70.00**	**61**
SS Nutrition -Meals SRC IIIE	Title III E	2	70.00	61
SRC Supplemental Services		**1**	**300.00**	**116**
SS Home Modification SRC IIIE	Title III E	1	300.00	116
SRC Supplemental Services		**1**	**212.60**	**1**
SS Other Support Linked to CG Role SRC IIIE	Title III E	1	212.60	1
SRC Access assistance		**8**	**0.00**	**11**
A Assess/Screen SRC IIIE	Title III E	8	0.00	11
Duplicated Count, Sum of Units for Santee-Lynches Region COG Caregi		169	18,937.27	3,190
	SRC Unduplicated Count	**64**		

Stories

When the advocate takes the grandparents or relatives shopping for clothing, school supplies, and all other items, it is always like Christmas. Over the loud speaker they are calling "would Ms. B please report to cash register 12 & 15". The cashiers and people at customer service always ask, "what program is this", "who do you work for"? Although the FCSP is paying for the clothing and supplies for the grandchildren, the caregivers and the cashiers are always telling me how wonderful I am. The advocate is always receiving hugs from the grandparents and even the children. One would think that the monies are coming from the advocate's pocket. It is really an exciting time! It is a wonderful feeling to be able to assist, know that you are helping, and that the people are so appreciative. For ten years the advocate has been shopping with the grandparents and children, and now they call me "The Angel".

In the Santee-Lynches Region, the advocate teaches an arthritis exercise class. Through the years the advocate has been going to senior centers and senior residential facilities demonstrating exercises on strength training, endurance, and flexibility. Most recently a senior informed the advocate that it is much easier for her to kneel at church for prayer. Hallelujah!

In June, the advocate received a letter from a caregiver to let us know how grateful she was for the services from the FCSP. The caregiver had given up her job and home to move in with her mother in South Carolina. She is living off her mother's income while she is in school. The caregiver has said that sometimes she just needs to get away from the routine of bathing, dressing, doing hair, cooking and getting ten different medications on a daily bases. The caregiver also commented on having no outside help. But now with the help of the FCSP she got some assistance. She also stated that she and her mom are looking forward to the next FCSP Lunch & Learn. We are making a difference in our communities.

Santee-Lynches Regional Council of Governments

ACTUAL REGIONAL III-E EXPENDITURES FOR FISCAL YEAR 2010-2011
CAREGIVER PROGRAM

(July 1, 2010 - June 30, 2011)

	PLANNING & ADMINISTRATION WITH MATCH	STAFFING WITH MATCH (Advocate & I&R)	CG-DIRECTED SERVICES (Federal only)	TOTAL PROGRAM ACTIVITY
Information to Groups		$7,535		$7,535
Access Assistance		$10,731		$10,731
Support Groups		$6,427		$6,427
Training		$5,166		$5,166
Counseling		$2,737		$2,737
Respite		$35,359	$89,385	$124,744
Supplemental Services		$4,305	$27,043	$31,348
TOTAL		**$72,259**	**$116,428**	**$188,687**
Grant Related Income from Caregivers (include Memorials here)				
Other Program Income				
TOTAL III-E PROGRAM FUNDS for CAREGIVER Program (excluding Grandparents Raising Children)				**$188,687**

Santee-Lynches Regional Council of Governments

ACTUAL REGIONAL III-E EXPENDITURES FOR FISCAL YEAR 2010-2011

SENIORS RAISING CHILDREN PROGRAM

(July 1, 2011 - June 30, 2012)

	PLANNING & ADMINISTRATION WITH MATCH	STAFFING WITH MATCH (Advocate & I&R)	CG-DIRECTED SERVICES (Federal only)	TOTAL PROGRAM ACTIVITY
Information to Groups		$1,175		$1,175
Access Assistance		$5,875,014		$5,875,014
Support Groups		$2,350		$2,350
Training		$1,567		$1,567
Counseling				$0
Respite		$392	$5,100	$5,492
Supplemental Services		$5,483	$7,989	$13,472
TOTAL		**$16,842**		$16,842
Grant Related Income from Caregivers (include Memorials here)				
Other Program Income				
TOTAL III-E PROGRAM FUNDS for SENIORS RAISING CHILDREN Program (excluding Caregiver Program)				**$29,931**

'12-'13 FCSP Y-T-D Expense and Balance of Contract Report

Report through [redacted]

Total Caregiver Direct Services Budget	Supplemental Services cannot be over max of 20% of total fed caregiver program budget 11.500% total caregiver program budget = $ 172,968.00					Grandparent Services optional 5% - 10% 8.500%	Respite Care balance of 2	Total Y-T-D s/b same as CG Serv Budget
$ 94,780	$ 19,891					$ 14,702	$ 60,186	$ 94,780
	Supportive	Home Modification	Nutritional Supplement	Incontinent Supplies	Assistive Technology			
Object Code #s	5349	5352	5353	5354	5355	5351	5350	
1st Quarter								
July								$ -
August								$ -
September								$ -
1st Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2nd Quarter								
October								$ -
November								$ -
December								$ -
2nd Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3rd Quarter								
January								$ -
February								$ -
March								$ -
3rd Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4th Quarter								
April								$ -
May								$ -
June								$ -
4th Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Year - to - Date								
Total pd out Y-T-D	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outstanding PO's / Invoices to date			$0.00			$ -		$ -

	Supplemental Services	Grandparent	Respite	Y-T-D Total
Total committed / paid to date	thru 1/0/1900 $ -	$ -	$ -	$ -
Total Remaining Funds per Service	$ - 19,891	$ 14,702	$ 60,186	$ 94,780

emailed to Toni and detail report in box
signed

Finance Assistant
Title

5/7/2013

'12-'13 FCSP Y-T-D Expense and Balance of Contract Report

* Note - A6(total Caregiver Service Budget) and yellow highlighted areas are the only areas other than monthly exps that should be changed.

The below are estimated numbers based on the Budget and the Total Committed/Paid to Date #s. These numbers are only to be used as a helpful tool for making programatic decisions. These are only estimates based on info I have received, not taking into account information I don't have or awards already promised to clients.

SServ	GParent	Respite	
Est amounts awarded per Client			
$300	**$150**	**$500**	
Estimated # of clients to be served per Category based on budget			
66	98	120	per year
6	8	10	per month

SServ	GParent	Respite
Following #s based on Est Total Committed / Paid to Date		
Est # of Clients Served/Category		
0	0	0
% of budget used / Category		
0%	0%	0%
Est # of Clients left to be Served		
66	**98**	**120**

Outstanding Purchase Orders listing through January 0, 1900

Notes:

Supplemental Services

Date	Payee	PO #	Client Name	Amount	Comments / Info Needed

Total Outstanding Supplemental Services POs = 0.00

Following I have invoices/receipts but no POs - please advise ASAP
None @ this time

Total undocumented expenses ***0***

Total Outstanding Supplemental Services
(entered on FCSP Services Sheet) $ -

Grandparent Services

Date	Payee	PO #	Client Name	Amount	Comments / Info Needed

Total Outstanding Grandparents POs = $ -

Following I have invoices/receipts but no POs - please advise ASAP
None @ this time

Total undocumented expenses ***0***

Total Outstanding GrandParent Services
(entered on FCSP Services Sheet) $ -

Total Est Amount of Purchase Orders Outstanding $ -

'12-'13 FCSP Y-T-D Expense and Balance of Contract Report

Report through

Total Caregiver Direct Services Budget	Supplemental Services (cannot be over max of 20% of total fed caregiver program budget)					Grandparent Services (optional 5% - 10%)	Respite Care (balance of 2)	Total Y-T-D (s/b same as CG Serv Budget)
	11.500%			total caregiver program budget =	$ 172,968.00	8.500%		
$ 94,780	$			19,891		$ 14,702	$ 60,186	$ 94,780

	Supportive	Home Modification	Nutritional Supplement	Incontinent Supplies	Assistive Technology		
Object Code #s	5349	5352	5353	5354	5355	5351	5350	
1st Quarter								
July								$ -
August								$ -
September								$ -
1st Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2nd Quarter								
October								$ -
November								$ -
December								$ -
2nd Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3rd Quarter								
January								$ -
February								$ -
March								$ -
3rd Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4th Quarter								
April								$ -
May								$ -
June								$ -
4th Quarter Totals	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Year - to - Date								
Total pd out Y-T-D	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outstanding POs / Invoices to date			#0.00			$		$

	Supplemental Services	Grandparent	Respite	Y-T-D Total
Total committed / paid to date	thru 1/0/1900 $ -	$ -	$ -	$ -
Total Remaining Units per Service	$ 19,891	$ 14,702	$ 60,186	$ 94,780

emailed to Toni and detail report in box
signed

Finance Assistant
Title

5/7/2013

'12-'13 FCSP Y-T-D Expense and Balance of Contract Report

* Note - A6(total Caregiver Service Budget) and yellow highlighted areas are the only areas other than monthly exps that should be changed.

The below are estimated numbers based on the Budget and the Total Committed/Paid to Date #s. These numbers are only to be used as a helpful tool for making programatic decisions. These are only estimates based on info I have received, not taking into account information I don't have or awards already promised to clients.

SServ	GParent	Respite	
Est amounts awarded per Client			
$300	**$150**	**$500**	
Estimated # of clients to be served per Category based on budget			
66	98	120	per year
6	8	10	per month

SServ	GParent	Respite
Following #s based on Est Total Committed / Paid to Date		
Est # of Clients Served/Category		
0	0	0
% of budget used / Category		
0%	0%	0%
Est # of Clients left to be Served		
66	98	120

Outstanding Purchase Orders listing through January 0, 1900

Notes:

Supplemental Services

Date	Payee	PO #	Client Name	Amount	Comments / Info Needed

Total Outstanding Supplemental Services POs = 0.00

Following I have invoices/receipts but no POs - please advise ASAP:
None @ this time

Total undocumented expenses ***0***

Total Outstanding Supplemental Services
(entered on FCSP Services Sheet) $ -

Grandparent Services

Date	Payee	PO #	Client Name	Amount	Comments / Info Needed

Total Outstanding Grandparents POs = $ -

Following I have invoices/receipts but no POs - please advise ASAP:
None @ this time

Total undocumented expenses ***0***

Total Outstanding GrandParent Services
(entered on FCSP Services Sheet) $ -

Total Est Amount of Purchase Orders Outstanding $ -

IX. Apendices- Required Documents:

□ **AAA Comprehensive Operating Budget** - Area Agency on Aging Comprehensive Operating Budget – State Fiscal Year 2013-2014 – Form: 4AP 2013-2014 AAA Comprehensive Oper budget

□ **Narrative Justification of AAA/ADRC Operating Budget** – Form: AP 2013-2013 AAA Narrative for Operations Budget

□ **PSA/AAA/ADRC Summary Program Budget-Computation of Grants** – Santee-Lynches Regional COG Summary Program Budget – Form: 7AP 2013-2014 AAA Summary Servs Budget

□ **AAA/ADRC Comprehensive Operating Budget State Fiscal Year 2014– 2017** – appears to be a duplication of item #1 above with dates changed to 2014-2017 - see Form: 4 AP 2013-2014 AAA Comprehensive Oper Budget

□ **Worksheet for Staffing Budget and NAPIS Staffing Profile for 2013 – 2014** – Form: 3AP 2013-2014 AAA Staffing Worksheet and NAPIS Data

□ **Four Year history of Contracted Units and Unit Costs of Services – State Fiscal Years Beginning July 1, 2012 –June 30, 2015** – Form: 9AP 2013-2014 Budget History of Units and Unit Costs

□ **Summary of Service Funding, Contracted Units and Average Cost SFY 2014 – 2017** – Appears to be a duplication of form 8AP Regional Summary of Service $ Units with dates changed to SFY 2014-2017 – see Regional Summary of Service Budgets, Units and Unit Costs below

□ **2014 – 2017 Expenditures and Budget for Priority Services** – Form: 6AP 2013-2014 Expenditures and Budget for Priority Services

□ **Minimum Expenditures for Priority Service Categories Requested Transfer of Federal Funds** – Requested Transfer of Federal Funds SFY 2013-2014; Form: 5AP 2013-2014 Budget Titles III-B and III-C Transfers

□ **Regional Summary of Service Budgets, Units and Unit Costs** – Summary of Service Funding, Contracted Units and Average Unit Cost – Form: 8AP 2013-2014 Regional Summary of Service $, Units, Unit Cost SFY 14

□ **Summary Program Budget and Computation of Costs Four Year History of Contracted Units and Cost Comparisons** – this seems to be a combination of wording from two different forms – see forms previously provided: 7AP 2013-2014 AAA Summary Servs Budget and 9AP 2013-2014 Budget History of Units and Unit Costs

□ Geographic Distribution of Revenue for Purchased Services – Word Document: Geographic Distribution of Purchased Services

□ AAA/ADRC Staffing Worksheet- this appears to be duplicative of the 5th item in the appendices list – see previously provided Form: 3AP 2013-2014 AAA Staffing Worksheet and NAPIS Data

□ Analysis of Targeted Population –

□ Minority Population–

□ Designated and Undesignated Focal Point Chart–

□ GIS Maps Highlighting Targeted Populations Being Served -

□ A Map of the Region-

□ County Maps for Region-

□Emergency Preparedness

□Observed Holidays

GEOGRAPHIC DISTRIBUTION OF REVENUE FOR PURCHASED SERVICES – Santee-Lynches Region – FY 2013-2014

Note: Funds for Purchased Services include all federal, state and local match or overmatch and GRI as projected in the Summary Program Budget- Computation of Grants. Legal Services programs are not yet determined but geographic distribution will be throughout the entire Santee-Lynches region of Clarendon, Kershaw, Lee & Sumter counties.

Service	Funds Budgeted	County of Service
Group Dining	$ 81,430	Clarendon
	$ 91,760	Kershaw
	$ 138,758	Lee
	$ 175,102	Sumter
Group Dining Total	**$ 487,050**	
Home Delivered Meals	$ 136,918	Clarendon
	$ 111,426	Kershaw
	$ 118,518	Lee
	$ 202,291	Sumter
HDMs Total	**$ 569,153**	
Home Care	$ 20,918	Clarendon
	$ 55,127	Kershaw
	$ 45,792	Lee
	$ 85,433	Sumter
Home Care Total	**$ 207,270**	
Transportation	$ 24,438	Clarendon
	$ 66,204	Kershaw
	$ 69,044	Lee
	$ 64,226	Sumter
Transportation Total	**$ 223,912**	
Health Promotion	$ 5,636	Clarendon
	$ 5,589 *	Kershaw
	$ 5,636	Lee
	$ 5,589	Sumter
Health Promotion Total	**$ 22,450**	

Totals by County		
	Clarendon	$ 269,340
	Kershaw	$ 330,106
	Lee	$ 377,748
	Sumter	$ 532,641
	Grand Totals	**$1,509,835**

* Service provided by Sumter Senior Services for Kershaw County

NARRATIVE FOR SANTEE-LYNCHES REGIONAL COG AAA OPERATIONS AND DIRECT SERVICE BUDGET FY 2013-2014

The Area Agency on Aging budget is currently based on the draft NGA issued by the Lieutenant Governor's Office on Aging in mid-May 2013 **and a request for at least an additional $15,000 in funding for administrative purposes**. The budget narrative below follows the sequence of the budget line items on required form 4 AP 2013-2014 AAA Comprehensive Operating Budget. This particular form does not provide for two program areas in which the SLAAA/ADRC is involved – the Assisted Rides program funded through SCLGOA via SC Department of Transportation and the Veterans Directed HCBS program which is a fee for services program. Therefore, excluding these two programs, the total budget of the SLAAA/ADRC as reported in the comprehensive operating budget is **$638,910.**

PERSONNEL SALARIES - $275,829 Total
This is the cumulative total of all salaries for the 7.58 full time equivalent staff of the Aging unit and supporting staff from the COG.

FRINGE BENEFITS - $91,435 Total
Fringe benefits for staff include FICA and Medicare, Workman's Compensation; health, dental, and group life insurance; retirement, and unemployment insurance.

CONTRACTUAL - $87,181 Total
Family Caregiver consumer directed services such as respite and supportive services

TRAVEL - $15,467 Total
The Area Agency on Aging uses the SLRCOG's travel policies for both in and out of state travel. A limited number of staff cars are available for AAA staff use; otherwise, staff is reimbursed for use of personal vehicles for necessary agency business and professional development activities per agency policy - $.50 per mile when no assigned staff car is available and $.285 per mile when assigned staff car is available but employee elects for convenience to use their personal vehicle. Based on agency policy, per diem allowances may be claimed for out of region and out of state travel but not for in region travel. For non-overnight trips of less than 10 hours, the per diem rate is $7.50. For overnight and out of state trips, per diem allowances are no more than $39.00 per 24-hour period and are based on a value for each meal and $3.00 for incidentals. Meals which are included in registration fees are deducted from the per diem allowance. Lodging and airfare costs are, by policy, to be obtained at the lowest rates available. Taxi/shuttle fares and parking fees are reimbursed at cost. With the exception of per diem allowances, receipts are required for all other costs incurred.

Volunteer Regional Aging Advisory Committee (RAAC) members are reimbursed for mileage expenses if they so request and are reimbursed based on the agency's policy of $.50 per mile.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	Region: Santee-Lynches RCOG - Region VI Worksheet for Staffing Budget and NAPIS Staffing Profile for SFY 2013-2014															
2	Enter the names of staff involved in each service or activity. If an individual is considered a member of a racial or ethnic minority put "(M)" after the name. Enter the number of hours in the SFY the staff in this position devotes to the specified activity. Then follow the instructions for completing the worksheet.															
3	**Santee-Lynches RCOG AAA**	**Enter Each Staff Name Only Once - Beside Their Primary Duty**	**Annual Hours Budgeted to these Activities or Services**	Hours Charged to P&A	Hours Charged to PD	Hours Charged to Ombudsman Services	Hours Charged to I&A III-B	Hours Charged to III-E	Hours Charged to I-CARE /SMP/III-D Med Mgmt	Hours Charged to Other III-B Services	Hours Charged to Discretionary Grants or Local Funding		**Enter Staff Names**	**Annual Payroll Hours** All Sources		
4	**Planning and Administration**			**2913**	**1269**	**1853**	**1950**	**2048**	**1603**	**1950**	**7377**		**AGENCY'S FTE**	**1950**		
5	Aging Unit Director	Shawn Keith (M)	1,950	1365	585						0		AUD	1,950		
6	COG Executive Director	M Mikota	1,950	49	49						1853		COG EX Dir	1,950		
7	Deputy & Finance Dir	Kathy Powell	1,950	244	98						1609		Dep & Fin Dir	1,950		
8	Aging Assistant ** (also shown in Ins counseling	Janae Allumbaugh	234	164	70					0	0		Aging Assistant	234		
9			0	0	0					0	0			0		
10	Aging Fiscal Accounting	Amanda Ridgeway	1,950	341	146			98		0	1365		AFA	1,950		
11	Aging Assistant/Data Entry	L Govan (M)	1,950	751	322	0	488	0	390	0	0		Aging Asst	1,950		
12	**FTEs**		**5.12**	**1.49**	**0.65**	**0.00**	**0.25**	**0.05**	**0.20**	**0.00**	**2.48**		Sr.LTCO	1,950		
13	**Ombudsman**		**1.00**			**1853**					**0**		LTCO	0		
14	Senior Ombudsman	Janice Coney (M) cuts in Omb require budgeting of 5% time to Medi Patrol to afford full time position's costs	1,950			1853	0				Medicare Patrol .05 98		LTCO	0		
15	Other Ombudsman Staff		0			0					0		LTCO	0		
16	**FTEs**		**1.00**	**0.00**	**0.00**	**0.95**	**0.00**	**0.00**	**0.00**	**0.00**	**0.05**		LTCO	0		
17	**I & A**		**1950**				**1950**	**0**	**0**				I&A	1,950		
18	Primary I&A and R	Yolanda Russell	1,950				1950		0		0		Aging Assistant	1,716		
19	Backup I&R												Resource Coordinat	1,950		
20														0		
21			0					0	0				FCA	1,950		
22	**FTEs**		**1.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**0.00**		Care Mgr	1,950		
23	**Insurance Counseling/SMP**		**3666**				**0**	**0**	**1213**	0	**2453**		SC	0		
24	Aging Assistant **	Janae Allumbaugh	1,716						1115	Medicare Patrol .3	601					
25	Resource Coordinator	Kristy Pritchard	1,950						98		1853					
26			0				0	0	0	0	0					
27	**FTEs**		**1.88**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.62**	**0.00**	**1.26**					
28	**Family Caregiver Program**		**1950**				**0**	**1950**	**0**		**0**					
29	Caregiver Advocate	Toni Brew (M)	1,950					1950			0					
30	Backup Advocate		0				0		0				Paid Hours	21450		
31	**FTEs**		**1.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**		Interns	0		
32	**Other AAA Direct Services**		**1950**						0	**1950**	**0**		Volunteers	0		
33	Care Manager	Gena Kiber	1,950						0	1950	0		**Total Hours**	**21,450**		
34			0						0	0	0					
35	**FTEs**		**1.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**					
36	**COMBINED SERVICE DELIVERY**		**9517**													
37	**Intern Hours**		0	0			0	0	0	0						
38	**Volunteer Hours**		0	0		0			0	0	0					
39	**TOTAL PAID HOURS**		**20,963**													
40	**TOTAL PAID FTEs**		**11.00**													
41		Total AAA funded	7.58	1.49	0.65	0.95	1.25	1.05	0.82	1.00	0.36					

NOTES:
1. Enter the agency's FTE hours **in cell N4**
2. **In Column M,** list each individual assigned to the aging unit either full or part time.
3. The annual payroll hours in Column N shall reflect the time charged, or allocated, to both the aging unit and any non-aging unit duties.
4. **Any staff charged to Indirect Costs in the aging budget shall not be listed as part of the aging unit.**
5. The total of an individual' s breakout hours in Column C of the spreadsheet must equal the number of hours shown in Column N.

It is understood that I&A, Caregiver, and Insurance Counseling staff are back up to each other. The amount of staff hours allocated to backup should cover the primary staff's allowed hours of paid annual leave, sick leave and time for mandatory trainings.

Only staff designated by the State Ombudsman may provide Ombudsman backup.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	REGION: Santee-Lynches Regional COG – Region VI	AREA AGENCY ON AGING COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2013 - 2014 Page 1												
2	LINE ITEM	100% AAA Budget	III- B &C Planning & Admin. 75/25	III-B Program Development 85/5/10	AAA Direct HCBS Services (See Note) 85/5/10	III-B I, R & A 85/5/10	III-B Ombudsman 85/5/10	VII Ombudsman 100	VII Elder Abuse 100	State Ombudsman Funds 100	III-E Planning & Admin 75/25	III-E I, R & A 88.24/11.76	III-E Services Staff 88.24/11.76	III-E Caregiver Services 100
3	Personnel Salaries	$275,829	$80,181	$36,006	$37,027	$27,536	$16,431	$5,132	$1,384	$5,570	$10,272	$3,588	$27,787	$0
4	Fringe Benefits	$91,435	$26,580	$11,936	$12,275	$9,127	$5,447	$1,701	$459	$1,846	$3,405	$1,189	$9,211	$0
5	Contractual	$87,181	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$87,181
6	Travel	$15,467	$4,349	$1,650	$1,064	$1,592	$1,844	$576	$155	$625	$756	$208	$2,044	$0
7	Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
8	Supplies	$9,910	$1,820	$780	$1,049	$1,327	$588	$184	$50	$199	$794	$173	$2,146	$0
9	Indirect Costs	$141,122	$41,023	$18,422	$18,943	$14,088	$8,407	$2,626	$708	$2,850	$5,256	$1,836	$14,216	$0
10	Allocated Costs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Other Direct Costs	$17,966	$6,361	$279	$755	$2,863	$610	$191	$51	$207	$988	$372	$2,674	$0
12	TOTAL OPERATING BUDGET	$638,910	$160,314	$69,073	$71,113	$56,533	$33,327	$10,410	$2,807	$11,297	$21,471	$7,366	$58,078	$87,181
13	**LESS: In-kind Above Match**	**$0**												
14	**LESS: Local Cash Above Match**	**$15,762**	$15,762											
15	TOTAL AREA PLAN BUDGET: LGOA	$623,148	$144,552	$69,073	$71,113	$56,533	$33,327	$10,410	$2,807	$11,297	$21,471	$7,366	$58,078	$87,181
16		Assumes an additional $15,000 from state for admin and local overmatch of $841		COMPUTATION OF GRANT										
17	APPROVED AREA PLAN BUDGET	$623,148	$144,552	$69,073	$71,113	$56,533	$33,327	$10,410	$2,807	$11,297	$21,471	$7,366	$58,078	$87,181
18	LESS: State 5%Match	$11,502		$3,454	$3,556	$2,827	$1,666							
19	LESS: Required Grantee Match	$75,683	$36,139	$6,907	$7,111	$5,653	$3,333				$5,368	$866	$6,830	
20	Federal Share	$524,666	$108,413	$58,712	$60,446	$48,053	$28,328	$10,410	$2,807		$16,103	$6,500	$51,248	$87,181
21	BREAKOUT OF LOCAL MATCH (L19):	$75,683	$36,139	$6,907	$7,111	$5,653	$3,333				$5,368	$866	$6,830	
22	Local Cash Match Resources	$75,682	$36,139	$6,907	$7,111	$5,653	$3,333				$5,368	$866	$6,830	
23	Local In-kind Match Resources	$0	$0	$0	$0									
24	State Funds Used as Local Match	$0	$0		$0						$5,368	$866	$6,830	$0
25	Total Local Match (Must = Line 25)	$75,682	$36,139	$6,907	$7,111	$5,653	$3,333							
27	FRINGE RATE AS % OF SALARIES: 33.15%										INDIRECT COST AS % OF FUNDED PERSONNEL:			38.43%
28	Yellow cells are calculated values-**DO NOT enter data in these** (Blue indicates cells in which data **normally** should not be entered. Use of State funds for local match must be approved BEFORE budget is submitted.													

	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
1	AAA COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2013 - 2014 Page 2														
2	I-CARE SHIP 100	MIPPA ADRC 100	MIPPA SHIP 100	MIPPA AAA 100	Senior Medicare Patrol 75/25	SMP Expansion 100	III B and C P&A and PD	III-B and III-E Information Referral and Assistance	AAA Direct HCBS Services (See Note) 85/5/10	III-B, VII and State Ombudsman	III-E P&A, Staff and FC Supports	I-CARE (SHIP), MIPPA and SMP	TOTAL AAA BUDGET	LINE ITEM	
3	$18,414	$0	$0	$0	$6,501		$116,187	$31,124	$37,027	$28,517	$38,059	$24,915	$275,829	Personnel Salaries	
4	$6,104	$0	$0	$0	$2,155		$38,516	$10,316	$12,275	$9,453	$12,616	$8,259	$91,435	Fringe Benefits	
5	$0	$0	$0	$0	$0		$0	$0	$0	$0	$87,181	$0	$87,181	Contractual	
6	$246	$0	$0	$0	$358		$5,999	$1,800	$1,064	$3,200	$2,800	$604	$15,467	Travel	
7	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0	Equipment	
8	$250	$0	$0	$0	$550		$2,600	$1,500	$1,049	$1,021	$2,940	$800	$9,910	Supplies	
9	$9,421	$0	$0	$0	$3,326		$59,445	$15,924	$18,943	$14,591	$19,472	$12,747	$141,122	Indirect Costs	
10	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0	Allocated Costs	
11	$1,605	$0	$0	$0	$1,010		$6,640	$3,235	$755	$1,059	$3,662	$2,615	$17,966	Other Direct Costs	
12	$36,040	$0	$0	$0	$13,900	$0	$229,387	$63,899	$71,113	$57,841	$166,730	$49,940	$638,910	TOTAL OPERATING BUDGET	
13							**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**LESS: In-kind Above Match**	
14							**$15,762**	**$0**	**$0**	**$0**	**$0**	**$0**	**$15,762**	**LESS: Local Cash Above Match**	
15	$36,040	$0	$0	$0	$13,900	$0	$213,625	$63,899	$71,113	$57,841	$166,730	$49,940	$623,148	TOTAL AREA PLAN BUDGET: LGOA	
16	**COMPUTATION OF GRANT**						**NOTE:** Legal Assistance, Med Management,Case Management, Minor Home Repair, and Consumer Directed HCBS								
17	$36,040	$0	$0	$0	$13,900	$0	**Use this space to breakout the home and community-based services delivered through the AAA that are budgeted in column E. If using State HCBS funded services for match, enter the amount of state funds on the appropriate services lines. If using in-kind or local cash for match, enter the total on line 28 in the appropriate column.**								
18															
19					$3,475		**Services**	**III-B**	**III-D**	**5% Match**	**10% Match**	**Total Title III**	**State Funds**		
20	$36,040	$0	$0	$0	$10,425	$0	Legal Assistance	$0		$0	$0	**$0**			
21					$3,475		Medication Management		$2,133	$125	$251	**$2,509**			
22					$3,475		Care Management	$58,313		$3,430	$6,860	**$68,604**	$0		
23							Minor Home Repair	$0		$0	$0	**$0**	$0		
24							Consumer Directed HCBS	$0		$0	$0	**$0**	$0		
25					$3,475		85% Federal	**$58,313**	**$2,133**				**TOTAL STATE**		
27							5% Match	**$3,430**	**$125**						
28							10% Match	**$6,860**	**$251**				**$0**		

REQUESTED TRANSFER OF FEDERAL FUNDS SFY 2013-2014

Per requirements of the Older Americans Act, the Area Agency on Aging may, without a waiver, elect to transfer not more than 40% of the funds received under Title III-C between subpart 1 and subpart 2, for use as the Area Agency considers appropriate to purchase services that meet the nutritional needs of older adults in the area served.

If the Area Agency on Aging determines that a transfer of more than 40% is required to purchase services at a level that satisfies the need for III-C-1 or III-C-2 services, the agency must request a waiver that justifies the transfer of an additional amount, not to exceed an additional 10% of the funds received under Title III-C, between Subpart 1 and Subpart 2.

To comply with OAA, Maintenance of Effort provisions for Ombudsman funding, LGOA transferred Title III-C-1 to Title III-B prior to allocating Title III services funds to the regions; ~~therefore, the AAA may elect to transfer not more than the percentage transferred out of Title III-C-1 into Title III-B for state fiscal year 2012.~~

~~The AAA may transfer up to 30% of the Title III-C-2 allocation to III-B for use as the Area Agency considers necessary to purchase services to meet the need for in-home and community based services.~~

~~It is the AAA's understanding that transfers between titles have already been made by SCLGOA; therefore, no transfers are currently requested. Funds needed to backfill service needs by service (such as transportation, HDMs, etc) will be obtained through State funds.~~

Santee-Lynches Regional COG (Region VI) **REQUESTED TRANSFERS**

TITLE	ORIGINAL ALLOCATION (See Note Below)	REQUESTED TRANSFER	REQUESTED ALLOCATION	% OF TRANSFER
III-B	$217,210	$0	$217,210	0.00%
III-C-1	$219,781	$0	$219,781	0.00%
III-C-2	$410,296	$0	$410,296	0.00%
TOTAL	$847,287	$0	$847,287	

INSTRUCTIONS

Total of ORIGINAL ALLOCATION column must total the Title III-B plus III-C-1 plus III-C-2 allocations for services transmitted to the region in the ALLOCATIONS FOR SERVICE PROVISION - AREA PLAN PERIOD 2011-2012.

Total of REQUESTED TRANSFER column must be **ZERO**

Total of REQUESTED ALLOCATION column must equal total of the ORIGINAL ALLOCATION column

A formula will compute the % of TRANSFER based on the OAA provisions cited at the top of this form.

All Title III-B service funds allocated to the AAA must be included on the III-B line in the Original and Requested Allocations columns including any III-B funds expended **at the AAA** for III-B community-based services to older adults. (*Do not include Program Development or III-B Ombudsman funds*)

REGION: Santee-Lynches Regional COG (Region VI)

EXPENDITURES FOR PRIORITY SERVICE CATEGORIES

As required by the Older Americans Act and State policy, an adequate amount of Title III-B shall be expended for the delivery of each of the categories of service identified on this form.

The AAA shall determine the "adequate amount" based upon the most recent needs assessment data, I&A reports, FCSP reports, and AIM data. The percentages set by the Area Agency on Aging for each priority service category, after careful analysis of the identified data and discussion with the legal services program manager at LGOA, shall be entered on line 5.

Access Services 88.86% In-Home Services 9.4% Legal Assistance 1.74%

Enter Total III B after Transfers for SFY 2012-2013		$291,724	**and SFY 2013-2014**	$254,348
ACCESS SERVICES	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
A. Transportation	$176,597	60.54%	$119,654	47.04%
B. Information & Assistance (III-B funding Only)	$40,328	13.82%	$48,053	18.89%
C. Case Management	$62,583	21.45%	$58,313	22.93%
D. Outreach	$0	0.00%	$0	0.00%
TOTAL ACCESS EXPENDITURES	$279,508	95.81%	$226,020	88.86%
IN-HOME SERVICES	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
A. Level I Housekeeping and Chore	$8,636	2.96%	$23,899	9.40%
B. Level II Homemaker with Limited Personal Care	$0	0.00%	$0	0.00%
C. Level III Personal Care with Limited Medical Assistance	$0	0.00%	$0	0.00%
TOTAL IN-HOME EXPENDITURES	$8,636	2.96%	$23,899	9.40%
LEGAL ASSISTANCE	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
LEGAL ASSISTANCE EXPENDITURES	$3,580	1.23%	$4,429	1.74%
Totals	$291,724		$254,348	

Note 1: State HCBS funds are also used for access and in-home services and may skew the percentages of III-B funds used for these services

Note 2: FY 2013-2014 budgeted numbers include internal, flow through and legal III-B funds- fed $217,210
per draft NGA May 2013 + projected carry over III-B fed funds $ 37,138

$254,348

	A	B	C	D	E	F	G	H	I	J	K	L	N	O
1		Santee-Lynches Regional COG **SUMMARY PROGRAM BUDGET-COMPUTATION OF GRANTS**										**SFY13-14**		**Page 1**
2		**IN-HOME & COMMUNITY-BASED SERVICES**							Includes $217,210 from draft NGA + $ 37,137 proj'd c/o				**NUTRITION SERVICES**	
3	**NOTE:** Match Ratio if using III-E is 88.24(F) to 11.76(L)	Transportation	Chore or House-keeping	Homemaker with Some Personal Care	Personal Care with Limited Medical Assistance	Home Living Support	Adult Day Services See NOTE Upper Left	Legal Assistance	Information & Assistance See NOTE Upper Left	Respite Care See NOTE Upper Left	Care Manage-ment	TOTAL Supportive Services	Includes $219,781 fed + $ 4,001 proj'd fed c/o Congregate Meals	Includes $410,296 fed + $2,707 proj'd c/o Home Delivered Meals
4	**CONTRACTED UNITS**	**175,590**	**11,872**	**0**	**0**	**0**	**0**	**35**	**6,000**	**0**	**1,800**	**N/A**	**59,627**	**93,015**
5	**Title III Federal B, C**	$119,654	$23,899	$0	$0	$0	$0	$4,429	$48,053	$0	$58,313	$254,347	$223,782	$413,003
6	**Title III Federal E**						$0		$6,500	$0		$6,500		
7	**State 5% Match B and C**	$7,038	$1,406	$0	$0	$0	$0	$261	$2,827	$0	$3,430	$14,962	$13,164	$24,294
8	**Local:Cash match**	$0	$0	$0	$0	$0	$0	$0	$6,519	$0	$6,860	$13,379	$0	$0
9	**Local:In-kind match**	$14,077	$2,812	$0	$0	$0	$0	$521	$0	$0	$0	$17,410	$26,327	$48,589
10	**Total Local Match**	$14,077	$2,812	$0	$0	$0	$0	$521	$6,519	$0	$6,860	$30,789	$26,327	$48,589
11	**ACE-Bingo**		$40,772	$0	$0	$0	$0		$0	$0	$0	$40,772		$0
12	**State H&C-B Services (ACE-CS)**	$74,829	$120,467	$0	$0	$0	$0		$0	$0	$0	$195,296	$134,241	$11,461
13	Restricted State Revenue (if applicable)	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0
14	**NSIP**											$0	$52,050	$58,694
15	**Cost Share/GRI -State Services**	$0	$0	$0	$0	$0	$0			$0	$0	$0	$0	$0
16	**GRI for Title III (Estimate)**	$0	$0	$0	$0	$0	$0			$0		$0	$16,787	$5,317
17	**Total Contracted Funds**	**$215,598**	**$189,355**	**$0**	**$0**	**$0**	**$0**	**$5,211**	**$63,899**	**$0**	**$68,603**	**$542,666**	**$466,351**	**$561,358**
18	**Contracted Rate**	**$1.2278**	**$15.9497**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**$148.87**	**$10.6499**	**#DIV/0!**	**$38.113**	**N/A**	**$7.8211**	**$6.0351**
19	**NOTE: Contracted rate includes Local Match**													
20	**COMPUTATION OF NET (AIM) UNIT COST AND UNITS PER FUNDING SOURCE**													
21	**Net Contracted (AIM) Rate**	$1.2278	$15.9497	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$148.87	$10.6499	#DIV/0!	$38.1129	NA	$7.8211	$6.0351
22	**AIM Units: ACE-BINGO**		2,556	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	0			0
23	**AIM Units:State H&CB Svs**	60,943	7,553	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	0		17,164	1,899
24	AIM Units: Restricted State Revenue (if applicable)		0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	0			0
25	**AIM Units: State Cost Share/GRI**	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	0			0
26	**NSIP Share of Meal Unit Cost**												$1.2258	$0.6442
27	**AIM Title III Meal Rate**												$6.5954	$5.3910
28	**AIM Units: Title III GRI (Estimate)**	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	0		2,146	881
29	**AIM Units:Title III (F+S+L)**	114,647	1,763	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	35	6,000	#DIV/0!	1,800		40,317	90,235
30	**TOTAL CONTRACT UNITS**	**175,590**	**11,872**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**35**	**6,000**	**#DIV/0!**	**1,800**	**N/A**	**59,627**	**93,015**
31	**NOTE: Contracted Units for All Services Include Units Projected for GRI and State Services Income**													
32	Total of All Other Resources by Service	$8,314	$17,915	$0	$0	$0	$0	$0	$0	$0	$0	NA	$20,699	$7,795
33	Total of Units Served with those Other Resources	6,707	1,123	0	0	0	0	0	0	0	0	NA	2,647	1,300
34	**TOTAL SERVICE BUDGET**	$223,912	$207,270	$0	$0	$0	$0	$5,211	$63,899	$0	$68,603	N/A	$487,050	$569,153
35	**Total Unit Cost**	**$1.2283**	**$15.9500**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**$148.8711**	**$10.6499**	**#DIV/0!**	**$38.1127**	NA	**$7.8211**	**$6.0346**

SUMMARY OF SERVICE FUNDING, CONTRACTED UNITS and AVERAGE UNIT COST SFY 2013-2014			
SERVICE	TOTAL AAA FUNDING PER SERVICE	TOTAL UNITS FOR REGION	REGIONAL AVERAGE UNIT COST
Transportation	$223,912	182,297	$1.2283
Housekeeping or Chore	$207,270	12,995	$15.9500
Homemaker with Limited Personal Care	$0	0	#DIV/0!
Personal Care with Limited Medical Assistance	$0	0	#DIV/0!
Home Living Support	$0	0	#DIV/0!
Legal Assistance	$5,211	35	$148.8857
Adult Day Care	$0	0	#DIV/0!
Respite Care	$0	0	#DIV/0!
Information, Referral & Assistance	$63,899	6,000	$10.6498
Care Management	$68,603	1,800	$38.1128
Group Dining	$487,050	62,274	$7.8211
Home Delivered Meals	$569,153	94,315	$6.0346
Health Screening	$0	0	#DIV/0!
Nutrition Risk Follow-Up	$0	0	#DIV/0!
Evidence Based Health Promotion Program	$22,450	1,872	$11.9925
Physical Fitness	$0	0	#DIV/0!
Home Injury Prevention	$0	0	#DIV/0!
Minor Home Repair (State Funds Only)	$0	0	#DIV/0!
Medication Management	$2,509	800	$3.1363
Outreach	$0	0	#DIV/0!
I-Care Calls/Contacts	$36,040	4,200	$8.5810
SMP Calls/Contacts	$13,900	1,200	$11.5833
Caregiver Services	$166,730	14,000	$11.9093

All entries must include both AAA delivered services and contracted services

NUMBER OF MINORITY PROVIDERS	5
NUMBER OF RURAL PROVIDERS	4
TOTAL NUMBER OF PROVIDERS	6

Santee-Lynches Reg COG- Region VI

REGION: VI- Santee-Lynches

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012

State Fiscal Year Beginning July	County or Provider	Congregate Meals Contracted Funds	Congregate Meals Contracted Units	Congregate Meals Contracted Unit Cost	Home Delivered Meals Contracted Funds	Home Delivered Meals Contracted Units	Home Delivered Meals Contracted Unit Cost	Health Screening Contracted Funds	Health Screening Contracted Units	Health Screening Contracted Unit Cost	Nutrition Risk Assessment Contracted Funds	Nutrition Risk Assessment Contracted Units	Nutrition Risk Assessment Contracted Unit Cost	Health Promotion Contracted Funds	Health Promotion Contracted Units	Health Promotion Contracted Unit Cost
2009-2010	Clarendon	$85,987	13,584	**$6.3300**	$145,838	26,043	**$5.5999**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$5,526	274	**$20.1679**
2010-2011	Clarendon	$81,421	12,782	**$6.3700**	$122,204	21,629	**$5.6500**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$4,932	274	**$18.0000**
2011-2012	Clarendon	$76,976	12,084	**$6.3701**	$128,860	22,807	**$5.6500**			**#DIV/0!**			**#DIV/0!**	$4,896	272	**$18.0000**
2012-2013	Clarendon	$74,279	11,534	**$6.4400**	$122,673	21,712	**$5.6500**			**#DIV/0!**			**#DIV/0!**	$5,635	420	**$13.4167**
2009-2010	Kershaw	$105,986	13,803	**$7.6785**	$130,243	20,608	**$6.3200**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2010-2011	Kershaw	$110,223	14,273	**$7.7225**	$110,003	17,269	**$6.3700**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2011-2012	Kershaw	$106,185	13,723	**$7.7377**	$110,557	17,356	**$6.3700**			**#DIV/0!**			**#DIV/0!**	$0	0	**#DIV/0!**
2012-2013	Kershaw	$72,023	9,140	**$7.8800**	$110,558	17,356	**$6.3700**			**#DIV/0!**			**#DIV/0!**	$0	0	**#DIV/0!**
2009-2010	Lee	$107,032	13,600	**$7.8700**	$131,026	22,907	**$5.7199**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$5,526	274	**$20.1679**
2010-2011	Lee	$101,778	12,867	**$7.9100**	$113,796	19,722	**$5.7700**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$4,932	274	**$18.0000**
2011-2012	Lee	$143,891	18,191	**$7.9100**	$116,808	20,244	**$5.7700**			**#DIV/0!**			**#DIV/0!**	$4,905	273	**$18.0000**
2012-2013	Lee	$95,760	12,000	**$7.9800**	$116,808	20,244	**$5.7700**			**#DIV/0!**			**#DIV/0!**	$5,635	480	**$11.7396**
2009-2010	Sumter	$206,430	26,230	**$7.8700**	$302,353	52,859	**$5.7200**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$11,114	551	**$20.1706**
2010-2011	Sumter	$208,682	26,382	**$7.9100**	$222,250	38,510	**$5.7712**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$9,783	544	**$18.0000**
2011-2012	Sumter	$191,509	24,211	**$7.9100**	$205,879	35,681	**$5.7700**			**#DIV/0!**			**#DIV/0!**	$9,738	541	**$18.0000**
2012-2013	Sumter	$174,012	21,750	**$8.0006**	$199,180	34,516	**$5.7707**			**#DIV/0!**			**#DIV/0!**	$11,176	972	**$11.4979**
2009-2010	SLRCOG	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2010-2011	SLRCOG	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2011-2012	SLRCOG	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2012-2013	SLRCOG	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2009-2010		$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2010-2011		$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2011-2012				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2012-2013				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2009-2010	REGIONWIDE	$505,435	67,217	**$7.5195**	$709,460	122,417	**$5.7954**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$22,166	1,099	**$20.1692**
2010-2011	REGIONWIDE	$502,104	66,304	**$7.5728**	$568,253	97,130	**$5.8504**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$19,647	1,092	**$18.0000**
2011-2012	REGIONWIDE	$518,561	68,209	**$7.6025**	$562,104	96,088	**$5.8499**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$19,539	1,086	**$18.0000**
2012-2013	REGIONWIDE	$416,074	54,424	**$7.6450**	$549,219	93,828	**$5.8535**			**#DIV/0!**			**#DIV/0!**	$22,446	1,872	**$11.9904**

Client Demographics - Target Populations Served Shown as % of Total Persons Served

REGION: | **YTD Data From AIM** | **SFY2012- (May) 2013**

Service Delivery Contractors	Total Unduplicated People Served (a)	Number of Unduplicated Minority Served (b)	Of Total Unduplicated Persons Served % Who Are Minority	Unduplicated Number in Rural Areas Served (c)	Of Total Unduplicated Persons Served % Who Live in Rural Area	Unduplicated Number at or Below Poverty Served (d)	Of Total Unduplicated Persons Served % Who Are Below Poverty	Unduplicated Number of Minority Poor Served (e)	Of Total Unduplicated Minority Served % Who Are Poor	Unduplicated Number of Non-Minority Poor Served (f)	Of Total Non-Minority Served % Who Are Poor	Unduplicated Number of Clients Served for First Time in SFY12 (g)	Of Total Persons Served % Who Received Services for the First Time in SFY'11
Claredon County	318	255	80.19%	314	98.74%	187	58.81%	160	62.75%	27	42.86%	0	0.00%
Greater Faith and Joy	28	26	92.86%	27	96.43%	19	67.86%	19	73.08%	0	0.00%	0	0.00%
Kershaw County	242	142	58.68%	220	90.91%	128	52.89%	81	57.04%	47	47.00%	0	0.00%
Lee County	317	279	88.01%	251	79.18%	208	65.62%	188	67.38%	20	52.63%	0	0.00%
Sumter Senior Services	783	542	69.22%	353	45.08%	591	75.48%	519	95.76%	72	29.88%	0	0.00%
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Regionwide	1688	1244	73.70%	1165	69.02%	1133	67.12%	967	77.73%	166	37.39%	0	0.00%

(a) This is the number of unduplicated persons in the region served directly by the AAA or under AAA purchase of service contracts in SFY'12.

(b) Of total persons served, this is the number who were minority (Show breakout of minority population on next page.)

(c) Of the total persons served this is the number that reside in rural areas (outside incorporated cities and towns.)

(d) Of the persons served, this is the number whose self reported income was at or below the 2011 poverty level established by the Bureau of the Census.

(e) Of those whose self reported income was below the 2011 poverty level cited above, this is the number who were minority

(f) Of those whose self reported income was below the 2011 poverty level cited above, this is the number who were not minority

(g) Of the total number served, this is the number who received services for the first time in SFY 2012 or who had not received any contracted service since June 30, 2010

Client Demographics - Target Populations Served Shown as % of Total Persons Served

REGION: | **YTD Data From AIM** | **SFY2011-2012**

Service Delivery Contractors	Total Unduplicated People Served (a)	Number of Unduplicated Minority Served (b)	Of Total Unduplicated Persons Served % Who Are Minority	Unduplicated Number in Rural Areas Served (c)	Of Total Unduplicated Persons Served % Who Live in Rural Area	Unduplicated Number at or Below Poverty Served (d)	Of Total Unduplicated Persons Served % Who Are Below Poverty	Unduplicated Number of Minority Poor Served (e)	Of Total Unduplicated Minority Served % Who Are Poor	Unduplicated Number of Non-Minority Poor Served (f)	Of Total Non-Minority Served % Who Are Poor	Unduplicated Number of Clients Served for First Time in SFY12 (g)	Of Total Persons Served % Who Received Services for the First Time in SFY'11
Care Pro	164	99	60.37%	116	70.73%	71	43.29%	50	50.51%	21	32.31%	0	0.00%
Claredon County	312	248	79.49%	308	98.72%	188	60.26%	158	63.71%	30	46.88%	0	0.00%
Greater Faith and Joy	29	27	93.10%	28	96.55%	22	75.86%	22	81.48%	0	0.00%	0	0.00%
Kershaw County	246	142	57.72%	221	89.84%	122	49.59%	81	57.04%	41	39.42%	0	0.00%
Lee County	325	287	88.31%	242	74.46%	228	70.15%	208	72.47%	20	52.63%	0	0.00%
Sumter Senior Services	789	555	70.34%	355	44.99%	587	74.40%	520	93.69%	67	28.63%	0	0.00%
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Regionwide	1865	1358	72.82%	1270	68.10%	1218	65.31%	1039	76.51%	179	35.31%	0	0.00%

(a) This is the number of unduplicated persons in the region served directly by the AAA or under AAA purchase of service contracts in SFY'12.

(b) Of total persons served, this is the number who were minority (Show breakout of minority population on next page.)

(c) Of the total persons served this is the number that reside in rural areas (outside incorporated cities and towns.)

(d) Of the persons served, this is the number whose self reported income was at or below the 2011 poverty level established by the Bureau of the Census.

(e) Of those whose self reported income was below the 2011 poverty level cited above, this is the number who were minority

(f) Of those whose self reported income was below the 2011 poverty level cited above, this is the number who were not minority

(g) Of the total number served, this is the number who received services for the first time in SFY 2012 or who had not received any contracted service since June 30, 2010

SUPPLEMENTAL DETAIL - Breakout of the ethnicity of the Minority Population SERVED in SFY 2011-2012					
Service Delivery Contractors	**African-American**	**Hispanic**	**Native American or Alaskan Native**	**Asian/ Pacific Islander**	**Unknown Ethnicity**
Claredon County	255	0	0	0	0
Greater Faith and Joy	26	0	0	0	0
Kershaw County	140	2	0	0	0
Lee County	279	0	0	0	0
Sumter County	554	1	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Regionwide	1254	3	0	0	0

(ENTER REGION NAME) **DESIGNATED AND UNDESIGNATED FOCAL POINTS IN THE PSA IN 2012-2013**

Minimum include all Contractors, all Senior Centers in the region and all Congregate Dining Centers not located in a Senior Center

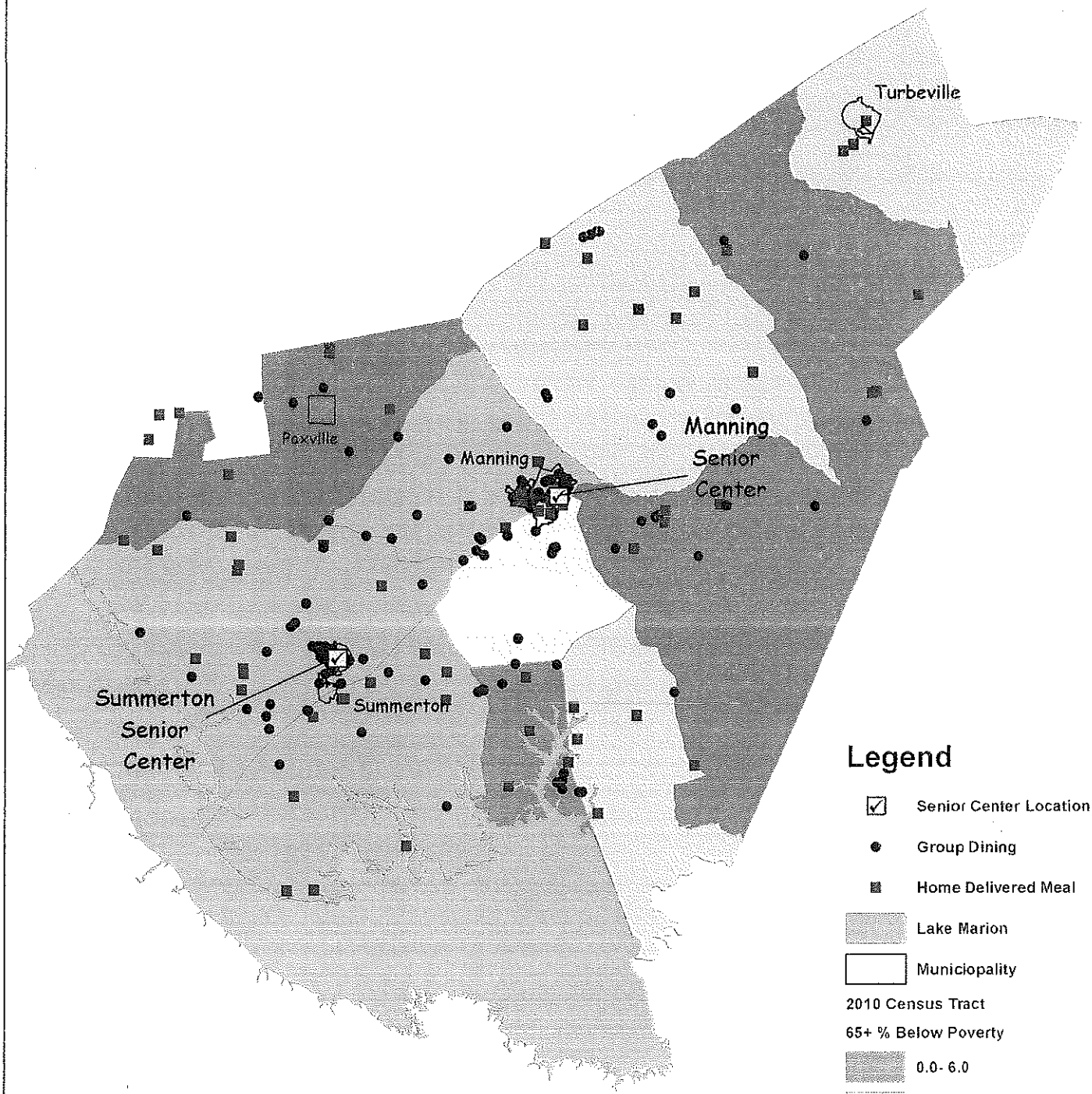
County	Focal Point Organization	Focal Point Street Address	AAA Designated Focal Point	Type of Facility	Owner of Facility
Clarendon County	Clarendon County Council on Aging	206 South Church Street Manning, SC 29102	yes	Group Dining	CCCOA
Clarendon County	Summerton Senior Center	1154 4th Street Summerton, SC 29148	yes	Group Dining	Clarendon District One
Kershaw	Kershaw County Council on Aging	906 Lyttleton Street Camden, SC 29020	yes	Group Dining	KCCOA
Kershaw	Bethune Rural Community Center	2916 Timrod Road Bethune, SC 29002	yes	Group Dining	Bethune Community Association
Kershaw	United Way of Kershaw County	110 East DeKalb Street Camden, SC 29020	no	Human Services	United Way of Kershaw County
Kershaw	Camden First Community Development Corp.	704 West DeKalb Street Camden, SC 29020	no	Community Services	Camden First UMC
Kershaw	Food for the Soul	110 East DeKalb Street Camden, SC 29020	no	Soup Kitchen & Overnight Shelter	Food for the Soul, Inc.
Kershaw	Community Medical Clinic of Kershaw County	110 East DeKalb Street Camden, SC 29020	no	Family Practice Medical Clinic	Community Medical Clinic of KC, Inc.
Kershaw	Christian Community Ministries	110 East DeKalb Street Camden, SC 29020	no	Emergency Assistance	United Way of Kershaw County
Kershaw	Wateree Community Action	710 West DeKalb Street Camden, SC 29020	no	Human Services	Camden First UMC
Kershaw	Kershaw Baptist Association	14 East DeKalb Street Camden, SC 29020	no	Human Services	Kershaw Baptist Association
Kershaw	Kershaw County Dept. of Social Services	110 East DeKalb Street Camden, SC 29020	no	Human Services	United Way of Kershaw County
Kershaw	Kershaw County Recreation Dept.	1040 west DeKalb Street Camden, SC 29020	no	Recreational Activities	Kershaw County government
Kershaw	Greater Faith & Joy Adult Services	1474 Highway 601 Lugoff, SC 29078	yes	Group Dining	Greater Faith & Joy Tabernacle Church
Lee	Lee County Council on Aging	51 Wilkinson Road Bishopville, SC 29010	yes	Group Dining	
Lee	Springhill UMC	446 Lloyd Road Rembert, SC	yes	Group Dining	
Sumter	Sumter Senior Services Activity Center	119 S. Sumter Street Sumter, SC 29150	yes	Senior Center	Sumter Senior Sevices
Sumter	Shiloh St. John	425 Pudding Swamp Road Lynchburg, SC	yes	Community Center/Senior Center	Sumter County Government
Sumter	Delaine Community Center	5400 Cane Savannah Road	yes	Community Center/Senior Center	DARD Sumter
Sumter	Shiloh Randolph Center	125 W Bartlette Street Sumter, SC 29150	yes	Senior Housing	Shiloh Randolph Corpation
USE MULTIPLE PAGES IF NECESSARY					

INSTRUCTION: In addition to any focal points officially designated by the Area Agency, include those community facilities and programs that are considered by older adults to be their community's source of information or access to services, activities and programs as <u>undesignated</u> focal points.

TITLE III-D EVIDENCE-BASED PROGRAMS FUNDED SFY 2012-2013

CONTRACTORS	EVIDENCE BASED PROGRAM(S) OFFERED (Frequency)	PROGRAM LOCATION(S) Street Address and Phone	TOTAL III-D FUNDS (Federal +Match)	CONTRACTED UNITS	CONTRACTED UNIT COST
Clarendon County Council on Aging	**Walk with Ease 9:30 MWF Limited to 13 persons per session**	Manning Senior Center 206 South Church Street Manning, SC 29102 (803) 435-8593	$5,636	420	$13.42
Kershaw County Council on Aging	**CDSME - Better Choices, Better Health Time & Date TBD Limited to 10 person per session**	KCCOA Senior Center 906 Lyttleton Street Camden, SC 29020 (803) 432-8173	$5,000	6	$833.33
Lee County Council on Aging	**Arthritis Foundation 10:30 MWF**	LCCOA 51 Wilkinson Road Bishopville, SC 29010	$5,635	480	$11.74
Springhill UMC	**Arthritis Foundation Tuesday and Thursday**	446 Lloyd Road Rembert, SC			#DIV/0!
Sumter Senior Services	**Walk with Ease**	SSS Activity Center 119 S. South Sumter, SC 29151 (803) 775-5815			#DIV/0!
Sumter Senior Services	**Walk with Ease**	Shiloh Randolph Center 125 W. Bartlette Street (803) 775-5156	$11,178	972	$11.50
Sumter Senior Services	**Walk with Ease**	Shiloh St. John 425 Pudding Swamp Road Lynchburg, SC 29080 (843) 659-4201			#DIV/0!

Santee-Lynches Region
Service Recipients
Clarendon County
65+ Population
Percent Below Poverty



Legend

- Senior Center Location
- Group Dining
- Home Delivered Meal
- Lake Marion
- Municiopality

2010 Census Tract

65+ % Below Poverty

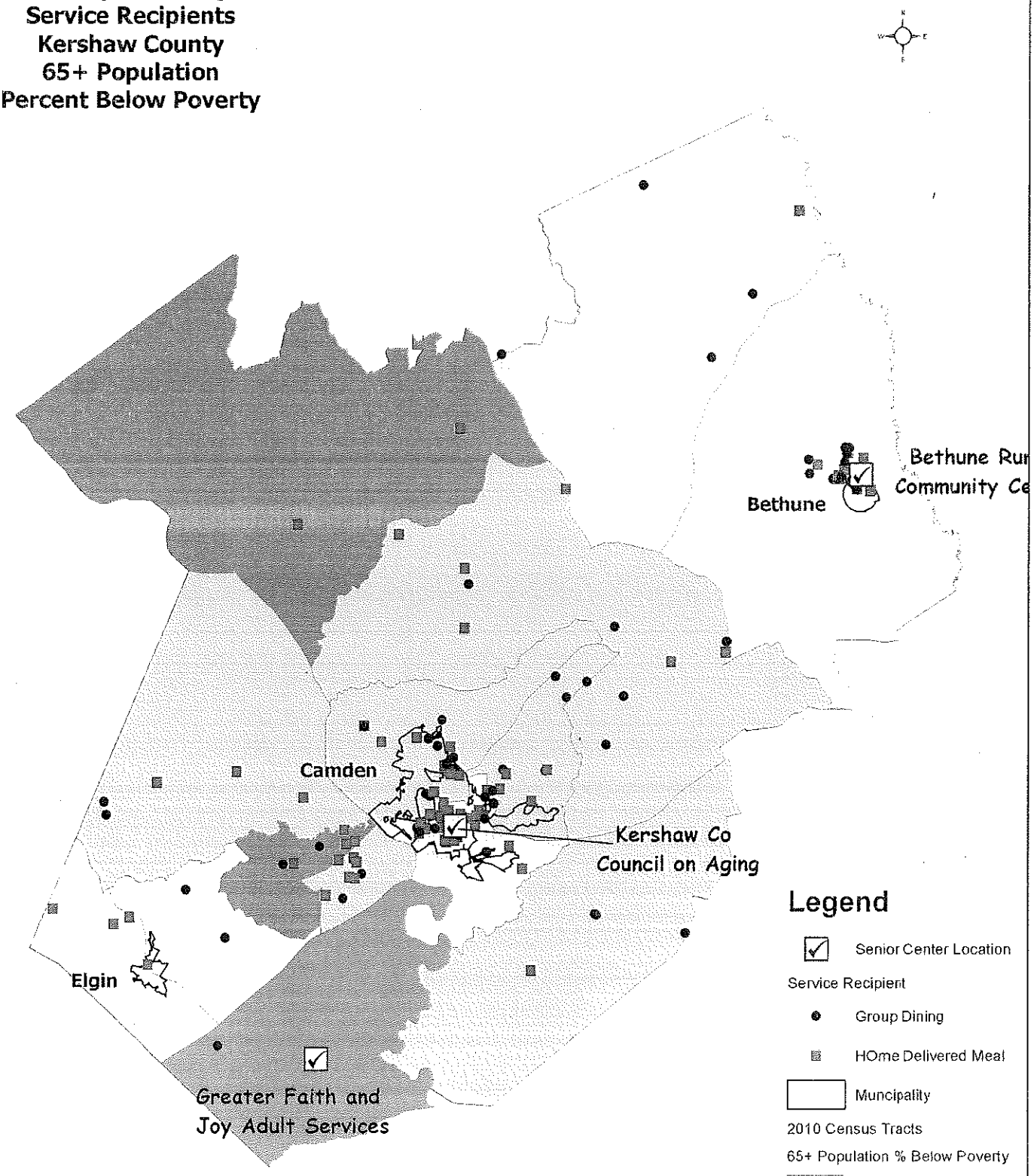
- 0.0 - 6.0
- 6.1 - 12.0
- 12.1 - 18.0
- 18.1 - 24.0
- 24.1 - 29.4

0 — 8 Miles

May 29, 2013
c\Aging\ClarMealRecTrct65+BlwPov

SOURCE: ACS, 2007 - 2011
5 Year Estimates

Santee-Lynches Region
Service Recipients
Kershaw County
65+ Population
Percent Below Poverty



Legend

- Senior Center Location

Service Recipient

- Group Dining
- HOme Delivered Meal
- Muncipality

2010 Census Tracts

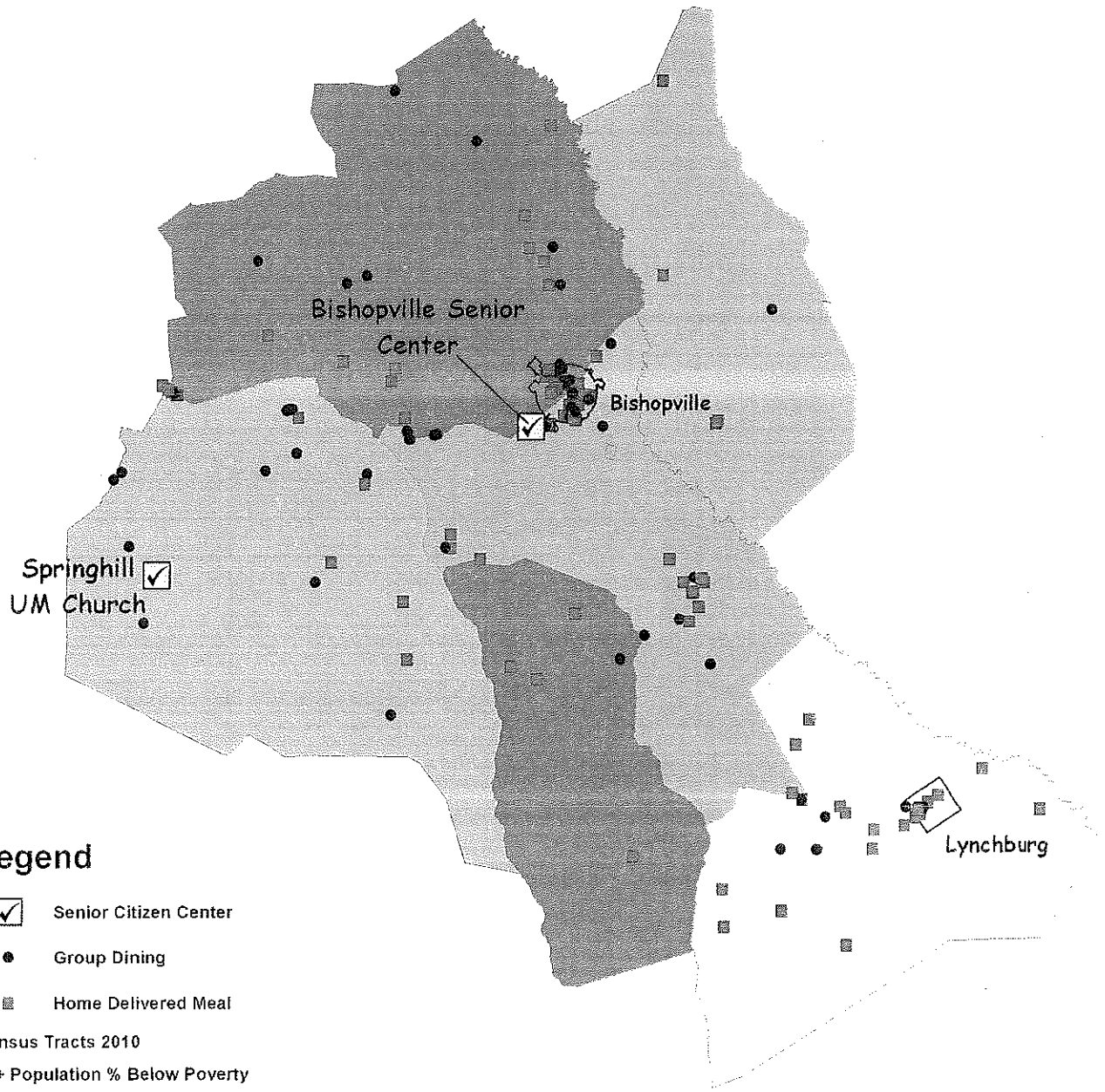
65+ Population % Below Poverty

- 4.3 - 6.0
- 6.1 - 12.0
- 12.1 - 18.0
- 18.1 - 24.0
- None

C\Aging_Shawn\KerMealRec65PerPov
May 29, 2013

SOURCE: ACS, 2007 - 2011
5 year Average

Santee-Lynches Region
Service Recipients
Lee County
65+ Population
Percent Below Poverty



Legend

- Senior Citizen Center
- Group Dining
- Home Delivered Meal

Census Tracts 2010

65+ Population % Below Poverty

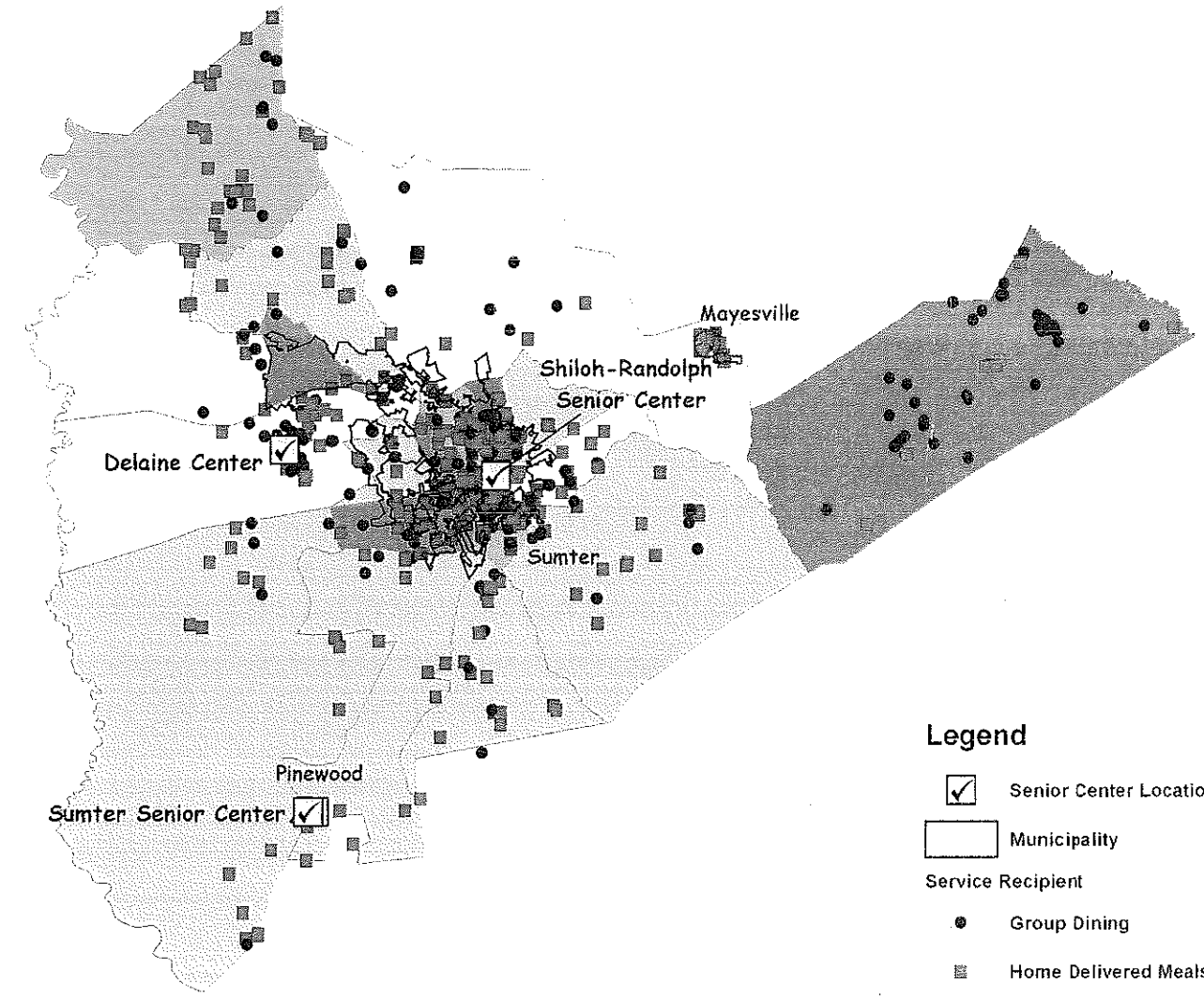
- 0.0 - 6.0
- 6.1 - 12.0
- 12.1 - 18.0
- 18.1 - 24.0
- 24.1 - 37.700001

0 5.5 Miles

SOURCE: ACS, 2007 -2011
5 Year Estimates

May 30, 2013
c\Aging\Shawn\LeeMealRec65+Pov%

Santee-Lynches Region
Service Recipients
Sumter County
65+ Population
Percent Below Poverty



Legend

- Senior Center Location
- Municipality

Service Recipient

- Group Dining
- Home Delivered Meals

2010 Census Tracts

65+ % Below Poverty

- 0.0 - 6.0
- 6.1 - 12.0
- 12.1 - 18.0
- 18.1 - 24.0
- 24.1 - 45.7

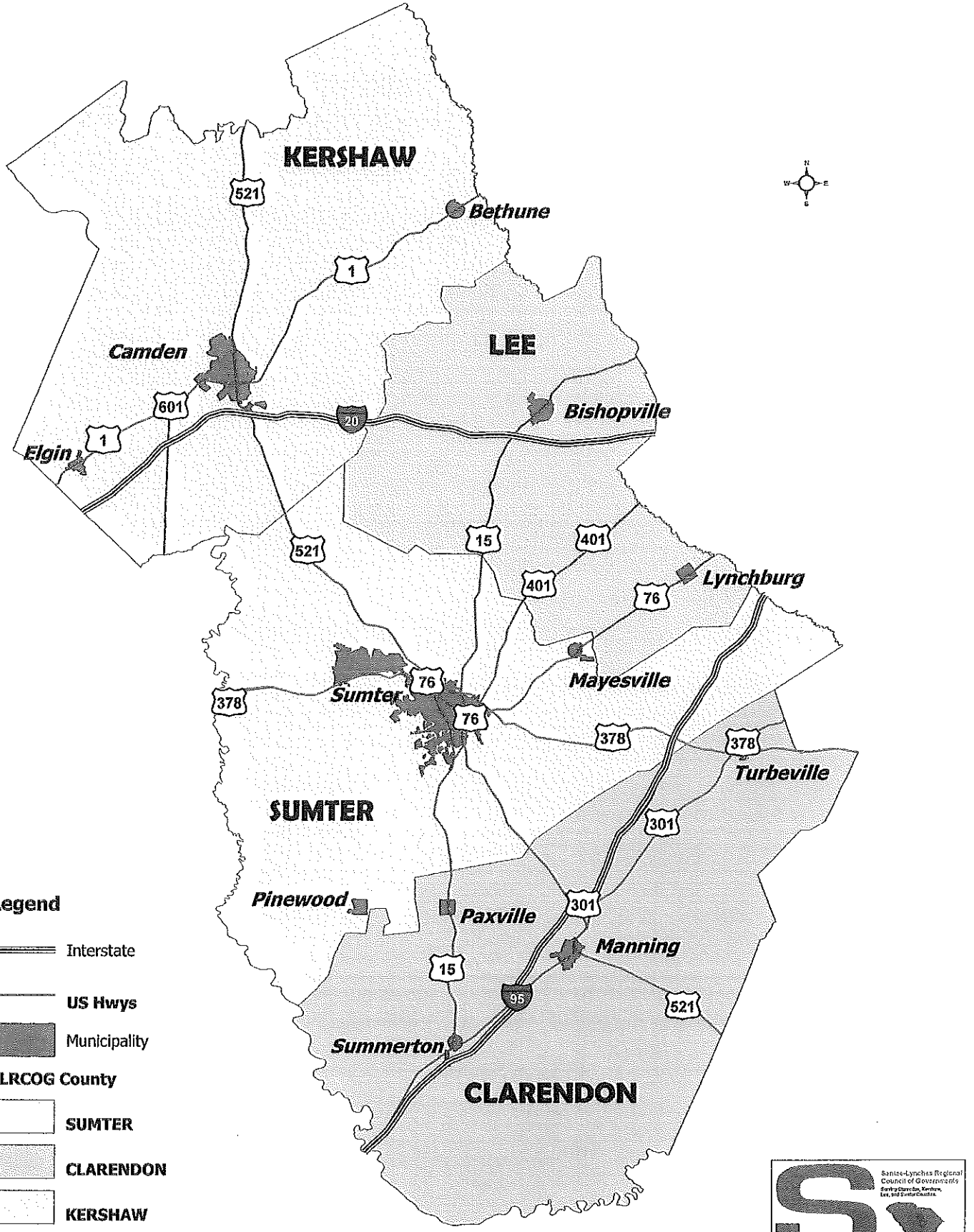
Santee-Lynches Regional Council of Governments

0 10 Miles

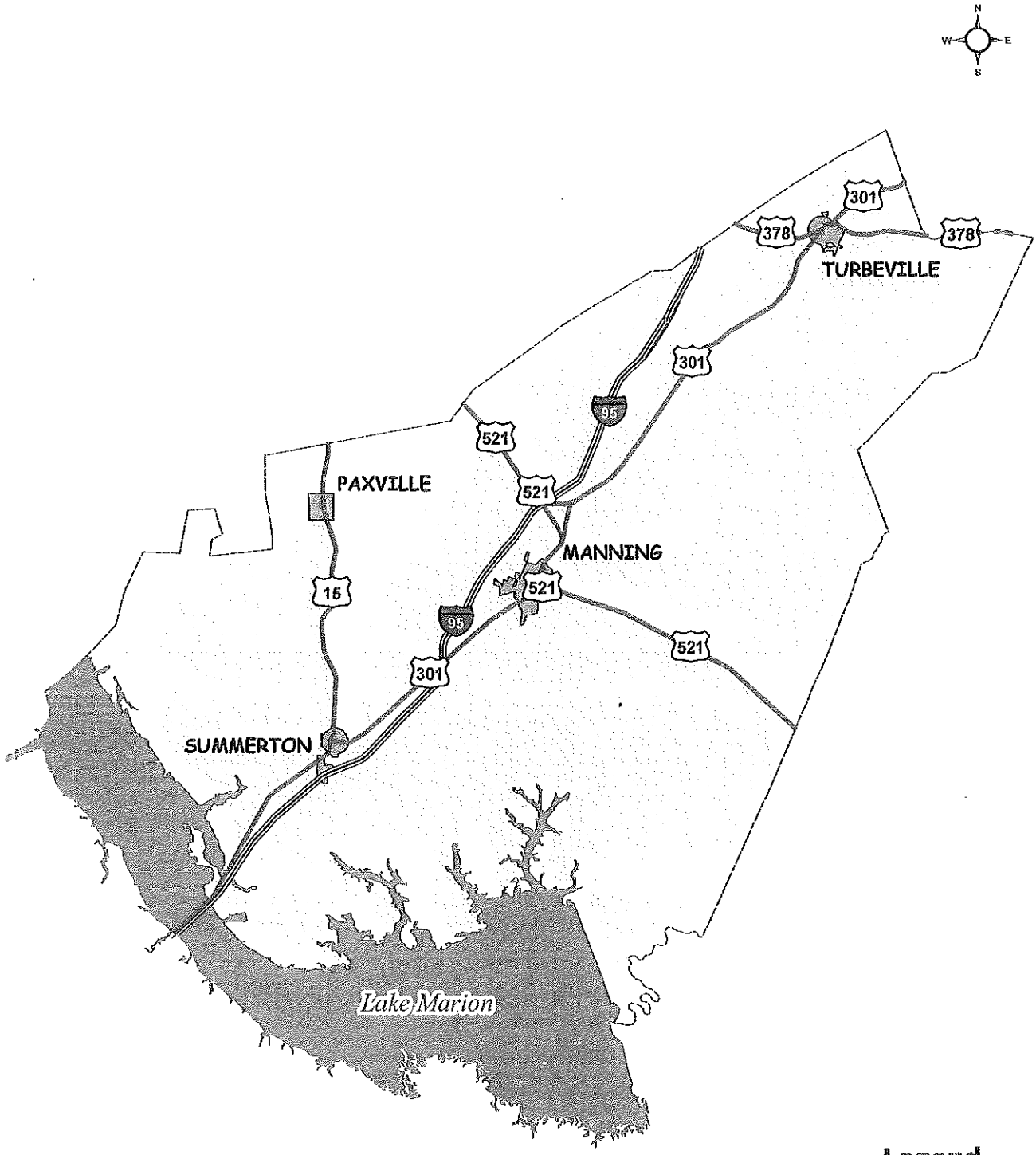
May 31, 2013
c\AgingShw\SumMealRecMay2013Pov65+

SOURCE: ACS, 2007 - 2011
5 year estimates

Santee-Lynches Region
COG Counties



Clarendon County



Legend

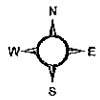
- US Hwys
- Interstate
- Municipality
- Clarendon County

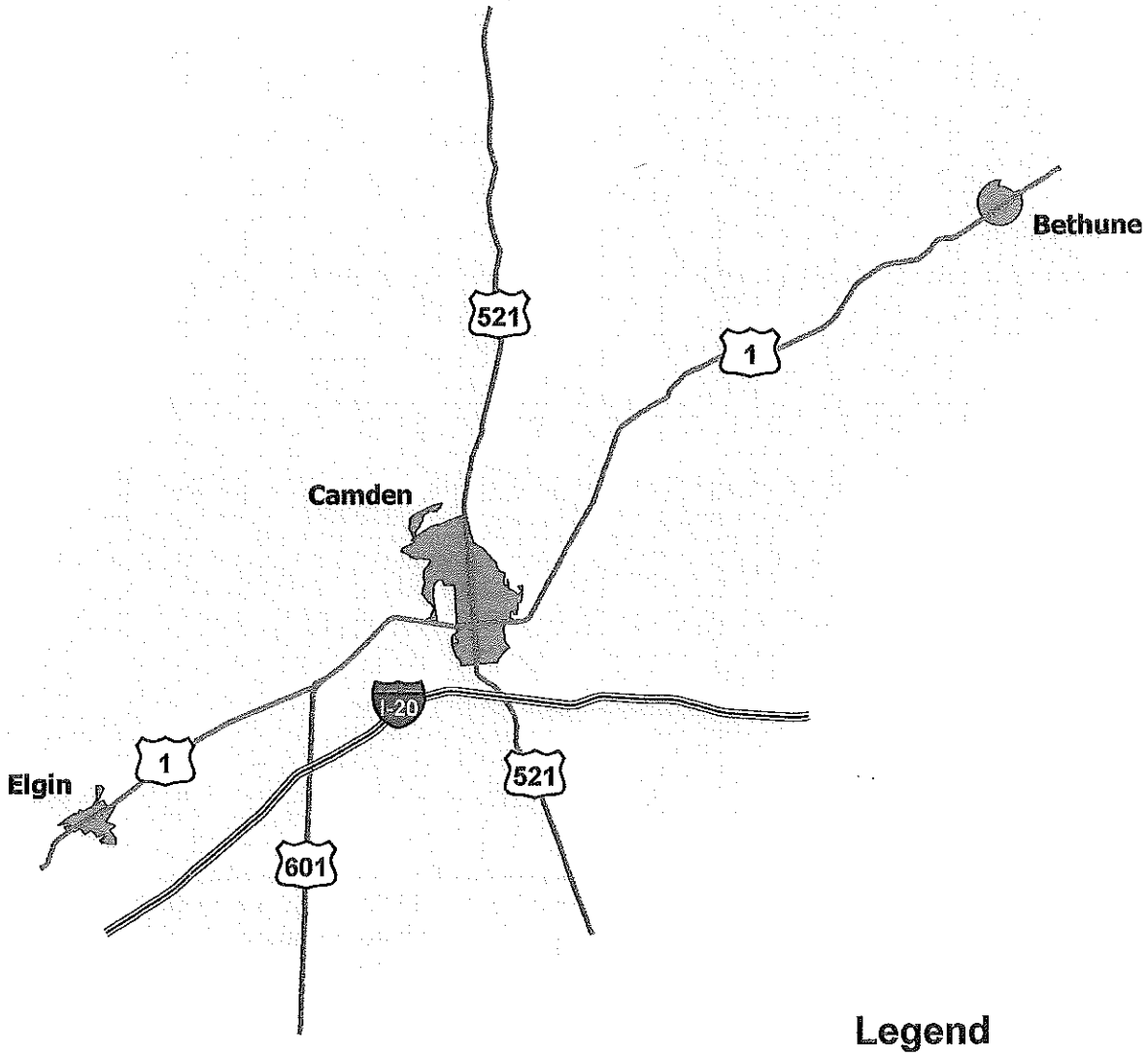
Santee-Lynches Regional Council of Governments
Serving Clarendon, Kershaw, Lee, and Sumter Counties

0 10 Miles

June 3, 1013
c\Clar\BaseMap2013

Kershaw County





Legend

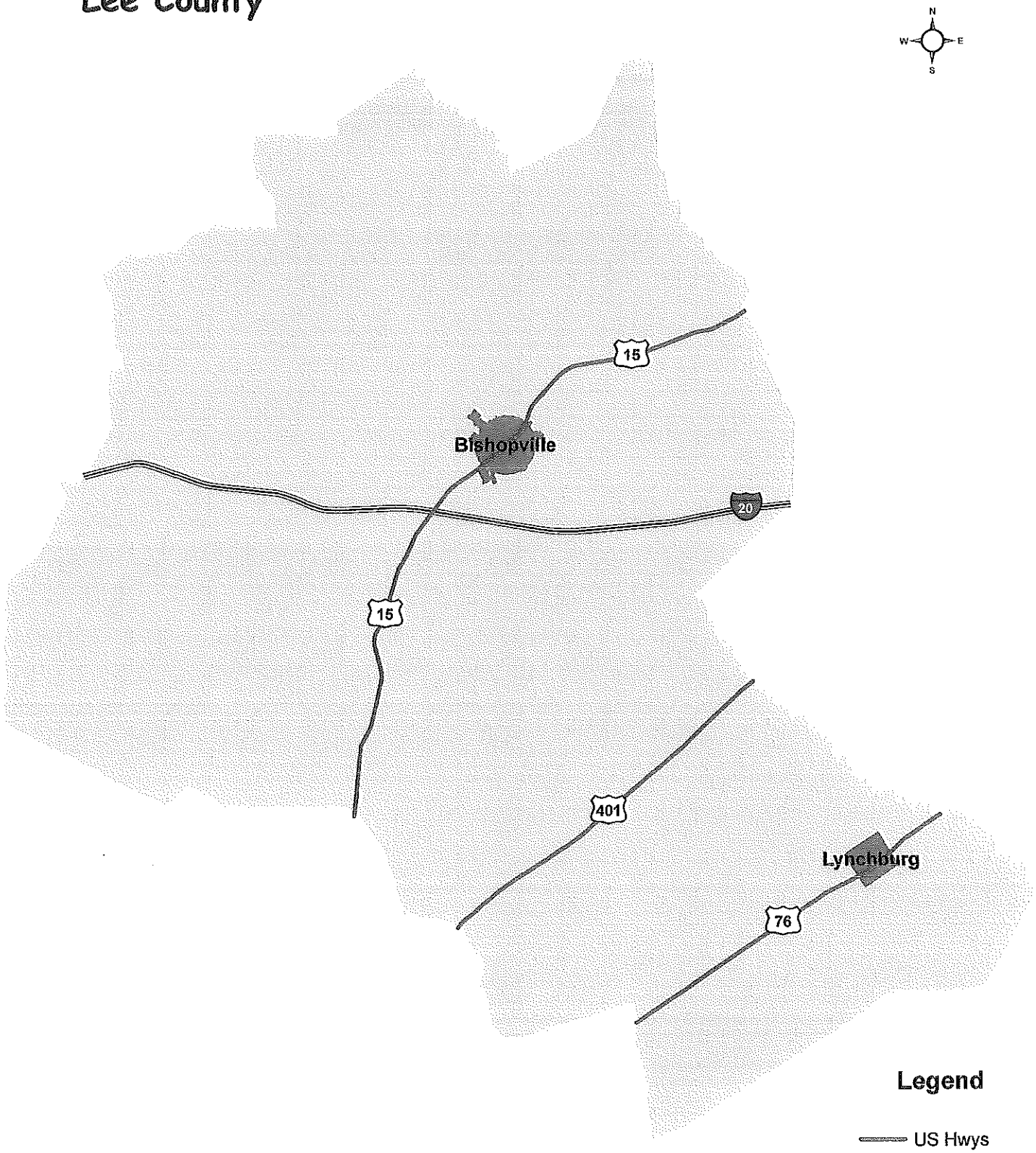
- Interstate20hh
- US Hwy
- Municipality
- Kershaw County

Santee-Lynches Regional Council of Governments
Serving Clarendon, Kershaw, Lee, and Sumter Counties.

0 2.75 5.5 11 Miles

June 3, 2013
c\Ker\BasicBaseMp2013

Lee County



Legend

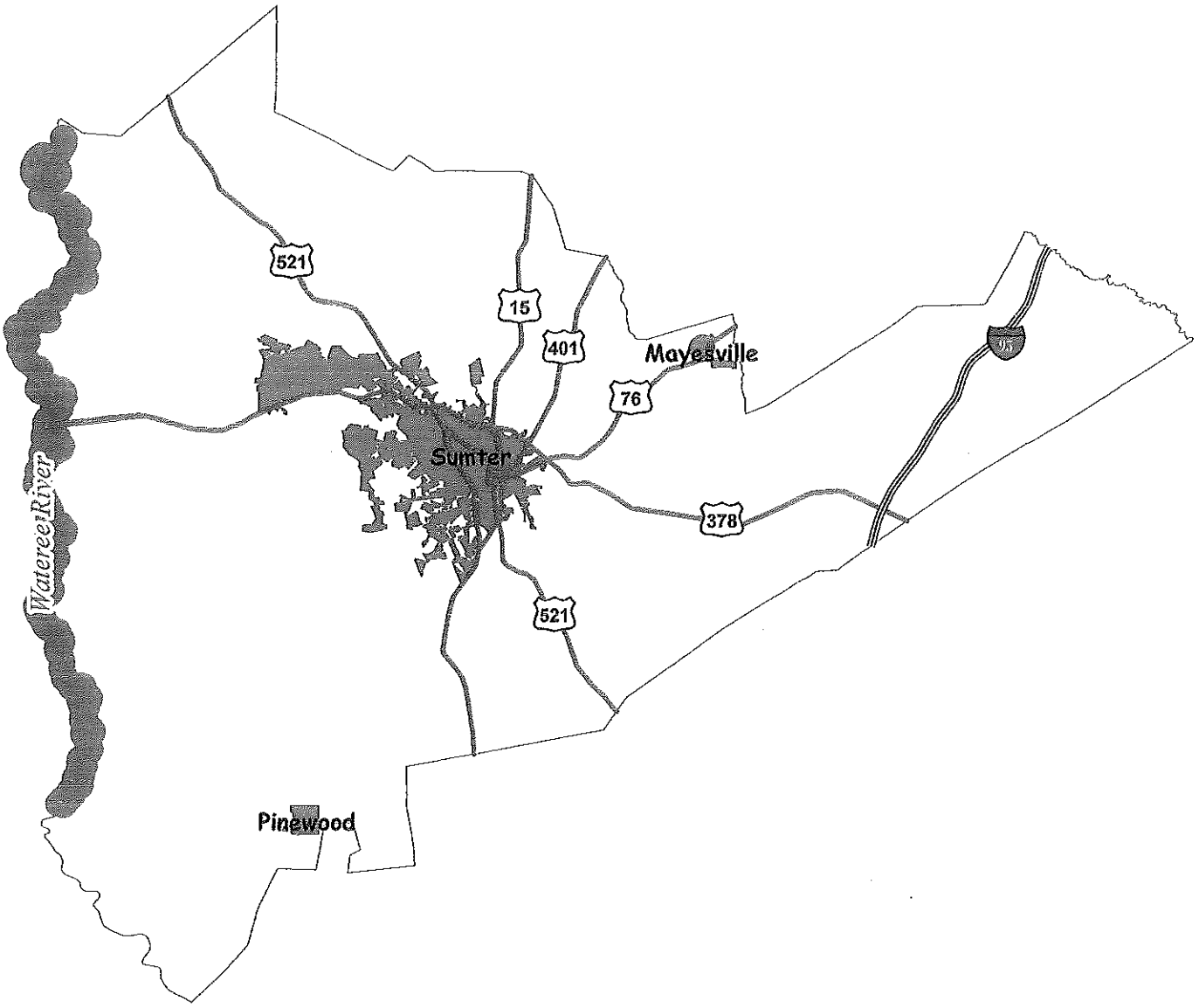
- US Hwys
- Interstate
- Municipalioty
- Lee County

Santee-Lynches Regional Council of Governments
Serving Clarendon, Kershaw, Lee, and Sumter Counties

0 5 Miles

June 3, 2013
C:\Lee\BasicBaseMap2013

Sumter County



Legend

- Interstate 95
- US Hwys
- Municipality
- Wateree River
- Sumter County

Santee-Lynches Regional Council of Governments
Serving Clarendon, Kershaw, Lee and Sumter Counties

0 5 10 Miles

June 3, 2013
c\Sumter\BasicBaseMap2013

ACCESS INFORMATION FOR EMERGENCY PREPAREDNESS ACTIVITIES

REGION: Santee-Lynches	FISCAL YEAR 2013-2014

COORDINATING AGENCIES (Agency Name & Street Address)	EMERGENY CONTACT STAFF (Names and Job Titles)	CONTACT NUMBER After Business Hours
Area Agency on Aging		
Santee-Lynches AAA, ADRC	Shawn V. Keith, Aging Director	(803) 968-5554
Santee-Lynches AAA, ADRC	Kristy Pritchard, Resource Coordinator	(803) 468-2605
Santee-Lynches AAA, ADRC	Gena Kiber, Resource Coordinator	(803) 499-2544
Santee-Lynches AAA, ADRC	Janice Reed Coney, Ombudsman	(803) 435-2821
Santee-Lynches AAA, ADRC	Toni Y. Brew, Caregiver Advocate	(803) 436-5656
Santee-Lynches AAA, ADRC	Yolonda Russell, IR & A Specialist	(803) 506-2244
Santee-Lynches AAA, ADRC	Janae Allumbaugh, Ship Coordinator	(803) 316-3299
Santee-Lynches AAA, ADRC	Lakeisha Govan, Data Clerk	(803) 458-1549
Area Agency Contractors		
Sumter Senior Services	Shirley Baker, Director	(803) 773-5508
Lee County COA	Shirley Baker, Director	(803) 773-5508
Kershaw County COA	Bruce Little, Director	(803) 425-1522
Clarendon County COA	Tom Mahoney, Finance Manager	(803) 773-9791
Greater Faith & Joy Adult	Marie Williams, Program Manager	(803) 432-0297
Care Pro (Home Care)	Valerie Aiken, Agency Director	(803) 758-4000
Emergency Management Offices		
Sumter County	Erik Hayes, Director	(803) 436-2158
Clarendon County	Anthony Mack, Director	(803) 435-9310
Kershaw County	Gene Faulkenberry, Director	(803) 425-1522
Lee County	Mike Bedenbaugh, Director	(803) 484-5274
Volunteer Organizations Active in Disasters		
American Red Cross	Nancy Cataldo	(803) 775-2363
Salvation Army	Maj. Newton Brown	(803) 775-9336
Santee-Wateree Mental Health	Larry Blanding	(803) 775-9364
DHEC		(803) 773-5511
Disabilities & Special Needs	Shelia Bell	(803) 778-1669 ext 151
Adult & Protective Services	Maggie B. MacDonald	(803) 773-5531 ext 300

REGION:SANTEE-LYNCHES FY 2013-2014		**HOLIDAY OBSERVED BY**						
COMMON HOLIDAYS OBSERVED		AREA AGENCY ON AGING	CLARENDON COUNTY COA	KERSHAW COUNTY COA	LEE COUNTY COA	SUMTER SENIOR SERVICES	GREATER FAITH & JOY	CARE PRO
Independence Day		X	X	X	X	X	X	X
Labor Day		X	X	X	X	X	X	X
Veterans Day								
Thanksgiving		X	X	X	X	X	X	X
Day after Thanksgiving		X	X	X	X	X	X	
Christmas Eve		X						
Christmas Day		X	X	X	X	X	X	X
Day after Christmas		X	X	X	X	X	X	
New Year		X	X	X	X	X	X	X
Martin Luther King Day		X	X	X	X	X	X	
Presidents' Day		X	X	X	X	X	X	
Good Friday		X	X	X	X	X	X	
Easter Monday								
Memorial Day		X	X	X	X	X	X	X
General Elections					X			

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Administrative Goals and Objectives Appendix I	
Goal/Objectives	**The AAA/ADRC shall adhere to the South Carolina Aging Network's Policies and Procedures Manual by developing a fully operational AAA/ADRC Policies and Procedure Manual. The goal will be obtained in three (3) months.** 1. SLAAA/ADRC will establish work groups to discuss and assign task within two (2) weeks. Note: Work groups will consist of aging staff, COG staff and providers/contractors. 2. SLAAA/ADRC will review other AAA/ADRC Policies and Procedure Manuals to determine format, protocols and methods etc. within one (1) month. 3. SLAAA/ADRC work groups will reconvene to discuss assigned task within one (1) month. 4. SLAAA/ADRC will provide a draft copy of AAA/ADRC Policies and Procedure Manual for review, comments and revisions within two (2) months. 5. SLAAA/ADRC will present revised AAA/ADRC Policies and Procedure Manual to RAAC for approval within three (3) months. 6. SLAAA/ADRC will present revised AAA/ADRC Policies and Procedure Manual to COG Board of Directors for approval within three (3) months.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Emergency Preparedness Goals and Objectives Appendix I	
Goal/Objectives	**The AAA/ADRC shall adhere to the policies and procedures on emergency preparedness found in the South Carolina Aging Network's Policies and Procedures Manual by developing a fully operational emergency/disaster preparedness and response plan for their planning and service area. The goal will be obtained in six (6) months.** 1. SLAAA/ADRC will establish contact/meet with all county emergency management directors in the region within one (1) month to ensure that there is a working relationship between the counties and the AAA/ADRC. 2. SLAAA/ADRC will establish protocol within one (1) month on how often the AAA/ADRC Emergency Coordinator attends meetings and trainings with the local EMD. 3. SLAAA/ADRC will establish protocol within one (1) month to determine the resources the AAA/ADRC has in place to maintain and manage an emergency operations center with computers and phones during a declared emergency. 4. SLAAA/ADRC will establish protocols within two (2) months for collaboration with providers/contractors to develop an emergency service delivery plan for group dining and home-delivered meals, transportation, home care, and other critical services until the declared emergency has ended and normal operations are back up. 5. SLAAA/ADRC will develop an emergency service delivery plan and include in each contract signed between the AAA/ADRC and an aging service provider/contractor. The emergency plan shall also cover general agency operations during periods of crisis, hazardous weather, emergencies, and unscheduled closings. Note: This objective will be addressed during procurement. 6. SLAAA/ADRC will develop protocols within three (3) months to identify those seniors with the greatest need to be evacuated before other individuals in the community; and what determines that priority.

Goal/Objectives	7. SLAAA/ADRC will develop a process within one (1) month for AAA/ADRC computer records being regularly backed up so that the agency can resume services immediately after an emergency, and the protocols for storing computerized backed up records at a safe location. 8. SLAAA/ADRC will develop a relationship within two (2) months with contacts and partners in the community for emergency preparedness and disaster relief, and how the AAA/ADRC collaborates with these partners. This will include, but not be limited to, the Salvation Army, American Red Cross, food banks, and United Way. 9. SLAAA/ADRC will develop specific protocols within two (2) months with providers/contacts to ensure that seniors continue to receive food, transportation, and other critical services until the declared emergency has ended and normal delivery systems resume operation. 10. SLAAA/ADRC will attempt to establish a Memorandum of Agreement (MOA)/partnerships with other AAAs/ADRCs regarding mutual aid provisions of staff and/or equipment to maintain operation of an AAA/ADRC impacted by an emergency or disaster within two (2) months.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Nutrition/Provider Monitoring Goals and Objectives Appendix I	
Goal/Objectives	**To adhere to the following South Carolina Aging Network's Policies and Procedures Manual the following will be implemented either before or by July 1, 2013.** **To improve the functions of Nutrition Services:** 1. Develop a protocol to address receipt and review of monthly activity calendar will be developed no later than July 1, 2103 2. SLAAA/ADRC will ensure the nutrition service contractors are accurately inputting client service data into the AIM system for each individual they serve and not collectively as an entire organization within one (1) week of the meal being served. This procedure will be implemented after procurement and will be included in the new contracts. 3. Contractors will be required upon request to provide daily records of participant attendance to include copies of sign-in sheets (Report LG-94). Ongoing 4. SLAAA/ADRC will develop a protocol by July 1, 2013 for home delivered meal contractors to scan a copy of the home delivered meal route to ensure all meals have been delivered. This documentation will be provided to the LGOA when submitting monthly units of service reimbursed invoices. 5. Effective July 1, 2013 nutrition sites will be required to complete an activity report monthly documenting the number of individuals participating in each daily activity and the time spent in each activity, due to the SLAAA/ADRC by the 5th day of the following month. 6. Effective July 1, 2013 the SLAAA/ADRC Director, or a designee, will also visit at least three (3) group dining sites monthly allowing for additional monitoring. 7. Effective July 1, 2013 SLAAA/ADRC Director or designated appointee shall personally deliver a minimum of three (3) home delivered meals from three (3) different home delivered meal routes monthly. Reports will be provided to the LGOA in reference to these home visits.

SANTEE-LYNCHES AREA PLAN 2014 – 2017

Nutrition/Provider Monitoring Goals and Objectives
Appendix I

Goal/Objectives	8. Effective July 1, 2013 SLAAA/ADRC will complete an activity report monthly documenting the number of individuals participating in each daily activity and the time spent in each activity, due to the AAA/ADRC by the 5th day of the following month. **To adhere to the following South Carolina Aging Network's Policies and Procedures Manual the following will be implemented either before or by July 1, 2013.** **Improve Nutrition Services to achieve regional success.** 1. Create and implement a customer satisfaction survey for additional feedback from participants in regards to meals, contractor services, and overall performance within three (3) months. 2. Nutrition training will continue to take place for all contractors and kitchen volunteers annually.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Care Coordination Goals and Objectives Appendix I	
Goal/Objectives	**The AAA/ADRC will establish policies and procedures within one (1) month to ensure only those consumers having the greatest need will receive aging services in a timely manner.** 1. Present draft copy of policies and procedures protocol on client selection to providers/contractors for review and comments. (Completed) 2. Schedule a meeting with providers/contractors to discuss draft copy of selection policies and procedures on client selection protocol within two (2) weeks. 3. Within two (2) weeks of the Area Plan's approval, finalize the draft instructions for establishing a Priority Selection System which designates three separate entities to assess, select, and serve consumers. These instructions will help ensure those having the most critical needs are provided aging services in priority order based on the requirements set forth in the Older Americans Act. 4. Within two (2) weeks of the Area Plan's approval ensure the established procedures for selection of consumers, having the highest needs, is accomplished in a timely manner by continuing to review and when necessary, streamline the process so there are no delays in services to our residents.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 VDHCBS Goals and Objectives Appendix I	
Goal/Objectives	**The goal of the VDHCBS program is to enroll and sustain twenty-five (25) veterans. This goal is ongoing.** 1. Assist in establishing a work group to include (VA staff, LGOA staff, AAA/ADRC staff, PPL staff) that meets at least quarterly to ensure communication and establish a partnership between agencies to benefit program. 2. Establish protocol based on business rules within first year of Area Plan. 3. Establish ongoing partnerships with other agencies and groups whom assist veterans to provide information about program. 4. Conduct presentations to inform targeted population to ensure success with SL region. (Ongoing)

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Assisted Rides Program Goals and Objectives Appendix I	
Goal/Objectives	**Improve Assisted Rides Program to achieve regional success.** 1. All events/presentations will continue to include ARP volunteer recruitment and program information each month. 2. Monthly ARP and transportation articles will continue to be advertised in the SLAAA/ADRC monthly newsletter and distributed to 900 plus individuals throughout the SLAAA/ADRC region. 3. The SLAAA/ADRC ARP events/presentations will be updated and displayed on the SC ACCESS webpage on a monthly basis. 4. Continue to provide ARP information to all Council on Aging facilities within the SLAAA/ADRC region. 5. Utilize newspapers to advertise ARP when costs are free and/or reasonable.

SANTEE-LYNCHES AREA PLAN 2014 – 2017

Information and Referral Program Goals and Objectives
Appendix I

Goal/Objectives	**Improve functions of the I&R/A Specialist** 1. Promote the local and toll free number to SLAAA/ADRC to provide accessibility to any client that seeks I&R/A services. 2. I&R/A Specialist will make follow up contacts monthly with a random selection on ten out of every 300 inquirers to determine if the referrals provided adequately met their needs. 3. I&R/A Specialist will make follow up contacts with those services providers/contractor to determine if the needed and requested services were offered. 4. I&R/A Specialist shall provide the inquirer with at least three (3) appropriate referral choices (per contact) when possible. 5. I&R/A Specialist shall encourage inquirers to notify I&R/A Specialist if the information provided proves incorrect, inappropriate, or insufficient to link client with needed services. 6. I&R/A Specialists shall participate in community health fairs, seminars, webinars, etc. that promote and identify appropriate providers/contractors, services, and service delivery system improvements. 7. I&R/A Specialists shall work closely with others in the aging network (SC Access staff, Family Caregiver Advocates, SHIP Counselors, Ombudsmen, etc.) to ensure that service and resource information is shared within the SLAAA/ADRC and appropriate LGOA staff. This will provide the best possible resources for community service information. 8. I&R/A Specialists shall provide information that has been requested by inquirers within a planning and service area to their appropriate community and funding organizations, in order to help identify any gaps in the services they currently provide.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Information and Referral Program Goals and Objectives Appendix I	
Goal/Objectives	**Improve the I&R/A program to achieve regional success.** 1. A comprehensive action plan detailing the accommodations to be made for non-English speaking constituents as required will be developed in three (3) months. 2. All SLAAA/ADRC staff will obtain AIRS certification within one (1) year. 3. Explore the possibility of implementing an automated phone system to track the volume and topics of calls within one year. 4. Establish individual staff member I&R/A contact goals within six (6) months. 5. A detailed policies and procedures manual will be developed in three (3) months. **Outreach and advertising efforts.** 1. Outreach events will continue to take place throughout the region on a monthly basis. 2. All events/presentations will continue to be documented on an outreach calendar each month. 3. The outreach calendar will continue to be attached to the SLAAA/ADRC monthly newsletter and distributed to 900 plus individuals throughout the SLAAA/ADRC region. 4. The SLAAA/ADRC events/presentations will be updated and displayed on the SC ACCESS webpage on a monthly basis. 5. Continue to provide the SLAAA/ADRC outreach calendar to all of the Council on Aging facilities within the SLAAA/ADRC region. 6. Implement a SLAAA/ADRC Facebook page within thirty (30) days. 7. Utilize newspaper local events column to advertise SLAAA/ADRC events/presentations within six (6) months. 8. Update SLAAA/ADRC webpage within one (1) year.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 SHIP/SMP Goals and Objectives Appendix I	
Goal/Objectives	**Improve functions of the SHIP/SMP program.** 1. Promote the local and toll free number to SLAAA/ADRC to provide accessibility to any client that seeks SMP/SHIP services. 2. SMP/SHIP Coordinator shall participate in community health fairs, seminars, webinars, etc. that promote and identify appropriate providers/contractors, services, and service delivery system improvements. 3. The SMP/SHIP Coordinator will continue to monitor each staff members SHIP contacts on a monthly basis to ensure individuals and interagency goals are met. 4. The SMP/SHIP Coordinator will obtain SHIP related webinars, conferences, etc to ensure that training is provide to all volunteers and staff. 5. All SLAAA/ADRC staff plans to obtain twelve (12) hours of SHIP update training to retain certification annually. 6. The SMP/SHIP Coordinator will continue to schedule monthly SMP/SHIP meetings for all staff. 7. The SMP/SHIP Coordinator shall work closely with others in the aging network (SC Access staff, Family Caregiver Advocates, I&R/A Specialist, Ombudsmen, etc.) to ensure that service and resource information is shared within the SLAAA/ADRC and appropriate LGOA staff. This will provide the best possible resources for community service information. 8. The SMP/SHIP Coordinator will continue to utilize the SHIP Talk system to monitor monthly SHIP contacts and for reporting purposes.

SANTEE-LYNCHES AREA PLAN 2014 – 2017

SHIP/SMP Goals and Objectives
Appendix I

Goal/Objectives	**Improve the SMP/SHIP program to achieve regional success.** 1. A comprehensive action plan detailing the accommodations to be made for non-English speaking constituents as required will be developed in three (3) months. 2. Explore the possibility of implementing an automated phone system to track the volume and topics of calls within one year. 3. The SMP/SHIP Coordinator will gain two (2) SHIP certified counselors within a year to meet the requirement set by the LGOA of ten (10) SHIP certified counselors for the region. 4. Recruitment and training of additional SHIP volunteers will take place to assist staff with open enrollment within (6) months. 5. All SLAAA/ADRC staff members will participate in assisting clients during open enrollment. 6. The SMP/SHIP Coordinator will attempt to coordinate SHIP training at the SLAAA/ADRC next year. 7. All SLAAA/ADRC staff will utilize the SMP form when discussing SMP information with all clients to ensure date is inputted into SMART FACTS accurately and in a timely manner. 8. Eight (8) retired SMP volunteers will be obtained within six (6) months. 9. SMP volunteer recruitment will take place with our Regional Aging advisory Committee (RAAC) members, Council on Aging (COA) sites, senior centers, and faith based organization over the next (6) months. 10. A detailed policies and procedures manual will be developed in three (3) months.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 SHIP/SMP Goals and Objectives Appendix I	
Goal/Objectives	**Outreach and advertising efforts.** 1. Outreach events will continue to take place throughout the region on a monthly basis. 2. All events/presentations will continue to be documented on an outreach calendar each month. 3. The outreach calendar will continue to be attached to the SLAAA/ADRC monthly newsletter and distributed to 900 plus individuals throughout the SLAAA/ADRC region. 4. The SLAAA/ADRC events/presentations will be updated and displayed on the SC ACCESS webpage on a monthly basis. 5. Continue to provide the SLAAA/ADRC outreach calendar to all of the Council on Aging facilities within the SLAAA/ADRC region. 6. Obtain partnership with the Department of Mental Health (DME). 7. Implement a SLAAA/ADRC Facebook page within thirty (30) days. 8. Utilize newspaper local events column to advertise SLAAA/ADRC events/presentations within six (6) months. 9. Update SLAAA/ADRC webpage within one (1) year.

SANTEE-LYNCHES AREA PLAN 2014 – 2017

Family Caregiver Support Program Goals and Objectives
Appendix I

Goal/Objectives	**Improve Family Caregiver Support Program.** 1. To develop a caregiver support group within six (6) months in all counties in the region. 2. To design a protocol to conduct visits to the home within six (6) months. 3. Update and review all caregiver protocols and policies within four (4) months. 4. To improve the quality and availability of information and services to caregivers. Note: The SLAAA/ADRC FCSP Advocate will be working on this daily. The FCSP Advocate will help caregivers become more pro-active in helping themselves. This objective will be met during daily telephone conversations, support groups and trainings, provided by the FCSP Advocate. 5. To ensure that all caregivers have evacuative plans in the home. Note: The SLAAA/ADRC FCSP will provide caregivers with information on the importance of making evacuation plans in case of an emergency or other disasters. The object will be completed during the assessment, support groups, and trainings.

SANTEE-LYNCHES AREA PLAN 2014 – 2017

LTC Ombudsman Goals and Objectives
Appendix I

Goal/Objectives	**Improve the quality and services within the SLAAA/ADRC Ombudsman Program.** 1. Maintain credentials necessary to effectively serve nursing home and community residential care residents. 2. Remain current and perform duties in accordance with State Ombudsman requirements. 3. Promote health, safety, and welfare of LTC Residents. 4. Protect health information of LTC residents. 5. Ensure data entered in Ombudsman reporting system timely and accurately. 6. Maintain and protect hard copy of case files. 7. Coordinate and collaborate with relevant LTC facility stakeholders. 8. Promote public understanding of resident's rights. 9. Evaluate case evidence thoroughly. 10. Respond quickly and consistently to Program requirements. 11. Ensure adequate/proper documentation of complaints. 12. Maintain relationship with residents and their families. 13. Keep facility staff abreast of abuse, neglect, and exploitation information. 14. Provide socialization aspect to residents' lives. 15. Keep community abreast of LTC facility issues. 16. Promote community/volunteer support of the LTC Friendly Visitor's Program.

SANTEE-LYNCHES AREA PLAN 2014 – 2017 Other AAA/ADRC Goals and Objectives Appendix I	
Goal/Objectives	**Maintain AAA/ADRC** 1. Look at options in one (1) by combining as it relates to streamlining ADRC and RACC committees.

SANTEE-LYNCHES
REGIONAL COUNCIL OF GOVERNMENTS

REGIONAL AGING ADVISORY COMMITTEE

Santee-Lynches Region: Clarendon, Kershaw, Lee, and Sumter Counties

BY-LAWS

P·R·E·A·M·B·L·E

The Regional Aging Advisory Committee of the Santee-Lynches Regional Council of Governments does hereby set forth the following BY-LAWS to govern its operation.

The term "Council" is used to designate the Santee-Lynches Regional Council of Governments. The term "Committee" is used to designate the Regional Aging Advisory Committee (RAAC). The Committee shall function in an advisory capacity and not in a policy-making or decision-making capacity.

ARTICLE I

OFFICIAL NAME

1.1.1 The official name shall be the Regional Aging Advisory Committee (RAAC).

ARTICLE II

PURPOSE AND RESPONSIBILITIES

2.1 The Purpose and Responsibilities of the Regional Aging Advisory Committee shall be to:

2.1.1 Promote and encourage local communities to recognize the needs and promote the establishment of programs for older persons.

2.1.2 Review and comment on all local community policies, programs, and actions which affect older persons.

2.1.3 Establish service and program priorities based upon the needs of the local communities and the region.

2.1.4 Review, on an annual basis, regional comprehensive Aging Program plans based upon the needs and established priorities.

2.1.5 Recommend to the Council, for approval or disapproval, applications for funding from local units of government, the Council, and/or local service provider agencies.

2.1.6 Conduct Public Hearings to solicit local community input regarding needs of older persons.

ARTICLE III

MEMBERSHIP

3.1.1 The membership shall consist of at least four (4) individuals from each county or persons knowledgeable about services provided in the Santee- Lynches region. Members are appointed by the Council,

3.1.2 At least fifty percent (50%) of the membership from each county shall be eligible for Program services. Other members should include health care provider organizations, supportive services providers' organizations, persons with leadership experience in private and voluntary sectors, local elected officials, and the general public.

3.1.3 Vacancies on the Committee shall be filled by the Council upon recommendations by the Membership Committee (see Section 6.1.4).

3.1.4 Terms of the Committee members shall be for two (years), established by the Council and on a staggered basis to ensure continuity. The Committee will determine the term of the member.

3.1.5 A member in good standing shall be eligible for re-appointment for one (1) consecutive term of two (2) years, for a total of four (4) years before rotating off.

3.1.6 A member is eligible for re-appointment in 6 months after rotating off.

3.1.7 Current sub-contractor and members of the Santee-Lynches Staff may not serve on the Committee.

ARTICLE IV

MEETINGS

4.1.1 The Committee shall meet as often as necessary in order to carry out its responsibilities. Regular meetings shall be held at least four (4) times during each fiscal year (July 1–June 30).

4.1.2 The Committee shall be notified by the Coordinator (see Officers and Their Duties 5.1.4) of the time and place of meetings at least seven (7) days in advance of such meetings.

4.1.3 One-third (33 1/3%) of the Committee shall constitute a quorum. A quorum shall be present before any business requiring final action is conducted. All meetings in which final actions are taken shall be open to the public.

4.1.4 Only duly-appointed members of the Advisory Committee may vote on any matter before the Committee.

4.1.5 Members missing three (3) consecutive meetings without a legitimate reason may be terminated from the Committee.

ARTICLE V

OFFICERS AND THEIR DUTIES

5.1.1 The Officers of the Committee shall consist of a Chairperson and a Vice-Chairperson. The Chairperson shall be elected by the Committee; the Vice-Chairperson shall be elected by the Committee.

5.1.2 The Chairperson shall preside at all meetings of the Committee and shall have the duties normally conferred upon such officers, including the appointment of Sub-Committees and project groups.

5.1.3 The Vice-Chairperson shall assume the duties of the Chairperson in the absence of the Chairperson.

5.1.4 The Aging Unit Director shall serve as the Coordinator. He/She shall keep the records and Minutes of the Committee; prepare, with the Chairperson, the Agenda of regular and special meetings; provide notice of such meetings; and other such duties normally conferred/associated with the position. The Director will be responsible for scheduling the meetings to meet this requirement of four (4) meetings per year.

5.1.5 The Chairperson will be responsible for submitting all the Committee recommendations to the Santee-Lynches Regional Council of Governments.

ARTICLE VI

ELECTION OF OFFICERS

6.1.1 The Chairperson shall be elected by the Committee as provided in Section 5.1.1. The Chairperson shall serve for a term of one (1) fiscal year (July 1 – June 30). The

Chairperson shall be eligible to succeed him/herself providing, however, that he/she shall serve no more than two (2) consecutive terms.

6.1.2 The Vice-Chairperson shall be elected at the last meeting of each fiscal year to serve the following fiscal year. The nominee receiving a majority vote of the members present shall be declared elected.

6.1.3 The Vice-Chairperson shall be elected for a term of one (1) fiscal year (July 1 – June 30). The Vice-Chairperson shall be eligible to succeed him/herself providing, however, that he/she shall serve no more than two (2) consecutive terms.

ARTICLE VII

COMMITTEES

7.1.1 Sub-Committees shall be formed to serve the full Committee. Each Sub-Committee shall research one particular phase of services for the elderly and report on that phase and/or make Program recommendations to the full Committee. Members of such Sub-Committees shall be appointed by the Coordinator.

7.1.2 Standing Sub-Committees shall be established for the areas of:

- Program Planning
- Resource Development
- Nutrition
- Advocacy
- Membership
- Family Caregiver Support Program

7.1.3 The basic responsibilities of the Sub-Committees shall be to assist in:

A. identifying the needs and problems faced by seniors;

B. recognizing and identifying gaps in the service systems;

C. analyzing needs in relation to available resources, programs, and services; and

D. implementing priorities, goals, and objectives established by the AAA.

7.1.4 A specific Sub-Committee to address Program Planning shall be formed to:

A. assist in initiating, expanding, improving and coordinating services for older persons;

B. identify and analyze barriers that prevent access to services; and

C. analyze feedback provided by older adults who participate in any aging program in the area-wide planning process.

7.1.5 A specific Sub-Committee to address Resource Development shall be formed to:

A. assist in finding resources available:

B. maintain or enhance existing programs using available resources; and

C. also develop new programs using available resources.

7.1.6 A specific Sub-Committee to address Nutrition shall be formed to:

A. assist in the procurement process of selecting a regional caterer;

B. review new and improved methods of service delivery attributed to nutrition;

C. review and make recommendations in establishing priorities and methods for serving older persons in the targeted populations; and

D. review socialization activities as needed in congregate meal sites.

7.1.7 A specific Sub-Committee to address Advocacy shall be formed to:

A. assist older persons to access service and benefits; and

B. keep informed about legislation which affects Aging services.

7.1.8 A specific Sub-Committee to address Membership shall be formed to:

A. assist in ensuring that the membership of the RAAC committee is maintained;

B. assist in recruiting new RAAC members; and

C. assist in all function identified in Article III. (Note: The Membership Committee shall be made up of one (1) member from each county.)

7.1.9 A specific Sub-Committee to address the needs of the Family Caregiver Support Program shall be formed to.

A. identify the needs and problems faced by Caregivers of the aging and disabled population and Grandparents or relatives raising children;

B. implement priorities, goals, and objectives as established by the Title III-E Program;

C. act as an advocate to Caregivers of older or disabled persons and Grandparents or relatives raising children 18 or younger in the Santee-Lynches Region;

D. keep informed about legislation which affects Aging services, as well as Caregivers of the elderly or disabled, and Grandparents or relatives raising children;

E. review Family Caregiver Advocate reports and recommendations; and

F. prepare to discuss, formulate, and forward well-developed thoughtful recommendations to the Family Caregiver Advocate.

7.1.10 Ad Hoc Sub-Committees and/or project groups shall be established as needed by the Committee. Members of these Sub-Committees/groups shall be appointed by the Chairperson. These Sub-Committees/groups shall disband upon fulfilling their mission.

ARTICLE VIII

RECORDS

8.1.1 The Coordinator will make and keep a record of all Committee recommendations, transactions, findings, and determinations. Such records shall be maintained in the Aging Department.

ARTICLE IX

BY-LAWS CONFLICT

9.1.1 In the event of conflict between the provisions of these By-Laws and the By-Laws or other policies of the Council, the By-Laws or other policies of the Council shall prevail.

ARTICLE X

ADOPTION AND AMENDMENT

10.1.1 These By-Laws shall be adopted by a majority vote of the membership present at a regular meeting of the Regional Aging Advisory Committee.

10.1.2 These By-Laws may be amended by a majority vote of the membership present at a regular meeting, provided the proposed Amendment has been submitted in writing to the membership at least seven (7) days before the meeting.

10.1.3 The original adoption/amendment of these By-Laws shall be effective February 9, 1990. An amendment to these By-Laws shall be effective June 24, 2010.

ARTICLE XI

RULES OF ORDER

11.1.1 Robert's Rules of Order shall be observed in the conducting of the meetings.

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Aging & Disability Resource Center
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Sumter, SC 29151
****
(803) 775-7381
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THE ADRC CONNECTION

Issue 45, May 2013

The purpose of this newsletter is to keep you updated on current issues concerning aging and adult disabilities. The newsletter is published several times a year by the Santee-Lynches Aging & Disability Resource Center. If you would like to submit an article for our newsletter, please contact the ADRC Center at (803) 775-7381 or 1-800-948-1042, Extension 118.

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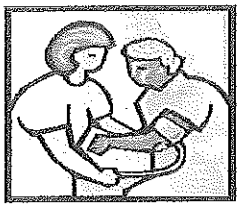
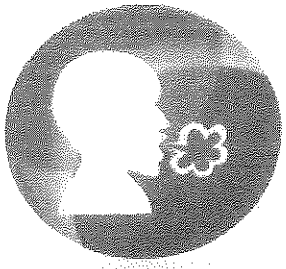
STUDIES INDICATE SOME TO PAY THE PENALTY INSTEAD OF GETTING INSURANCE--AT LEAST FOR THE 1st YEAR: According to Kiplinger studies, many young people, who are required to buy their own health insurance in 2014, may opt out for the first year and pay the federal penalty that will kick in for those who aren't insured under the new health care act. Why? The penalty is just $95 for 2014, rising to $695 in 2016 – far less than the hundreds of dollars the health insurance is expected to cost per year. Hopefully this risk is not too costly should they become ill.

CULTURE CHANGE IN NURSING HOMES

One of the roles of the Long Term Care Ombudsman is to advocate for residents and their right to make choices regarding care and life in long-term care facilities. Culture change is a movement that seeks to create an environment for nursing home residents that follows the residents' routines rather than those of the facility. It also encourages appropriate assignments of staff with a team focus; allows residents to make their own decisions; allows spontaneous activity opportunities; and encourages and allows residents to be treated as individuals. Deep culture change is an important component of residents' right to "care and services to attain or maintain the highest practicable physical, mental and psychosocial well being;" as promised in the 1987 Nursing Home Reform Law. ***(Article Source: The National Ombudsman Resource Center website)***



COULD A BREATH TEST IDENTIFY A HEART CONDITION? According to a recent Cleveland OH study -- It looks very promising. An experimental breath test, designed to quickly identify patients suffering from heart failure was tested by simply analyzing the contents of a single exhaled breath. The study demonstrated promise in early trials, according to the team of researchers. The Cleveland Clinic investigators stressed that their evaluation is based on a small group of patients, however, the test correctly diagnosed the problem with 100% accuracy. The study indicates that every individual has a breath print that differentiates them from other people, depending on what's going on in their body. That "print" indicates exactly what a person has been exposed to and what disease they have -- which makes the new field of breath testing so promising. The test is inexpensive, and non-intrusive, so there is no risk involved. It can be done quickly, and at any location, in a clinic, a hospital, or in an ambulance. Currently a blood test is done, which often delays the diagnosis while waiting for the analysis of the blood sample to be accomplished. There is no identification delay with the breath test so treatment can begin immediately. There is more work to be done to get the breath test to the point where it would become widely available, but because of its fast and accurate results, approval of the procedure should come quickly. (Source: March 2013 edition of the *Journal of the American College of Cardiology)*



THE SC SILVER HAIRED LEGISLATURE – Another part of the Lt. Governor's Office on Aging: The Santee-Lynches Silver Haired Legislature (SLSHL) Caucus is one of ten regions that make up the South Carolina Silver Haired Legislature (SCSHL). The four counties that make up our region are Clarendon, Lee, Kershaw and Sumter. The ten caucuses work directly with the South Carolina Area Agencies on Aging/ADRCs.

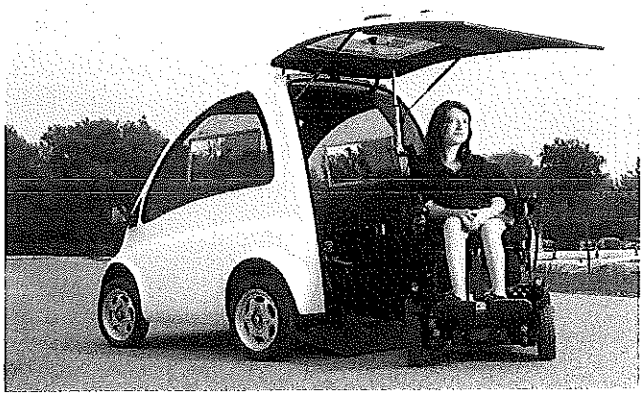
The SCSHL was created for the following seven purposes: (1) to identify issues, concerns, and possible solutions for problems facing the aging population in SC; (2) to make recommendations to the Governor and to members of the SC General Assembly; (3) to educate the public on senior issues; (4) to encourage seniors to participate actively in public affairs; (5) to function on a nonpartisan basis; (6) to promote good government for all South Carolinians; (7) and to conduct assembly sessions annually in the State Capitol.

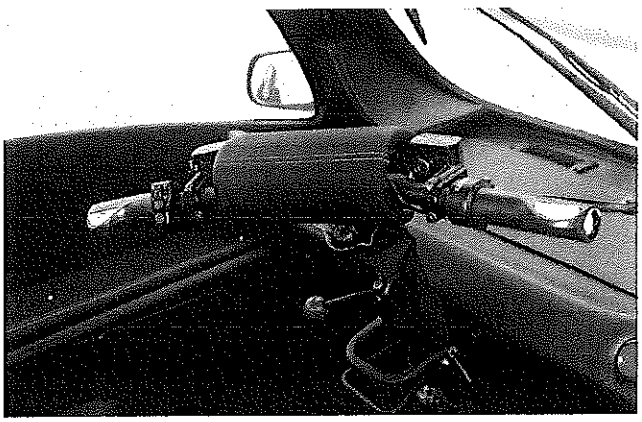
Our SLSHL Caucus is Area #6 and was reactivated in the summer of 2011. We currently have 11 representatives and members, including our officers: Caucus Chair, Loretta Pollard from Clarendon County; Vice Chair, Rev. Ed Stokes from Kershaw County; and Board Member, James Felix from Lee County. Other members include Phyllis Way, Bernard MacDonald and Mary Wilson from Clarendon County; Remond E. Cooper from Kershaw County; Elvertta Coker from Lee County; and David O'Brien, Frances Hill and Nancy Stark from Sumter County. We have two vacancies that need to be filled – one for Sumter County and one for Kershaw County. Our members must be at least 60 years of age and a registered voter. If interested, please contact our Caucus Chair, Loretta Pollard, at 803-485-2071 for further details.

Our next Santee-Lynches Silver Haired Legislature meeting is scheduled for Thursday, May 16, 2013 at 2:00 p.m. at Santee-Lynches Regional Council of Governments located at 36 West Liberty Street, Sumter, SC.

You can find more information about the SC SHL at http://www.scsilverhairedleg.org.

MORE FREEDOM FOR WHEELCHAIR USERS: Beginning this fall you may begin seeing the "Kenguru" – a small, single-user electric car. A new Texan company named Community Cars is manufacturing a vehicle that may very well change the lives of those who use wheelchairs. Currently many wheelchair users are frustrated because they would like to visit friends on the spur of the moment, make a fast trip to the grocery store, or go to an appointment, but they must ask friends, family, or transportation services for help getting themselves there. However, with a "Kenguru" they have the freedom to go when and wherever they want, and by themselves. The Kenguru is fairly lightweight (900 pounds to include the battery) and is 7 feet long and 5 feet tall. It has a steel frame with an outer body made of laminated fiberglass. The interior is vinyl and molded plastic. The driver enters through a remote-controlled back hatch. A ramp lowers as the hatch swings up. The driver remains in his/her wheelchair and then controls the electric vehicle with handlebars. The Austin-based company plans to sell the vehicle for $25,000. Buyers should also expect to qualify for zero-emission and/or vocational rehabilitation tax incentives. This vehicle is efficient, convenient, and makes you truly mobile on your own! Visit www.Kenguru.com for more information.





Q & A – ADVANCE CARE PLANNING:

Q: What is advance care planning?
A: Advance care planning is a process in which you explore your values and wishes about your health care, learn about treatment options and decisions you may face, talk with your loved ones and health care providers about your wishes and record your wishes. It is done before a health care crisis takes place.

Q: What are advance directives?
A: An advance directive is a written record of your wishes regarding your health care that you make while you are able to do so and long before there is a medical crisis. Advance directives help your loved ones and health care providers know what kind of health care you want. Advance directives go into effect ONLY when you are not capable of making decisions for yourself.

Q: When should I complete my advance directives?
A: Advance directives should be completed by competent adults 18 years of age or older while they are still capable of making decisions for themselves. Many people choose to complete their advance directives at an important life event such as a marriage or birth of a child and often as they are completing other legal documents such as a will.

Q: Where can I get copies of the SC statutory advance directives forms?
A: SC law provides for several "statutory" forms: **Health Care Power of Attorney** (SC Code of Laws Title 62 Chapter 5)--allows you to designate someone to make all health care decisions for you when you temporarily or permanently cannot make them for yourself.

Living Will (SC Code of Laws Title 44 Chapter 77)--also known as the Declaration of Desire for a Natural Death, this form allows you to express your choices about your care ONLY if you are terminally ill or permanently unconscious.

Other documents that meet state standards including the **Five Wishes document** are accepted as advance directives in SC. The Five Wishes document allows you to communicate your wishes to your family, friends and health care providers including decisions about medical treatments you may elect to receive or decline, what you want your loved ones to know about your health and who you would want to make sure your wishes are followed.

(continued next column)

Contact Santee-Lynches Aging and Disability Resource Center/AAA at its toll free number (800-948-1042) to obtain more information on these directives and copies of the forms.

MEDICARE AND YOUR EYE CARE: Medicare generally does not cover routine eye care. However, It will pay for some eye care services if you have a chronic eye condition, such as cataracts or glaucoma. In these cases, Medicare will cover:

- Surgical procedures to help repair the function of the eye.

- Eyeglasses or contacts only if you have had cataract surgery during which an intraocular lens was placed into your eye.

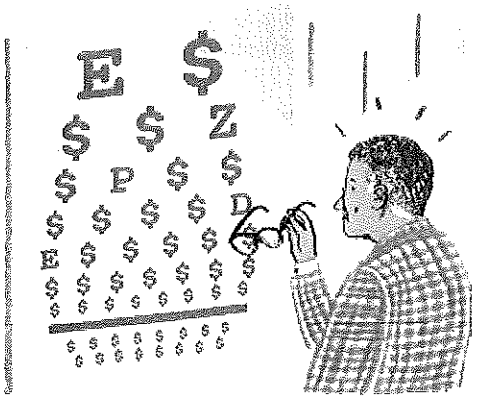
- An eye exam to diagnose potential vision problems.

- If you have diabetes or you are at high risk for glaucoma, Medicare will pay for an eye exam once every 12 months to check for eye disease due to either condition.

Keep in mind that while Medigap policies cover the 20% copayments for "approved services," they generally don't cover eyeglasses and exams.

Also remember that certain Medicare Advantage plans may offer limited vision coverage. We recommend you call your Medicare Advantage Plan directly or check your policy booklet before making your eye care appointment.

You may also get coverage for vision care by going to reduced-cost clinics or by purchasing separate vision insurance.



THE GRAY-JOB MARKET FOR ALL AGES: By 2050, according to Pew Research projections, about 1 in 5 Americans will be over age 65, up from 1 in 8 now in the U.S. This demographic shift is already creating new fields and opportunities for workers of all ages. As the population ages, more "gray-jobs" such as nurses, home health aides, and health navigators, etc., will need to be filled.

To obtain one of these jobs, resumes must be adjusted to include these skills. If you need to head back to school, remember that many of gray-jobs only need a professional certification to fit the bill, not completion of a full degree program. This could help save you time and money picking up these new skills. Here are 4 gray-jobs to consider that will be needed to serve an aging population:

Home Modification Pro: Remodeling designer and interior decorators to make homes easier and safer for older adults to live in after retirement.

Move Manager: For those downsizing to smaller quarters later in life — usually an apartment or retirement community — a move manager can coordinate a move. Clients need advice on choosing which furniture, collectibles and household goods make the cut to head over to the new residence. A move manager can assess what can be sold, donated or given to friends/family, and they might even be in charge of shopping for new furniture that suits the new home, or organizing and running an estate or yard sale.

Patient Advocate: The role of patient advocate varies. Some advocates tackle billing mistakes and insurance coverage rejections. Others might help in choosing doctors, offer guidance in treatment choices, assist in locating a specialist or hospital, go with patients to doctor appointments and keep track of prescriptions.

Fitness Trainer: Aqua aerobics is a growing specialty, as is "accessible" yoga, which adapts techniques for people with chronic illness and disabilities. Instructors tweak traditional yoga positions for people who are in a chair or wheelchair or have other physical issues.

Financial Planners/Manager: Certified financial planners and managers who help manage assets, and/or people who can offer monthly help with finances and bill-paying.

THE DIRECTOR'S CORNER

Shawn Keith
Director, Santee-Lynches AAA/ADRC
(803) 775-7381/1-800-948-1042

OLDER AMERICANS MONTH: For 50 years, May has been a month to appreciate the vitality and aspirations of older adults and their many contributions to our communities. Older people across our region, state, and nation are achieving remarkable things in later life. They are experts in their fields, have years of valuable experience, and we thank them for using that knowledge to improve the lives of others.

This year's Older Americans Month theme -- "Unleash the Power of Age" – emphasizes the important role of older adults. The 2013 theme has never been more fitting either. Older adults are productive, active, and influential members of our society.

While Santee-Lynches AAA/ADRC and our contractors provide services, support, and resources to older adults year-round, Older Americans Month is a great opportunity to show special appreciation. We will continue to provide opportunities for seniors to come together and share their experiences with one another, as well as with individuals of other generations.

We urge you to join us in honoring our region's older residents. The "Unleash the Power of Age is an opportunity to recognize these individuals. who are using their talents and expertise to make a positive impact in our region and beyond.

I leave you with the following question…

PRE-SEASON CHECKUP FOR WET-WEATHER DRIVING FROM THE AMERICAN AUTOMOBILE ASSOCIATION: Rain, slush and mud are hard on your vehicle. Be prepared for the rainy season by conducting a thorough checkup. Use the following checklist as a reference:

☐ **Battery**

Wet weather places heavy demands on the battery and charging system. Recharge or replace weak batteries. Check fluid levels, battery posts, and charging system.

☐ **Lights**

Check the headlights, side-marker lights, emergency flashers, parking lights, front and rear directional signals, taillights and brake lights. Make sure they work and are clean -- a quick wipe can make a big difference.

☐ **Brake System**

Check brakes for proper operation. Pulling to one side, a taut pedal or an unusual squealing or grinding could indicate the need for brake repair. Don't delay!

☐ **Tires**

Traction is the key to good movement, turning and stopping on wet surfaces. Good tire tread allows water to escape from under the tires, preventing loss of traction. Consider changing to tires designed for increased traction on wet surfaces. Make sure tires are properly inflated to the pressure shown in the owner's manual or on the door frame.

☐ **Windshield Wipers and Washer Fluid**

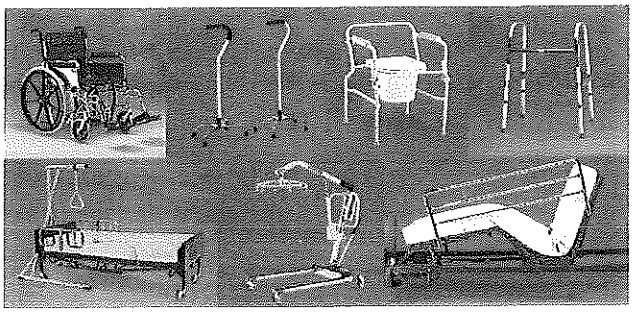
Are wipers functioning properly? Blades that streak should be replaced. Fill the washer reservoir bottle with a washer solvent.

☐ **Emergency Kit**

Keep these items in your vehicle in case of an emergency:

- Flashlight
- Mats that can be placed under tires to increase traction
- Small bag of sand, salt, or kitty litter to spread around tires to increase traction
- Shovel
- Cloth or roll of paper towels
- Blanket
- Booster cables
- Window-washing solvent to keep the reservoir filled and windshields clean
- Warning devices – flares or triangles
- Cellular phone

MEDICAL EQUIPMENT FRAUD SCAM: Senior citizens are frequent targets of Medicare schemes, especially by medical equipment manufacturers who offer seniors **free** medical products in exchange for their Medicare numbers. Because a physician has to sign a form certifying that equipment or testing is needed before Medicare pays for it, con artists fake signatures or bribe corrupt doctors to sign the forms. Once a signature is in place, the manufacturers, who want to commit fraud, bill Medicare for merchandise or services that were not needed or were not ordered.



Tips for Avoiding Health Care Fraud or Health Insurance Fraud, as listed at www.fbi.gov/scams-safety/fraud/senior:

- Never sign blank insurance claim forms.
- Never give blanket authorization to a medical provider to bill for services rendered.
- Ask your medical providers what they will charge and what you will be expected to pay out-of-pocket.
- Carefully review your insurer's explanation of the benefits statement. Call your insurer and provider if you have questions.
- Do not do business with door-to-door or telephone salespeople who tell you that services of medical equipment are free.
- Give your insurance/Medicare identification only to those who have provided you with medical services.
- Keep accurate records of all health care appointments.
- Know if your physician ordered equipment for you.

Report Suspected Fraud: Help stop Medicare Fraud and Abuse by calling Santee-Lynches Aging and Disability Resource Center at our toll free number (800-948-1042).

ARE ENERGY DRINKS SAFE OR HARMFUL?

Since 1997, energy drinks have seen a major growth, outpacing nearly every other offering in the beverage market. From supermarkets to gas stations to drug stores, energy drinks have dominated prime display space on shelves and in coolers. Responding to extensive advertising, consumers now spend more than $12.5 billion a year on these drinks.

But do we really know what we're buying? Are these drinks safe? Do they carry health risks? Before you reach for that magic can that promises enhanced alertness, concentration, and physical performance, you need the facts.

Even though the recipes vary from drink to drink, they all have a common element – caffeine (and a lot of it). A comparison follows:

Beverage	***Amount of Caffeine***
1 cup of coffee	100 milligrams
1 cup of tea	50 milligrams
1 can of cola	35-55 milligrams
1 can of energy drink	100-500 milligrams – also most energy drinks have guarana (a South American plant extract) which contains additional caffeine and sugar which provides natural energy

The Food and Drug Administration regulates the amount of caffeine in soft drinks to a maximum of 71 milligrams per 12-ounce serving; however, there is no such limit for energy drinks.

Caffeine is a stimulant which usually increases alertness, improves concentration and enhances mood. Modest caffeine intake (less than 400 milligrams per day) is usually safe for most adults. But too much caffeine can cause problems, including restlessness, irritability and difficulty sleeping. Massive caffeine overdoses can also cause reduced blood flow to the heart and abnormal and serious heart rhythms.

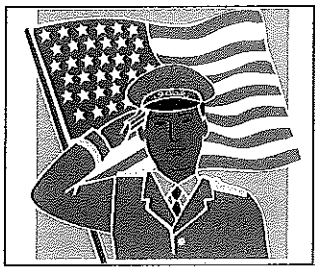
Energy drinks have not yet been proven safe. They are classified as supplements so they are not regulated by the FDA. We do think that an adult who consumes an occasional energy drink is unlikely to suffer harm, but too much can lead to caffeine overdose and health problems.

Further mixing energy drinks and alcohol is an unsafe practice. On Nov. 17, 2010, the FDA ruled that premixed drinks that include both alcohol and caffeine cannot be sold. Although this stopped sales of such beverages, the ruling did not curtail the practice. Recent surveys indicate that some people (especially college students) just mix the drinks themselves.

Energy drinks vs. sports drinks: Although often displayed in the same section of the store or even right next to each other, energy drinks (e.g. Monster, Five Hour Energy) and sports drinks (e.g. Gatorade, Powerade) are not interchangeable. Sports drinks help athletes to rehydrate and replenish electrolytes and carbohydrates lost during strenuous athletic activity. Energy drinks are different. They do not replenish electrolytes. Furthermore, caffeine can be dangerous for the dehydrated athlete who already has an elevated heart rate and blood pressure from physical exertion. Please do not use energy drinks during sports; they do not provide the right type of energy you need.

Dangerous for children and teens! Because energy drinks boost blood pressure by an average of 3.5 systolic points (top reading) and make the heart more susceptible to electrical short circuit, these drinks should not be given to children and teens. There is enough research information that indicates that it takes longer for the heart to reset itself electronically while it beats after drinking an energy drink. Federal officials would raise an alarm if a medication produced this level of an effect, but since the drinks are not yet in the same category as medication, the effects are not regulated.

The Bottom Line -- Until further studies are done, researchers recommend adults should limit the number of energy drinks per day, so not to exceed more than 300 milligrams of caffeine. Young children and teens should not be given or allowed to have these drinks at all.



Learning to
Better Serve
those
Who
Have
Served

Veteran-Directed Home and Community Based Services gives Veterans of all ages the opportunity to receive the Home and Community Based Services they need in a consumer-directed way.

Veteran-Directed Care is for Veterans who need skilled services, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines); are isolated, or their caregiver is experiencing problems.

Veterans in this program are given a flexible budget for services that can be managed by the Veteran or the family caregiver. Veteran-Directed Care can be used to help Veterans continue to live at home or in their community.

As part of this program, Veterans and their caregiver have more access, choice and control over their long term care services. For example, Veterans can:

- Decide what mix of services will best meet their needs
- Hire their own personal care aides
- Buy items and services that will help them live independently in the community

Since Veteran-Directed Care is part of the VHA Medical Benefits Package, all enrolled Veterans are eligible IF they meet the clinical need for the service and it is available. NOTE: This is a new and emerging VA program and is currently serving VA Dorn Veterans.

The Veteran is able to use a Shared Decision-Making Worksheet to help them figure out what long term care services or settings may best meet their needs now or in the future.

There's also a Caregiver Self-Assessment. It can help the caregiver identify their own needs and decide how much support they can offer the Veteran. Having this information from the caregiver, along with the involvement of the Veteran's care team and social worker, will help them reach good long term care decisions.

The physician or other primary care providers can answer questions about the Veteran's medical needs. Some important questions to talk about with the social worker and the family include:

•How much assistance does the Veteran need for activities of daily living (e.g., bathing and getting dressed)?
•Can the Veteran personally select and coordinate the needed services?
•What are the caregiver's needs?
•Is the caregiver able to assist with coordinating the selected services?
•How much independence and privacy does the Veteran want?
•What sort of social interactions are important to the Veteran?
•How much can the Veteran afford to pay for the selected services each month from his or her newly authorized VA Budget?

If the Veteran-Directed Care Program seems right for you, or a Veteran you know, please talk with your Social Worker at VA Dorn.

DEPRESSED OLDER ADULTS ARE AT GREATER RISK OF STROKE: A new study found that older adults who are depressed, stressed, or dissatisfied with their life are at increased risk of suffering a stroke and of dying from that stroke, The study showed that those who faced the highest level of psychosocial distress had a significantly increased risk of having a stroke and **up to 3 times** the risk of stroke mortality compared with those with the least amount of distress. In the study, the most distressed seniors were less educated, less physically active, had more chronic health conditions, and used antidepressants. (Source: ***Medpage Today*** dated 12/13/12)

NEVER MAKE
A PERMANENT
DECISION BASED ON
TEMPORARY FEELINGS

CONFUSION REMAINS HIGH AS ENROLLMENT FOR THE AFFORDABLE CARE ACT DRAWS NEAR: In just 6 months (October 1, 2013), open enrollment in the new health coverage created under the Affordable Care Act (ACA) is set to begin; however, much of the public remains confused about the status of the law.

According to an April 2013 poll conducted by the Kaiser Health Foundation, data indicates that many Americans are not well informed on the law. Because of the current findings, the Kaiser Health Foundation will continue to monitor these numbers to ascertain if the public will be ready to begin enrolling in October. Among the key findings of the new poll:

- 4 in 10 Americans (42%) are unaware that the ACA is still the law of the land, including 12% who believe the law has been repealed by Congress, 7% who believe it has been overturned by the Supreme Court and 23% who say they don't know enough to say what the status of the law is.

- About half the public (49%) says they do not have enough information about the health reform law to understand how it will impact their own family.

-The share of the public that says they lack enough information to understand how the ACA will affect their family is higher among the two groups the law is likely to benefit most – the uninsured (58% of whom say they lack enough information) and low-income households (56%).

-When it comes to where they are getting information about the law, Americans most commonly cite friends and family (named by 40%), newspapers, radio news, or other online news sources (36%), and cable news (30%). About 1 in 10 report getting information from a health insurer, a doctor, an employer, or a non-profit organization. Some say they have gotten information from federal agencies such as the Department of Health and Human Services (9%) or state agencies such as the state Medicaid office or health department (8%).

The Federal Government plans to launch their in-depth awareness campaign beginning in August. The government is delaying this activity because it wants the information to remain fresh in the minds of those that must enroll or be prepared to pay the penalty.

PROPOSED MEDICARE DRUG SAVINGS ACT: The 2013 Medicare Drug Savings Act would allow the Medicare program to benefit from the same discounts received for people with Medicaid. Many believe that restoring the rebates is a good deal for seniors, who might see lower Medicare Part D premiums, while also lowering the nation's deficit. The 2013 Medicare Drug Savings Act, is a bill introduced by Senator Jay Rockefeller and Congressman Henry Waxman. This policy would save the federal government more than $140 billion over 10 years by restoring the federal government's ability to secure more reasonable drug prices for low-income people with Medicare through the same drug rebates used for people with both Medicare and Medicaid.

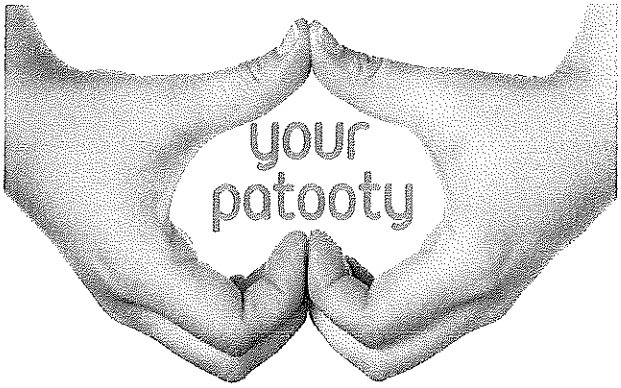
This is not a new concept, this practice was in place before Medicare Part D came on board, but it was only for those on Medicaid. Now the proposed act will expand this assistance to others to help lower the cost of premiums and co-pays.

Currently at least 50% of our Medicare beneficiaries live on less than $1,875 per month and about 15% of their total income is consumed by health care costs. Cost savers like the 2013 Medicare Drug Savings Act because it would help alleviate some of their prescribed drug expenses.

The PhRMA (Pharmaceutical Research and Manufacturers of America) is opposed to this act, as they insist the dollar savings will go to the government and not the people. Co-pays and premiums will remain the same or higher prices will be passed on to others (i.e., employers or those with higher incomes). They say it will also restrict PhRMA from developing new medications, especially in the area of biopharmaceutical research. Those that support the law are dismissing these claims as being unfounded.

We, in the Santee-Lynches ADRC, will continue monitoring this subject and update you on the results of this law.

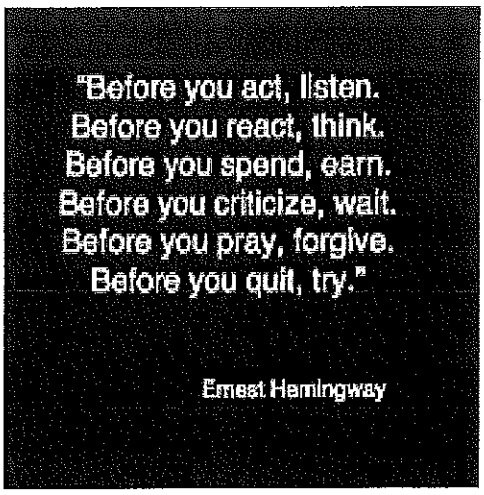
DON'T BE SHY – IT COULD SAVE YOUR LIFE: The Centers of Disease Control and Prevention have launched a new campaign aimed at helping people overcome the stigma of colon cancer screening. The catchy symbol is shown below and depicts an upside heart indicating you should love your "patooty," "bum," "tushy," "bottom," "caboose," or in Spanish your "trasero." ***No matter what you call it* – have it checked!**



No matter what you call it...
Have it checked.

Colon cancer is one of only two cancers that can actually be prevented through screening (cervical cancer is the other). About **one-half** of all colon cancer deaths, in the US, could be prevented each year if everyone age 50 and older got screened for the disease. Because of this prevention rate, public health advocates have been laboring for years to get people in for colonoscopies, but so far just about 50% have been screened.

So don't be shy, colonoscopies are really the best available screening tool for preventing colon cancer.

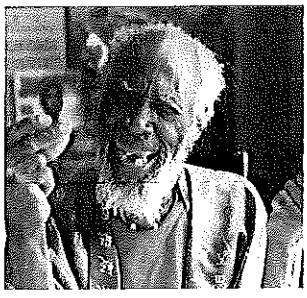


SOCIAL SECURITY AND SSI PAYMENT SCHEDULE FOR 2013: In order to prevent confusion on when your Social Security and SSI benefit payments should arrive, we have attached a payment schedule to this month's newsletter. The schedule is from the Social Security Administration's Website.

OBAMA ADMINISTRATION SIMPLIFIES ENROLLMENT APPLICATIONS FOR HEALTH INSURANCE: After the first draft was criticized for its length, the administration made the new enrollment application for health insurance much shorter and simpler. The first version was 18 pages for a single person. This form was reduced to 3 pages. The old version for a family was over 20 pages but now it has been cut by 66%. The actual length depends on how many children are in the family.

The first versions were said to be even more complex than the tax forms, but thankfully that has been fixed. Copies of these updated forms are dated 4-30-2013 and are located at the site listed below. However, enrollees will have an opportunity to complete and submit the forms on-line. This will eliminate even more time because you won't have to mail or fax them into the Healthcare Exchange/Market Place. http://cciio.cms.gov/resources/other/index.html#hie

DON'T WORRY, BE HAPPY – IT'S TIME TO PUT A TWINKLE IN YOUR WRINKLE !!



Schedule Of Social Security Benefit Payments 2013

JANUARY 2013

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
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FEBRUARY 2013

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MARCH 2013

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APRIL 2013

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SEPTEMBER 2013

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OCTOBER 2013

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NOVEMBER 2013

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DECEMBER 2013

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Benefits paid on	Birth date on
Second Wednesday	1st – 10th
Third Wednesday	11th – 20th
Fourth Wednesday	21st – 31st

Supplemental Security Income (SSI)

Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

Please allow three additional mailing days before contacting the Social Security Administration to report nonreceipt of your payment.

Social Security Administration
SSA Publication No. 05-10031
ICN 456100
Unit of Issue - HD (one hundred)
January 2012 (Recycle prior editions)

www.socialsecurity.gov

D-R-A-F-T May 22, 2013

SANTEE-LYNCHES AAA/ADRC

Policy and Procedures for Client Administration

(Determining Eligibility, Assessing, Selecting, Serving, and Terminating Clients)

The purpose of this document is to ensure there are sufficient checks and balances in place to reduce mistakes and eliminate or minimize improper actions/decisions while providing aging services within the Santee-Lynches Region. These instructions ensure one single entity will not conduct the assessments, select the clients, and deliver the service. By accomplishing these procedures, consumers having the greatest needs will be selected using a comprehensive priority system.

1. **Introduction**:

a. These policies and procedures will help the AAA/ADRC and its providers/ contractors achieve the intent of the Older Americans Act (OAA) which mandates that service preference be given to older individuals and persons with disabilities having the ***greatest economic or social need***, with particular attention to:

1. Minorities,
2. Those with limited English proficiency,
3. Those at risk of institutionalization,
4. Those having Alzheimer's and related disorders, and
5. Those residing in rural areas.

b. In order to do this, every individual receiving an aging service must receive an assessment prior to receipt of the service. Referrals for service come into the region from a variety of sources (i.e., self-referrals, physicians, family members, neighbors, discharge nurses, and other helping agencies, etc.).

2. **Eligibility Determination:**

a. Within two (2) business days of a referral, an eligibility screening will be accomplished using the Eligibility Screening Form provided by Santee-Lynches AAA/ADRC (attachment 1). This form provides the eligibility requirements for each service area. It may be completed by telephone or during a face-to-face meeting with the potential client.

b. The purpose of this step is to determine if the individual qualifies to be served according to the eligibility criteria set forth by the OAA, LGOA, and this region. If a client is found eligible, an assessment will be scheduled within two (2) business days of the determination. This form will be maintained in the client's file for three (3) years.

c. If the individual does not qualify, the person will be notified immediately and provided other options, if available. These options may include referrals to another helping agency, whether non-profit. public, or private pay. If the individual requests the notification in writing, forward that request within two (2) business days of their request. Maintain the Eligibility Screening Form and a copy of the letter for three (3) years.

3. **Assessments/Reassessments**:

a. An initial assessment will be accomplished on each individual requesting an aging service, even if the individual is a volunteer or it becomes obvious he/she must be added to a wait list. When accomplishing the assessment the "Lieutenant Governor's Office on Aging (LGOA) Assessment/Reassessment Form" must be used (see attachments 2 and 3). Attachment 2 is a copy of the form that is designed to take into the field and attachment 3 contains guidelines from LGOA on use of the form.

b. Prior to conducting the assessment interview, obtain the client's consent by having the client read and sign page 7 of the LGOA Assessment/ Reassessment Form.

c. Ensure the client understands that he/she has a right to refuse to provide some of the requested information, but refusing to provide any of the following specific details may result in waiving his/her right to receive services: zip code, race/ethnicity, gender, date of birth, income, English/Non-English speaking information, and number in household

d. Means Testing: According to OAA policy, there is no means testing when conducting assessments; however, Federal law requires that aging programs be directed toward the following persons: Those 60 years of age or older who are in the greatest social and/or economic need, are limited English-speaking, are those living in rural areas, and are low-income minorities.

e. Assessments for Home Delivered Meals and Level I Homemaking services will be accomplished in-person and in the client's home. Assessments for other aging services (group dining, physical fitness, transportation, etc.) may be conducted at a Group Dining Facility.

f. Reassessments will be conducted at least annually during the anniversary month or whenever the client has a life altering change (i.e., change in health status, etc.)

g. Once the assessment/reassessment is accomplished, the results are entered into the AIM system in order to obtain a Priority Risk Score and a Nutrition Screening Score. Enter the assessment for new clients in the system as "Waiting." A new client will remain in "Waiting" status until he/she can be moved into a service slot or the record is "Closed" for a justifiable and documented reason.

h. Run AIM report HHS25a once each assessment/reassessment is placed into AIM. This is an error listing that identifies any omitted entries (IADLs/ADLs, etc.). Review listing and correct entries as needed.

i. Hard copy assessments/reassessment (AIM Report 52) will be run and maintained in the client's file for no less than three (3) years. All client information shall be maintained in such a manner as not to violate confidentiality or privacy.

4. **Waiting Lists**:

a. Once an assessment is accomplished and scores are obtained, open the AIM Client Screen for that individual and go to the Waiting List Tab. Select the "Edit All" tab and enter the client's priority scores. Run AIM Report LG 65a for each of the following aging services: Congregate Meals, Home Delivered Meals, Level I Home Maker, Transportation, and Physical Fitness. This report will provide a listing of the clients in wait status, along with their calculated priority scores. These documents will be used when selecting a client to fill a service slot.

b. Maintenance of the Waiting Lists. Each waiting list must be reviewed on a quarterly basis to keep updated. Phone calls or letters to the waiting clients will be made to ensure the list is accurate. If the clients on the waiting list no longer need or qualify for the service, the provider/contractor must document the reason in AIM and close the file. In some cases, the assessment may need to be updated if the health or the status of the client has changed significantly.

5. Excel Listings of Active Clients: Other listings needed to ensure the right clients are filling the region's service slots are the Excel Listings of Active Clients. These listings can be prepared by first running an AIM Report LG51 for each of the 5 areas listed below and forward the listings to an approved email account. Upon receipt, they will be converted to an Excel format. Select Columns F (first name), H (last name),

BQ (Nutrition Score), and BF (Priority Risk Score) for sorting. Sort scores by largest to smallest. Be sure to "expand the selection" so the client's data remains with the correct client. The following lists the 5 required Excel reports with their sorting requirements:

Report of Active Clients	***Sort Score by Using the Below as the "Primary" Sort Factor***	***Also List Client's***
Congregate Meals	Nutrition Screening Score (Sort on BQ)	Priority Risk Score
Home Delivered Meals	Nutrition Screening Score (Sort on BQ)	Priority Risk Score
Level I Home Care	Priority Risk Score (Sort on BF)	Nutrition Screening Score
Transportation	Nutrition Screening Score (Sort on BQ)	Priority Risk Score
Physical Fitness	Priority Risk Score (Sort on BF)	Nutrition Screening Score

The Excel Listing should be arranged as follows:

Home Delivered Meals Time Period: March 1, 2013 to April 1, 2013 Source: AIM Report LG 51			
first_name	last_name	priority_sc	nut_score
Mary	Smith	106	15
Eva	White	103	14
Catherine	Moore	100	14
Laura	Williams	90	9

6. <u>Selecting Clients to Serve</u>:

a. **<u>New Clients</u>**: The assessment of a new client, the Wait List, and Excel Listing of Active Clients for service area requested must be reviewed to determine which clients have the most critical needs.

(1) If there is an available service slot and no waiting list, the new individual will be placed against that service slot immediately.

(2) However, if there is a new client that has been added to the wait list and there is no available service slot, an AAA/ADRC decision must be made as to whether to retain the client on the wait list or "switch" an active client (having a lower priority score) with the new individual who has a higher, critical need. Should this be required, the procedures in Paragraph 8 of these policies and procedures must be carefully followed.

(3) To begin the selection process, the assessor in the contractor's office, will

complete a Client Selection Form (attachment 4) for all new clients entering the system. The form will be completed in full and forwarded to Santee-Lynches AAA/ADRC for action. The form will include any extenuating circumstances that should be considered during the determination process. The form will also indicate the contractor's recommendation.

(4) Every effort will be made to uphold the OAA/LGOA policy to select consumers with the highest needs. However, from time-to-time, there will be circumstances that will support over-riding the priority scores to select a person with critical needs that are not reflected in the scores. When this occurs, the rationale will be entered into AIM Assessment (General Tab) and also entered in writing into the client's record that is maintained by the provider/contractor.

(5) To ensure a speedy decision so that services can be provided to the affected client in optimum time, the following package will be submitted to Santee-Lynches AAA/ADRC when a new client is brought into the system:

(a) Client Selection Form
(b) Assessment (AIM 52)
(c) Current Wait List for the service area requested (AIM 65a)
(d) Excel Listing of Active Clients for the service area requested
(e) Eligibility Screening Form

EXCEPTION: If the assessment of a new client indicates an extremely low assessment score with little hope of receiving a service slot, the only document that needs to be sent to the AAA/ADRC is a completed Client Selection Form.

(6) The AAA/ADRC representative will review the package and complete the bottom section of the Client Selection Form indicating the action(s) the provider/contractor will take.

(a) New client approved: If the client is approved to receive service, the provider/contractor will be immediately notified and they will make arrangements to begin serving the client as soon as possible.

(b) New client is to remain on the waiting list: If the assessment and priority scores don't justify moving the client into a service slot, the provider/contractor will be notified right away and the client will be provided other options by the provider/contractor, as appropriate. Examples of these options may be:

1 Using local funds to begin serving the client.

2 Offering cost sharing (client funds and local-area funding). If this is accomplished a pre-approved sliding scale based on income should be developed by the provider/contractor. The recommended scale should be forwarded to the AAA/ADRC for review and approval prior to offering this option.

3 Informing client of private pay options.

b. **Active Clients Undergoing an Reassessment**: If the reassessed client's priority score (either nutrition or priority risk) has increased or decreased significantly, the client will be treated much like a new client entering the system. In order to make a decision if the client remains in their service slot or is moved to a waiting list, the following documents must be submitted to the AAA/ADRC:

(1) Client Selection Form
(2) Assessment (AIM 52)
(3) Current Wait List for the service area requested (AIM 65a)

(4) Excel Listing of Active Clients for the service area requested
(5) Eligibility Screening Form

NOTE: If the reassessment of an active client indicates little to no change in rating, the only form needed by the AAA/ADRC is a completed Client Selection Form.

7. Creating a Service Care Plan and Progress Notes:

a. Service Care Plan:
(1) A Service Care Plan is created, signed, and dated when:
(a) Client is new to the system
(b) Client receives an annual reassessment, or
(c) Client has a change in health or other significant life changing event, resulting in an out-of-cycle reassessment.
(2) The plan will contain:
(a) The service(s) to be provided,
(b) The client's problem/need(s),
(c) The service goal(s),
(d) The service time frame(s) (usually 12 months unless the client requires closer monitoring),
(e) Intervention responsibilities, and
(f) The start and end service dates.
(3) A Service Care Plan Form provided by the Santee-Lynches AAA/ADRC will be used for this purpose (see attachment 5). The Service Care Plan will be finalized no later than seven (7) business days after assignment to a service slot. This form will be filed in the client's file for at least a three (3) year period. A new Service Care Plan will be completed at least every year.
(4) If the client is requesting frozen home delivered meals, the Service Care Plan must address if the client would like a daily reassurance phone call since contact between the client and the provider/contractor will usually take place only once a week. If the client wishes this service, a daily service call log will be maintained by the provider/contractor and will be made available for review by the LGOA or AAA/ADRC upon request. The Daily Telephone Reassurance Call Log, provided by the AAA/ADRC, will be used (see attachment 6).
b. Progress Notes: Progress notes addressing a client's problem/needs and/or goals will be prepared each time there is activity concerning the client's progress or any problems found while helping the client achieve his/her established goals. These notes will be documented using the Service Care Plan Progress Notes Form provided by the AAA/ADRC (attachment 7). Significant information should also be placed in the AIM Assessment, General Information area.

8. Termination of Services: Every effort will be made to prevent curtailment of services to clients when they have not asked to end the assistance/services, but it must be ended due to the situation at hand. Whenever possible, the following steps will be taken within the time frame listed below. Termination of services must be thoroughly justified and documented in AIM and in the client's record. A letter to the client on the curtailment of services must be sent before the service actually ends except in 7a(3) below:

a. Immediate termination may be taken when:

(1) The service is no longer desired according to the client or the client's authorized representative.

(2) The client has moved outside the county and region.

(3) The client is deceased.

b. Two week notification will be provided to the client in writing so other arrangements may be made when:

(1) According to a reassessment, the client's condition has improved and he/she is no longer in critical need of the service. The client should be moved to the wait list and/or offered other options (i.e., local funding, cost sharing with local funds and sliding scale, or private pay, etc.)

(2) Client is not available to accept the services (i.e., low attendance at the group dining facility, etc.). Contact the client in writing and give the client an opportunity to either provide reason for poor attendance of time to improve attendance. If no response from the client, move the client to "Inactive."

c. Time Frame Depends on the Situation: Client's condition has now outgrown the capabilities of our authorized services, therefore, assistance should be provided by another agency (i.e., CLTC, Nursing Home, extended hospital stay with rehab, etc.). Close coordination will be accomplished between the provider/contractor and the family, caregiver, CLTC, etc., to ensure there is a smooth transition.

9. **Training for Assessors**: New assessors must receive training by the Santee-Lynches ADRC before beginning to assess clients. If another experienced assessor is available within the provider/contractor's staff, the AAA/ADRC will be contacted to obtain a waiver of this training. Update training for all assessors will be held as policies or procedures change or whenever the quality of the assessment/reassessment packages indicates additional training is required.

ATTACHMENT 1

ELIGIBILITY SCREENING FORM

Santee-Lynches AAA/ADRC **ELIGIBILITY SCREENING**	Screening Date:	Assessor:
Client's Name (First, Middle Initial, Last):	☐ Male ☐ Female	Date of Birth:
Client's Address:	Client's Home Phone #: Client's Cell Phone #:	Preferred Point of Contact if desired (Name, Phone #, & Relationship):

Instructions: This form should be completed within 2 business days of referral to determine service eligibility. The potential client must meet all requirements listed for each of the below services he/she (or the caregiver) is requesting. A check (✓) indicates the client meets the requirement (rqmt). If the referral is an emergency, the timeline should be escalated as needed.

	Group Dining Eligibility Criteria	***Meets Rqmt***
1	The person is age 60 or older or one of the following: (a) a spouse of a member (at any age), (b) an adult with a disability (at any age) who resides in senior housing that provides group dining services, (c) a person with a disability under age 60 if he/she resides with a member, (d) a person under age 60 who volunteers at the center 5 or more hours a week during mealtime.	
2	The client is a resident of your designated county.	
3	The person is not an employee, volunteer (volunteering less than 5 hours per week), or other person compensated by the AAA/ADRC or provider/contractor.	
	Home Delivered Meal Eligibility Criteria	***Meets Rqmt***
1	The person is homebound. Note: Homebound is defined as an individual who resides at home, and may be at risk for institutionalization, and is incapable of performing at least 2 or more ADLs without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for another essential, non-medical reason/appointment that is infrequent and of short duration.	
2	Person is age 60 or older or one of the following: (a) a client's spouse (at any age), or (b) another member of the household when it is in the best interest of the homebound client.	
3	Person is a resident of your designated county.	
4	The person has at least one of the following conditions making him/her homebound: (a) an illness, (b) an incapacitating disability, or (c) a situation where they have become unavoidably isolated.	
5	The person does not have (a) the ability to purchase and/or prepare food due to his/her disability, and (2) does not have anyone to prepare a nutritious meal on a daily basis.	
6	The person is able to self-feed or has someone available to assist with his/her feeding at mealtime.	
7	If request is for frozen meals, the person has the appropriate kitchen appliances to store and heat the meals.	

8	The client is not receiving services under CLTC.	
9	The person is not an employee, volunteer (volunteering less than 5 hours per week), or other person compensated by the AAA/ADRC or the provider/contractor.	May 2013
	Level I Homemaking Eligibility Criteria	***Meets Rqmt***
1	Person is age 60 or older.	
2	The person is a resident of your designated county.	
3	The person is homebound. Note: Homebound is defined as an individual who resides at home, and may be at risk for institutionalization, and is incapable of performing at least 2 or more ADLs without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for another essential, non-medical reason/appointment that is infrequent and of short duration.	
4	The client has at least one of the following conditions that make him/her homebound: (a) has a chronic illness, (b) has limitations in 2 or more activities of daily living, or (c) Has an acute episode of chronic illness that affects his/her ability to provide self-care and being able to maintain a safe and sanitary home environment without assistance.	
5	The client's needs are within the scope of the Level I homemaking/chore/companion services (i.e., needs are primarily simple and deal with taking care of the recipient's living environment).	
6	The client is not receiving care under CLTC or a Hospice Program.	
7	The person does not work as an employee, volunteer, or other person compensated or uncompensated by the AAA/ADRC or the provider/contractor.	
	Transportation Eligibility Criteria	***Meets Rqmt***
1	The person is age 60 or older or one of the following: (a) a spouse of a member (at any age), (b) an adult with a disability (at any age) who resides in senior housing that provides group dining services, or (c) a person with a disability under age 60 if he/she resides with a member and attends group dining.	
2	The person is a resident of your designated county.	
3	The person: (a) is unable to drive safely, (b) has no access to a vehicle, or (c) does not have access to affordable, convenient public transportation.	
4	The client requires transportation service due to at least one of the following in order to remain active in the community: (a) Needed to participate in social service programs, (b) Have access to businesses and health resources, (c) Needed to reduce social isolation, (d) Required to maintain health and independence, (e) Needed to prevent premature institutionalization.	
5	The person is not financially compensated by the AAA/ADRC or provider/contractor to provide services.	
	Physical Fitness Eligibility Criteria	***Meets Rqmt***
1	The person is age 60 or older or is one of the following: (a) a spouse of a member (at any age), (b) an adult with a disability (at any age) who resides in senior housing that provides group dining services, or (c) is a person with a disability under age 60 and he/she resides with a member who attends a group dining facility.	
2	The person is a resident of your designated county.	
Eligibility Criteria of Other Services as Listed: _____		***Meets Rqmt***
1		

2		
3		
	SUMMARY	
	☐ Eligible for Identified Services – Schedule an Assessment within 2 business days. Retain this document in client's file. ☐ Ineligible for Identified Services -- Notify client of reason for ineligibility and offer other appropriate options if available. If client desires this information in writing, forward the response with rationale within 2 business days. Retain this document on file for 3 years for future review if necessary. Page 2	

ATTACHMENT 2

LGOA Assessment/Reassessment Form

Lieutenant Governor's Office on Aging Assessment/Re-Assessment

☐ New Client ☐ Annual Reassessment ☐ Significant Change in Condition

Initial Contact Date: _____ Status: _____
Unique ID#: _____ Assessment Score: _____
DOB: ____/____/____ ☐ Refused Nutrition Score: _____
Client Type: ☐ Client/Care Receiver ☐ Caregiver Target Score: _____
County: _____ Region#: _____ Caregiver Score: _____

Individual Intake Information

Last Name: _____
First Name: _____ Middle Name: _____
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____
Email: _____

Emergency Contact Information

E Contact Name: _____ E Relationship: _____
E Contact Name ( ) _____ E Relationship _____

Physical Address: _____
Apt, Lot, Box: _____
City: _____ State: SC Zip: _____
Mailing Address If Different: _____
City: _____ State: SC Zip: _____

Race: (check one

☐ Refused
☐ African American/Black
☐ American Indian/Alaskan
☐ Asian
☐ Hawaiian/Pacific Islander
☐ White
☐ Some Other Race
☐ 2 or more Races
☐ Race Missing

Ethnicity: (check one)

Monthly Family Household Income
(Client, Spouse, Dep. Child)

☐ Refused
$_____ Job
$_____ SS
$_____ SSI
$_____ VA
$_____ FoodStamps
$_____ Other

$_____
Total Family Household Income

Marital Status

☐ Married ☐ Divorced
☐ Single ☐ Separated
☐ Widowed ☐ Unknown
☐ Other

Monthly Expenses: (best estimate)

$_____ Food
$_____ Prescriptions
$_____ Medigap
$_____ Housing
$_____ Utilities
$_____ Phones
$_____ Other

☐ Hispanic/Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Refused	**Total # in HouseHold:** #_____ (Client, Spouse, Dep Child) ☐ Refused **Gender:** ☐ M ☐ F ☐ Refused	$_____Total Expenses **Limited English Proficiency:** ☐ Yes ☐ No Primary Language: _____

Client Name: _____ Uniq ID#: _____

Special Eligibility: ☐ Spouse of Client ☐ Meal Volunteer ☐ Disabled < 60 ☐ Emergency ☐ Other
☐ None ☐ Waiver ☐ < = 18 child ☐ ADRD < 60

Income Comments: (Viewable by all users)

_____

_____

_____

Other Information Comments (Directions, Dog, Smoker, Do not go alone, etc): (Viewable by all users)

_____

_____

_____

_____

Assess Date: _____ Assessment Method: ☐ In Person ☐ By Phone

Spouse Name: _____ Primary Doctor: _____

Assessor: _____ Doctor Phone 1: _____

Operator: _____ Doctor Phone 2: _____

Services Requested: (check all that apply)

- ☐ IR&A
- ☐ Group Meal
- ☐ Home Delivered Meal
- ☐ In-Home Care
- ☐ Transportation
- ☐ Adult Day Care
- ☐ Sitter Service
- ☐ Assisted Transportation
- ☐ Emergency Food
- ☐ Exercise
- ☐ Nutrition Counseling
- ☐ Nutrition Education
- ☐ Ombudsman
- ☐ Outreach
- ☐ Respite
- ☐ Benefits Assistance
- ☐ Case Management
- ☐ Residential Maintenance
- ☐ Home Injury Prevention
- ☐ Financial Assistance
- ☐ Insurance Counseling
- ☐ Sr. Center Activities
- ☐ Dental
- ☐ Vision
- ☐ Hearing
- ☐ Prescriptions
- ☐ Yard Maintenance
- ☐ Legal Assistance
- ☐ Utility Assistance
- ☐ Health Promotion
- ☐ Medical Escort
- ☐ Housing

Client Referred by: (check one)

- ☐ Self
- ☐ DSS
- ☐ AAA
- ☐ Friend
- ☐ Comm Base Org
- ☐ Family
- ☐ Nursing Home
- ☐ Provider
- ☐ CLTC
- ☐ DDSN
- ☐ Hospital
- ☐ Doctor
- ☐ Home Health
- ☐ Other

In-Home Services Currently Receiving:
(check all that apply)

- ☐ CLTC
- ☐ Home Delivered Meal
- ☐ Home Health
- ☐ Homemaker
- ☐ Hospice
- ☐ Transportation
- ☐ VA
- ☐ None
- ☐ Other

IN THE EVENT OF A DISASTER (Required)

Will someone check on you during a disaster? Y or N
Do you have meds that need refrigeration? Y or N
Are you on Oxygen? Y or N
Will you need help during an emergency evacuation? Y or N

Type of Transportation Needed in an Evacuation:
(Check ONE)

☐ Non ☐ Lift Accessible
☐ Regular ☐ Ambulance

OPTIONALS:

Education:
- ☐ <3rd grade
- ☐ 3rd- 8th grade
- ☐ Some HS
- ☐ HS Grad
- ☐ Some College
- ☐ College Grad

Locomotion:
- ☐ Needs assistance to go outside
- ☐ Unable to climb stairs
- ☐ Uses cane/walker/crutch
- ☐ Uses wheelchair on occasion
- ☐ Uses wheelchair all the time

Client Name: _____ Uniq ID#: _____

IADLS ☐ Refused	Independent	Needs Some Assistance	Dependent
Preparing Meals			
Microwave Use			
Light Housekeeping			
Heavy Housekeeping			
Telephone Use			
Money Management			
Shopping			
Medication Management			
Driving or using Public Transportation			

ADLS ☐ Refused	Independent	Assistive Technology Only (No Help)	Supervision and/or Coaching	Limited Assistance (Some Help)	Extensive Assistance	Total Dependence
Walking/Mobility						
Dressing						
Eating						
Toilet Use						
Transferring						
Bathing						
Personal Grooming						

Continence	Continent	Usually Continent	Occasionally Incontinent	Frequently Incontinent	Incontinent
Bladder Incontinence					
Bowel Incontinence					

Health and Safety Health Limitations Due to the Following (Check all that Apply)	Yes		Yes
Specific Diseases:		**Broad Health and Disability Categories:**	
Alzheimer's, Dementia and Related Disorders (ADRD)		Blood Diseases/Disorders	
Arthritis		Circulatory System/Heart Diseases/Disorders	
Diabetes		Cognitive Diseases/Disorders	
Kidney/Renal Disease/ESRD (End Stage Renal Disease)		Digestive System/Diseases/Disorders	

Cancer		Hearing/Ear Diseases/Disorders	

Health and Safety (Cont.) Risk Factors Part 1	0	1	2	3-5	6-8	9+
Number of Daily Prescription Medications						
Number of Falls in the Past 6 Months						

		Intellectual/Mental Disabilities	
		Mental Illness/Disorders	
		Neurological Diseases/Disorders	
		Physical Disabilities/Diseases/Disorders	
		Respiratory Diseases/Illnesses	
		Speech Disorders	
		Vision/Eye Diseases/Disorders	
		Other Disabilities/Diseases/Disorders	

Client Name: _____ Uniq ID#: _____

Health and Safety (Cont.) Risk Factors Part 2 - Please answer the following Y/N	Y/N
Do you have:	
Prescriptions from more than one Doctor?	
Prescriptions filled at more than one Pharmacy?	
Nutritional concerns as determined by a healthcare professional?	
Less than a 3 day supply of food on hand?	
Were you seen at the ER or admitted to a Hospital, Rehab Facility or NH in the last 6 months?	

Health and Safety (Cont.) Risk Factors Part 3					
Do you Live with? (All people in same Household)	An Independent Spouse/ Partner/Adult	1 or 2 Dependent Children <18	More than 2 Dependent Children	Dependent Adult/ Spouse/Partner	Live Alone
Where do you live?	Boarding Home/ Assisted Living/ Group Home	Rented Room or Apartment	Home	In a Shelter	Homeless
Transportation	Has Transportation	Needs Transportation	Needs Transportation and Escort	Needs Specialized Transport	

In the last 6 months have you: Y/N	Y/N
Missed a rent/mortgage payment because you did not have the money?	
Missed a utilities payment because you did not have the money?	
Gone without medication because you could not afford it?	
Gone without food because you could not afford it?	

Support

How close is your nearest support person?	< 20 mi	20-30mi	31-50mi	51-99mi	100+mi
Do you:					**Y/N**
Have anyone you can call if you need help or assistance?					
Live 20 or more miles from the following:					**Y/N**
Shopping (grocery, clothes, personal care items, etc)					
Pharmacy					
Your doctor					
Hospital					
Have you ever been denied services based on where you live?					

Client Name: _____ Uniq ID#: _____

Nutritional Screening Y/N (a Yes response = points)	Y/N	Pts.	Score
Do you have an illness or condition that has made you change the kind or amount of food you eat?		2	
Do you eat fewer than 2 meals a day?		3	
Do you eat a few (or less) fruits or vegetables, or milk products?		2	
Do you have 3 or more drinks of beer, liquor, or wine almost every day?		2	
Do you have tooth or mouth problems that make it hard for you to eat?		2	
Do you sometimes not have enough money to buy the food you need?		4	
Do you eat alone most of the time?		1	
Do you take 3 or more different prescribed or over the counter drugs per day?		1	
Without wanting to, have you lost or gained 10 pounds within the last 6 months?		2	
\re you sometimes physically unable to shop, cook, or feed yourself?		2	
Max Points		21	

*REQUIRED QUESTIONS: (Not Part of Priority Score. For Reporting Purposes)

***Homebound:** ☐ Yes ☐ No

An individual who resides at home, and maybe at risk for institutionalization, and is incapable of performing at least two or more activities of daily living (ADLs) without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for short, infrequent non-medical reasons.

***Living Alone:** ☐ Yes ☐ No

A one person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.

General Comments: (View Restricted to Provider)

_____

_____

_____

_____

_____

Medical Comments (Current and Past Health Conditions): (View Restricted to Provider)

Medication Comments: (View Restricted to Provider)

Client Name:

__ Uniq ID#: _____

Residential – Client Has:	YES
Safe access to all necessary areas	
Access to working laundry/washer	
Adequate cooling & heating	
Adequate electricity	
Adequate plumbing	
Animal/Pest control	
Essential repairs/replacements	
In-home safety items	
Security (window and door locks)	
Working microwave	
Working refrigerator/freezer	
Working stove	
Personal Emergency Response System	

Benefits (Currently Receiving)	YES
Medicare	
Medicaid	
Medigap	
Private Health	
Social Security	
SSI	
Food Stamps	
Rental Assistance	
Fuel Assistance	
No Health Insurance	
VA Benefits	
Other	

Non-weighted questions

Behavior/Psychosocial	YES
Family Caregiver states client has issues with:	
Aggressive behaviors	
Agitation	
Fear/Paranoia	
Hallucinations/Delusions	
Hoarding	
Socially Inappropriate/Disruptive	
Sundown Syndrome	

CONSENT TO RELEASE INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Lieutenant Governor's Office on Aging and the U. S. Federal Government. The information provided will be kept confidential and guarded

Client Referred to (Check all that apply)	YES
CBO	
CLTC	
COA	
DDSN	
DHEC	
DHHS	
DMH	
DSS	
Home Health	
Hospital	
Housing	
Legal/SC Bar	
Physician	
VA	

Level of Activity	Yes
No Activity/Bedridden	
Moves around the house	
Walks in yard	
Walks in Neighborhood, Mall, Park, Gym, etc.	
Goes places (Shopping, etc.)	
Exercises at home once a week	
Exercises at home 2 or more times a week	
Exercises at Sr. Center, Church, Gym, etc. once a week	
Exercises at Sr. Center, Church, Gym, etc. 2 or more times a week	

Legal Summary	Yes
Legal Will	
Living Will	
Durable Power of Attorney	
Health Care Power of Attorney	
5 Wishes	

against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for client (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client.)

My information may be used to arrange for these services: ☐ **Yes** ☐ **No**

Some of the data asked for is required by either the South Carolina Lieutenant Governor's Office on Aging and/or the U. S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

My information may be shared with the entity(ies) funding my service(s): ☐ **Yes** ☐ **No**

Client Signature: _____ Date: _____

If read to client, by whom : _____ Date: _____

Relation: _____

Assessor Signature: _____ Date: _____

Services you will receive:	Date Service Starts:	Frequency of Service:
____ Congregate Meals	_____	_____
____ Home Delivered Meals	_____	_____
____ Transportation	_____	_____
____ Homemaker	_____	_____
____ Other _____	_____	_____

ATTACHMENT 3

Guidelines for the Use of the LGOA Assessment/Reassessment Form

ASSESSMENT SUPPORTING DOCUMENT

Refused – the client has the right to refuse to answer any question. The refused selection lets the data entry person know the question was not skipped and will serve as backup in the event a client is denied service due to a scoring issue.

GENERAL INTAKE INFORMATION

1. **Initial Contact Date**: Date initial contact was made with the client.
2. **Unique ID#**: System generated number. Will replace the client's SSN.
3. **REQUIRED - Date of Birth**: Required question and is weighted on the assessment under Health and Safety Part 3. Client may Refuse to answer, but it may have an effect on his overall score and services. If the client will only give his age, enter 07/01/yyyy.
4. **Client Type**: Client/Care Receiver or a Caregiver
5. **REQUIRED - County**: County in which client resides.
6. **Region**: AAA Region of which provider is a part of.
7. **Client Address Is Rural:** Calculated and populated by AIM based on the client's Zip Code and Census data.
8. **Status**: In order to access the Status and Status Date fields, you must click on the OWNERS screen. The **Status** AND the **Status Date** are critical fields. They are used to pull clients for reporting. If the client's status is Closed, Deceased, Inactive, or Pending, the client will not be included in some reports and rosters.

> **NOTE:** The **Status Date** DOES NOT automatically change when you change a clients status, you must change the date manually.

- **Active** - For a new client. **Status Date** = effective date client approved for services and **must** be entered manually. (Status Date defaults to the date the record is being inserted and is not usually the date the client became active.)
- **Closed** - **Status Date** = date client becomes ineligible for services (date client is terminated).
- **Deceased** - If a client is deceased, **Status Date** = date of death or date agency learned of client's death.
- **Inactive** - If a client becomes ineligible for services, and there is reason to believe this is only a temporary situation. **Status Date** = effective date of ineligibility for services.
- **Pending** - When information on a new client is entered into ***AIM*** before client is determined to be eligible for services. **Status Date** = date the preliminary information is entered into the system.
- **Pending** - If client is entered onto a Waiting List, BUT NOT receiving any services. **Status Date** = date client was put on Waiting List.
- **Active** - If a client is entered onto a Waiting List, BUT is currently receiving another service. **Status Date** = remains the date client became Active. (The Status Date would NOT change.)

9. **Status Date**: See above.

SCORES The scores will be generated AFTER the questions are answered in AIM and will automatically populate on the screen. The data entry person will then handwrite the score on this form for the benefit of the assessor.

10. **Assessment Score**: Derived from assessment questions.
11. **Nutrition Score**: Derived from Nutrition questions.
12. **Target Score:** Derived from General Information.
13. **Caregiver Score:** Derived from Caregiver Assessment.

INDIVIDUAL INTAKE INFORMATION

14. **Title**: Optional
15. **Last Name**: Client's last name
16. **First Name**: Client's first name
17. **Middle Name**: Client's middle name. This box can also be used for alias names or individual identifiers
18. **Home Phone**:
19. **Work Phone**:
20. **Cell Phone**:
21. **Email**:

EMERGENCY CONTACT INFORMATION

22. **E Contact Name**: Client's personal contact in case of an emergency
23. **E Contact Phone**:
24. **E Cell Phone**:
25. **E Relationship**: Contacts relation to client
26. **E e-mail**:

INDIVIDUAL INTAKE INFORMATION

27. **Physical Address (Add 1)**: Address where client resides
28. **Apt, Lot, Box (Add 2)**: Additional line for identifying street information
29. **City**:
30. **State**:
31. **REQUIRED - Zip Code**:
32. **Mailing Address if Different (Add 1)**: Address where client receives mail if different than the residential address.
33. **City**:
34. **State**:
35. **Zip**:

OTHER INFORMATION

36. **REQUIRED - Race**: Drop down - select ONE. Client has the right to refuse, however this is a target weighted question.
    African American/Black
    American Indian/Alaskan
    Asian
    Hawaiian/Pacific Islander
    White
    Some Other Race
    2 or more Races
    Race Missing

    REQUIRED - Ethnicity: Drop down, select ONE. Client has the right to refuse, however this is a target weighted question.
    Hispanic/Latino
    Non-Hispanic or Non-Latino
    Unknown
    Refused
37. **REQUIRED - Monthly Family Household Income**: Total household income for EITHER...

    a) a single client who lives alone (HH = 1), or

    b) the family household income for the client and/or spouse and/or dependent children (HH = # in family dependent upon the client).

You are encouraged to obtain all income sources as this may lead to additional services the client may qualify for. However, if you can only obtain the TOTAL FAMILY HOUSEHOLD INCOME, that is acceptable. Place it in "Income From Other". **Click OK.**

If Client's Income is UNKNOWN and an "educated" estimate is not feasible, refer to the most current HHS Poverty Guidelines. Ask the client for the "Household Size" (number in the household) and then ask if they are below the corresponding income figure. If YES, enter that dollar figure. If NO, and they are above that figure, enter $9999 as their income. If they still refuse, check Refused.

NOTE: You **MUST** click on Income Source AND click OK, even if you do not plan to enter information: Income reports will not be correct, unless OK has been clicked from this window for EVERY client. It is a peculiarity of the ***AIM*** system.

Helpful TIP: You can tell whether or not the Income Source window has been "OK'd" by whether or not the BUTTON is in **Bold Print**: If "**Income Src**"is **Bold**, then it has been "OK'd". If "Income Src" is NOT Bold, then it has NOT been "OK'd".

38. **REQUIRED - Total # in Household**: It will either = 1 if the client is single and lives alone. Or, it will = the client plus all family members in household dependent upon him, to include spouse and dependent children.
    *****INCOME AND #HH should not be entered haphazardly and requires the use of professional judgment.**

    These two fields are calculated behind the scenes in AIM to determine poverty levels based on the income and household size as set forth in the current year of HHS Poverty Guidelines. In turn, this calculation will be used to determine if your Region is targeting this population. These figures will also be report to NAPIS.

39. **REQUIRED - Gender**: Male, Female and Refused.
40. **Marital Status**: Married, Single, Widowed, Divorced, Separated, Unknown and Other.
41. **Monthly Expenses**: Many of the expenses in this section are variables and change from month to month. It is not imperative for you to have the client go obtain current billing statements to gather this information. We will accept "best estimates" that are reasonable. For ex, if they know their power bill runs $120 to $150 a month, you can estimate $135. This section will help prepare the assessor for the ADLs/IADLs by looking for additional assistance for the client.
42. **REQUIRED - Limited English Proficiency**: Yes or No. If NO, you do not need to answer #44 or type English.

43. **Primary Language**: Current options are:

Spanish or Spanish Creole	Korean
French (inc Patois, Cajun)	Italian
German	Japanese
Chinese	Greek
Tagalog (Philippines)	Arabic
Vietnamese	Gujarathi (India)

None - In the event you enter a language by mistake and want to remove it immediately, you can tab the Undo button on the toolbar. However, if it not noticed until later, select None.

CLIENT's NAME AND UNIQUE ID# - OPTIONAL at the top of each new page. Included at the request of many providers so they can identify client's pages if they become separated.

44. **Special Eligibility:**
    Client type = Client - Special Eligibility options would be Client's Spouse, Meal Volunteer, Disabled < 60, Waiver, Emergency.
    Client type = Care Receiver - Special Eligibility options would be Disabled < 60, < 18 child or ADRD < 60.
    None – During re-assessment, if it is determined the special eligibility status is now None, the system will not allow you to uncheck one box without checking another. So, we have included None so that you can clear out the previous option.
    Waiver –
    Other –
    Emergency – Any event that would identify the client as an Immediate At-Risk individual.
45. **Income Comments**: These comments can be viewed by all users. They are comments that may have relevance to the client's income.
46. **Other Information Comments**: These comments can be viewed by all users. They are "catch-all" comments that may have relevance to the client's home directions, which door to knock on, if there are dogs, if there is a smoker in the home, if the assessor should not go alone.... Or any other information that the assessor may want to share with others or for future knowledge.
47. **Assess Date**: This is the date the assessment or reassessment was conducted.
48. **Spouse Name**: Name of client's spouse.
49. **Assessor**: Name of person conduction the interview with the client.
50. **Operator**: Name of the person entering the data into AIM.
51. **Assessment Method**: Was the assessment conducted in person with the client or by phone.
52. **Primary Doctor**: This will be the client's primary doctor, family physician or general practitioner.
53. **Doctor Phone 1**:
54. **Doctor Phone 2**:
55. **Services Requested**: You will check all that apply to the client.
56. **REQUIRED - In the Event of a Disaster**: This is a new section and will be need to assist the client in an event of a disaster. They are Y/N questions.
    Type of Transportation Needed: Check only ONE. This determines how a client would be taken out of their home in the event of an evacuation or emergency.

57. **Client Referred by**: Check only ONE. How the client came to our agency.
58. **In-Home Services Currently Receiving**: Check ALL that apply.
59. **Optionals**: Education and Locomotion: Many providers asked that we return these fields for their own information. They are here to help assist you in how to conduct an interview with the client or what type of transportation assistance they may need.
60. **IADLS:**
    You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks:

    The IADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall IADL ability.

    - Preparing Meals: Ability to prepare a full, nutritious meal at least twice a day;

- Light Housekeeping: Ability to pick up small, light items, dust, sweep, wash own dishes or put dishes in dishwasher, do light laundry;
- Heavy Housekeeping: All of the above plus vacuum, heavy laundry, mop, clean bathroom(s);
- Telephone Use: Ability to look up numbers, dial phone, and carry on a conversation;
- Money Management: Ability to manage household finances properly;
- Shopping: Ability to purchase items, get them into the house, and put them away;
- Managing Medications: Ability to take medications timely and properly.

61. **ADLs**:

You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks and to accurately assess the client's level of ability:

The ADL self-performance categories measure what client actually did without assistance in the last 7-14 days, indicating balance between client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall ADL ability.

- Transferring: Indicates how client moves between surfaces, i.e., to/from bed, chair, wheelchair, standing position (excludes to/from toileting).
- Codes:
- Walking/Mobility: Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating the ability to walk or propel a wheelchair.
- Dressing: Assessment should focus on client's ability to dress self
- Bathing: This activity rates the maximum amount of physical assistance client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part of bathing activity (washing off) indicates client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)
- Eating: relates to activities client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.
- In the home, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, facility staff should evaluate client's ability to accomplish these activities.
- Toilet Use: Indicate how client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.
- Note Regarding Ostomy Care: when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

62. **Bladder and Bowel Incontinence**: These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the *AIM* Assessment Form.

Note: If client is incontinent, but self-care indicated, this does not constitute a deficit.

Note Regarding Ostomy Care: when assessing a client who has a colostomy of ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

63. **Health and Safety**: This section has been re-written to address CURRENT LIMITATIONS as a result of a Specific Disease or Health and Disability Category. This means they are LIMITED in their daily activities as a result of their condition. Ex. If the individual IS NOT LIMITED by High Blood Pressure, do not check HBP.

    Please refer to the Health Assessment Limitations Due to Any of the Following sheet. If the client has several conditions that fall under one category, they will only receive one check mark for THAT category. However, they can receive a check for more than one category.

64. **# RX Medications:**
65. **# Falls:**
66. **Do you have:**

    Prescriptions from more than one Doctor?
    Prescriptions filled at more than one Pharmacy?
    Nutritional concerns as determined by a healthcare professional?
    Less than a 3 day supply of food on hand?
    Were you seen at the ER or admitted to a Hospital, rehab Facility or NH in the last 6 months?

67. **Do you live with? (All people in same household):**
    - An Independent Spouse/Partner/Adult
    - 1 or 2 Dependent Children < 18
    - More than 2 Dependent Children
    - Dependent Adult/Spouse/Partner
    - Live Alone

    It is important to know the living arrangement the client has. It can be a determining factor for the kind of services placed in the home. Start off by asking client if he lives with anyone. If "Yes", follow with, "Whom do you live with?" If client is living alone then case manager needs to determine if it is a safe environment. Please choose and answer ONLY ONE of the Living Arrangements question-and-answer pairs. If client lives with spouse, then determine if spouse is dependent on the client or not and choose the "spouse - questions" that best applies. If client lives with spouse AND others, then choose one of the "spouse - questions".

68. **Where do you live?**
    - Boarding Home/Assisted Living/Group home
    - Rented Room or Apartment
    - Home
    - In a Shelter
    - Homeless

69. **Transportation**
    - **Has Transportation** – If client has a vehicle they operate.
    - **Needs Transportation** – If client needs to find transportation to get places.
    - **Needs Transportation and Escort** – If client has to find transportation and someone to assist them.
    - **Needs Specialized Transport** – If client needs an ambulance or other specialized vehicle to transport them.

    Client's ability to be self-sufficient depends on transportation, especially for those living in rural communities. Important to ask client as many of these questions as necessary to determine their transportation needs. If client cannot get medications or food or keep a doctor's appointment, then her health status is at risk. Answer as many questions as are pertinent to this client.

70. **Age (from DOB)** – Field will be calculated in AIM taken from the DOB

71. **Income and Number-In-Household from Client Screen:** - Field will be calculated in AIM taken from the Income screen.

In the last 6 months have you:

72. **Missed a rent/mortgage payment because you did not have the money?**
73. **Missed a utilities payment because you did not have the money?**
74. **Gone without medication because you could not afford it?**
75. **Gone without food because you could not afford it?**
76. **How close is your nearest support person?**
77. **Have anyone you can call if you need help or assistance?**

Live 20 or more miles from the following?

78. **Shopping (grocery, clothing, personal care items, etc.**
79. **Pharmacy**
80. **Your doctor**
81. **Hospital**
82. **Have you ever been denied services based on where you live?**

Nutritional Screening

http://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdfhttp://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdf

83. **Do you have an illness or condition that has made you change the kind or amount of food you eat?**
84. **Do you eat fewer than 2 meals a day?**
85. **Do you eat few (to none) fruits or vegetables, or milk products?** This question presents the most problems for providers. The intent of this question is to see if the client has a well-balanced diet to include fruits or vegetables, or milk. It is not looking for a specific number on a daily basis. You want to know if the client has little to none in their diet – if so, answer yes. If they answer that they eat more than a few, that would be no.
86. **Do you have 3 or more drinks of beer, liquor, or wine almost every day?**
87. **Do you have tooth or mouth problems that make it hard for you to eat?**
88. **Do you sometimes not have enough money to buy the food you need?**
89. **Do you eat alone most of the time?**
90. **Do you take 3 or more different prescribed or over the counter drugs per day?**
91. **Without wanting to, I have lost or gained 10 pounds within the last 6 months?**
92. **Are you sometimes physically unable to shop, cook, or feed yourself?**
93. ***Homebound:** An individual who resides at home, and maybe at risk for institutionalization, and is incapable of performing at least two or more activities of daily living (ADLs) without substantial/extensive assistance, and is unable to leave home unassisted. When the individual does leave home, it must be to receive medical care or for short, infrequent non-medical reasons.
94. ***Living Alone:** A one person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
95. **General Comments**: These comments can only be viewed by the owning provider. They are "catch-all" comments.
96. **Medical Comments**: These comments can only be viewed by the owning provider. They are "catch-all" health related comments.

NON-WEIGHTED QUESTIONS are all pretty self-explanatory. If there appear to be concerns, I will continue this tutorial to include them.

ATTACHMENT 4

Client Selection Form

SANTEE-LYNCHES AAA/ADRC	Client's Name:	Date of Submission Date to

CLIENT SELECTION FORM		AAA/ADRC:
Client's Priority Risk Score:	Client's Nutritional Score:	☐ A New Client ☐ A Reassessed Client	Emergency Service Needed ☐ Yes ☐ No

Instructions: *If screening indicated client is eligible for requested service(s), complete AIM Assessment as a "Waiting Client" and attach the LG52 Report and the Eligibility Screening Form to this form. Also add an Excel Listing of Active Clients and a current AIM LG65a Report. Submit entire package to the AAA/ADRC for final approval of your recommendation. If more information is needed, a policy and procedure instruction is available to assist you*

✓	***Service(s) Requested***	***Units Requested Per Week***	***Available Funding***
	Level I Homemaking		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Group Dining		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Home Delivered Meal – Hot		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Home Delivered Meal – Frozen		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Transportation		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Physical Fitness		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____
	Other as specified:		☐ Full Funding ☐ No Funding ☐ Partial Funding If partial funding, provide the # of units that you can support each week: _____

Provider/Contractor Recommendation(s)

A--Serve Client immediately with "available" funding:	**B--Retain client in wait list status for service(s) listed:**
☐ Level I Homemaking	☐ Level I Homemaking
☐ Group Dining	☐ Group Dining
☐ Home Delivered Meal – Hot	☐ Home Delivered Meal – Hot
☐ Home Delivered Meal – Frozen	☐ Home Delivered Meal – Frozen
☐ Transportation	☐ Transportation
☐ Physical Fitness	☐ Physical Fitness
☐ Other: _____	☐ Other: _____

Recommended Start and Stop Dates of Service(s) listed in Section A, above. Stop Date(s) can be a specific date or identified as "Until Further Notice."

Extenuating circumstances that should be considered when determining status of client *(if additional space needed, attach further information):*

Signature of Provider/Contractor:	Phone Number:

AAA/ADRC Decision

☐ Approved as Recommend ☐ Submission incomplete or comments attached	AAA/ADRC Signature:	Date: Phone:

May 2013

ATTACHMENT 5

Service Care Plan

SANTEE-LYNCHES AAA/ADRC **SERVICE CARE PLAN**	**Client's Name:**	Date of Care Plan: _____ Date of Assessment: _____	**Prepared by:**

Service(s) to be Provided	*Problem/Need*	*Goal*	*Time Frame*	*Intervention*	*Service Dates:*
▫Group Dining Meals(C-1)	Client is relatively isolated and needs a nutritious meal and socialization _____ days a week	Client will be provided meals and recreation as scheduled	▫12 Months ▫6 Months ▫Other: _____	Site Manager will call client if he/she is a "no show" or assist the client if he/she becomes ill at the site	Start Date: End Date:
▫Home Delivered Meals - Hot (C-2)	Client is homebound and needs assistance in meal preparation	Client will receive a hot meal 5 days a week and a check on the health and well-being of the client. Client will be able to remain in his/her home and remain independent as long as possible	▫12 Months ▫6 Months ▫Other: _____	Van driver will report any pertinent information concerning client to Site Manager. The provider/contractor will take appropriate action if situation requires additional follow-up as necessary	Start Date: End Date:
▫Home Delivered Meals - Frozen (C-2)	▫Client is homebound and is unable to prepare or needs assistance to prepare complete meals. ▫Client requires an individual to check on him/her by phone on a regular basis due to lack of a support system	Client is able to use the microwave and will receive ____ frozen meals per week. Client will be able to remain in his/her home and remain independent as long as possible. Provider/contractor will be able to check on the client's health and well-being weekly or more often as requested by client or caregiver.	▫12 Months ▫6 Months ▫Other: _____	▫Van driver will report any pertinent information concerning client to Site Manager. The provider/contractor will take appropriate action when necessary ▫Due to lack of a support system, assessor/assistant will contact client by phone 5 days a week to check on his/her status if requested by client	Start Date: End Date:
▫Level I Homemaking III-B	Client is homebound and is unable to perform normal ADLs/IADLs. Client is in need of help with these activities. _____hours, ____days a week	Homemaker will assist in enabling client to remain in his/her own home. Client will receive the necessary help with requested home care chores	▫12 Months ▫6 Months ▫Other: _____	▫Homemaker will report pertinent changes in client's condition to supervisor. ▫Homemaker will perform short term respite care as needed.	Start Date: End Date:
▫Physical Fitness III-B	Client requires physical exercise to maintain or improve good health	Client's will have access to exercise equipment as often as they can attend the facility during the work week	▫12 Months ▫6 Months ▫Other: _____	Site manager will monitor client's use of equipment. Client will be encouraged to have a physical exam by his/her physician prior to use of equipment and then on a recurring basis	Start Date: End Date:
▫Transportation III-B	Client needs door-to-door transportation to and from the Senior Center and to medical appointments, etc.	Having access to public transportation will allow client more options for attending activities and to socialize as needed. Transportation to the	▫12 Months ▫6 Months ▫Other:	The provider/contractor will provide or arrange transportation for client in order to improve client's quality of life/independent living	Start Date: End Date:

		center will be required ____ days per week	_____		
☐Other Needed Services (attached)	Problem/Need:	Goal:	Time Frame:	Intervention:	Start Date End Date:

ATTACHMENT 6

Daily Telephone Reassurance Log

DAILY TELEPHONE REASSURANCE CALL LOG FOR RECIPIENTS OF FROZEN HOME DELIVERED MEALS (HDM)	Date: Individual Making the Calls

Instructions: According to the LGOA, those receiving frozen home delivered meals must be offered an opportunity to receive a daily reassurance call to check on their Health and Well-Being. If the individual fails to respond to your call, use client's assessment/reassessment to obtain the client's emergency contact information. If your efforts do not produce a response, request the police to physically check on the client. Document any action(s) you took during the daily calls.

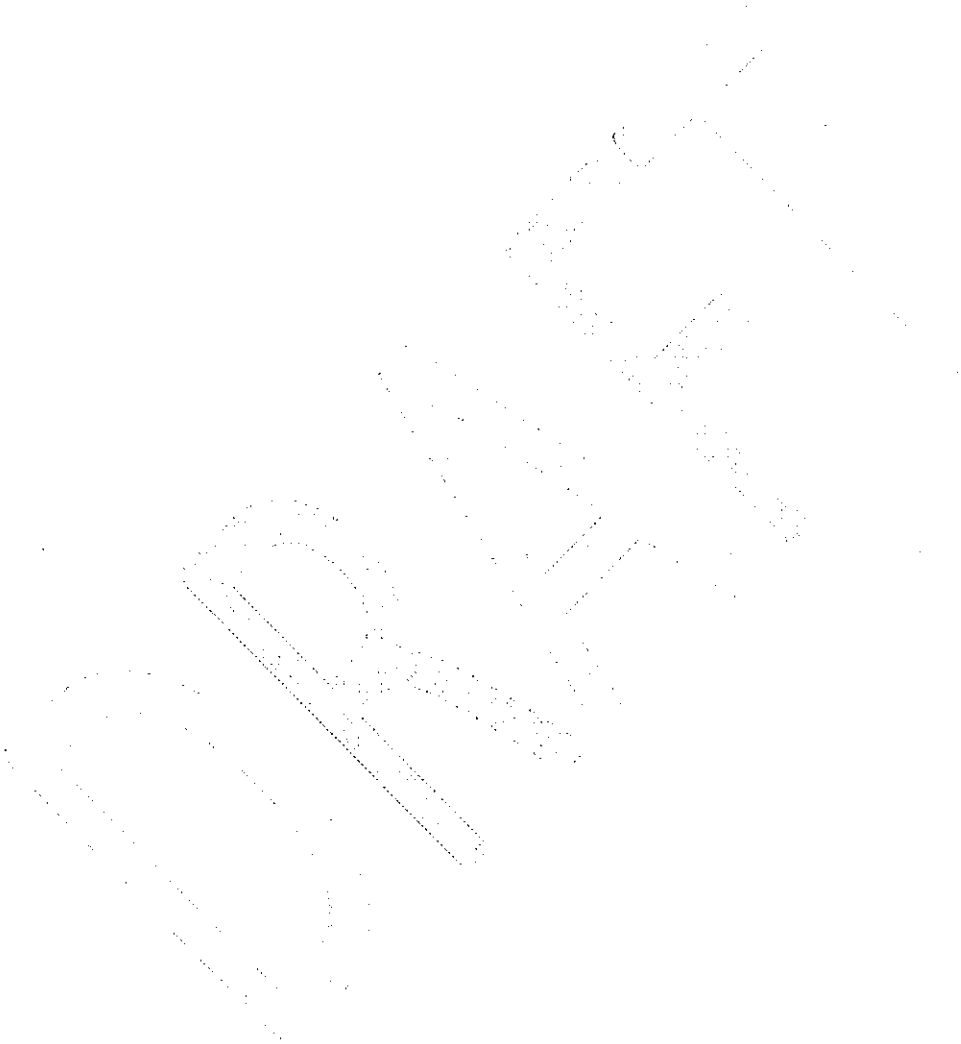
#	*Client's Name*	*Phone Number*	*Response Received*
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status
			☐ Client reached no further action needed ☐ Open Status

ATTACHMENT 7

Service Care Plan Progress Notes

SERVICE CARE PLAN PROGRESS NOTES	Client's Name:	
Date	Reason for Action and Results Affecting Client's Need or Achievement of Client's Goal	Action taken by or Info received by

May 2013



Site/Date:

Client's Name:

RECORD'S REVIEW - ACTIVE CLIENT

Type of Service(s) Received (√):

Grp Dining/Cong Meal ___	*Transportation___*
Hot Home Del Meal ___	*Physical Fitness/Exercise___*
Frozen Home Del Meal ___	*Homemaking Level I___*

Other Service:

#	*Item Required in File*	*Yes*	*No*	*Date*
1	Original Assessment			
	Reassessment			
	Consent Form			
2	Was it Completed & Signed			
	Problem(s):			
3	Priority Rating Form			
	Was it Completed & Signed			
	Problem(s):			
4	Service Plan			
	Was it Completed & Signed			
	Does it match AIM Report			
	Does it match Assessment or Reassessment & Quick Assessment (if used)?			
	Problem(s):			
	Diabetic Client (or)			
	Other Needing Special Meal			
	Modified Meal Served			
	Regular Meal Served			
	Dr's Approval on File			
	Client's Waiver on File			
	Problem(s):			
6	Summary: Was Service Plan, Assessment of Client & Client's Situation Logical?			
	Problem/Issue(s):			
7	Other Comments (use reverse if needed):			

RECORD'S REVIEW - INACTIVE CLIENT

Type of Service(s) Received (√):

Grp Dining/Cong Meal ___	*Transportation___*
Hot Home Del Meal ___	*Physical Fitness/Exercise___*
Frozen Home Del Meal ___	*Homemaking Level I___*

Other Service:

1	Date Terminated:
2	Reason for Termination:
3	Comments (use reverse if needed):

Site/Date:

Client's Name:

RECORD'S REVIEW - ACTIVE CLIENT

Type of Service(s) Received (√):

Grp Dining/Cong Meal ___ Transportation___
Hot Home Del Meal ___ Physical Fitness/Exercise___
Frozen Home Del Meal ___ Homemaking Level I___

Other Service:

#	Item Required in File	Yes	No	Date
1	Original Assessment			
	Reassessment			
	Consent Form			
2	Was it Completed & Signed			
	Problem(s):			
3	Priority Rating Form			
	Was it Completed & Signed			
	Problem(s):			
4	Service Plan			
	Was it Completed & Signed			
	Does it match AIM Report			
	Does it match Assessment or Reassessment & Quick Assessment (if used)?			
	Problem(s):			
5.	Diabetic Client (or)			
	Other Needing Special Meal			
	Modified Meal Served			
	Regular Meal Served			
	Dr's Approval on File			
	Client's Waiver on File			
	Problem(s):			
6	Summary: Was Service Plan, Assessment of Client & Client's Situation Logical?			
	Problem/Issue(s):			
7	Other Comments (use reverse if needed):			

RECORD'S REVIEW - INACTIVE CLIENT

Type of Service(s) Received (√):

Grp Dining/Cong Meal ___ Transportation___
Hot Home Del Meal ___ Physical Fitness/Exercise___
Frozen Home Del Meal ___ Homemaking Level I___

Other Service:

1	Date Terminated:
2	Reason for Termination:
3	Comments (use reverse if needed):

APPENDIX 500B: INSPECTION CHECKLIST FOR SENIOR CENTERS/NUTRITION SITES

Service Provider: _____

Site: _____

Inspector: _____ **Date:** _____

PERSONNEL ISSUES

_____ 1. All serving personnel are clean, wear gloves, aprons, and head/hair covering, and are free of cuts and infections.
_____ 2. All personnel eat, drink and smoke only in approved areas or break room.

FACILITY AND EQUIPMENT ISSUES

_____ 3. Facility is handicap accessible.
_____ 4. Floors and walls are clean, clear of clutter, and in good repair.
_____ 5. Room is well ventilated and has a comfortable temperature.
_____ 6. Lighting is adequate.
_____ 7. Tables, counter-tops, and surfaces near food serving areas are clean, sanitized, and well maintained. Wiping Cloths, of not disposable, must be kept in sanitizing solution of one part bleach to ten parts water during the Day, washed and dried at night.
_____ 8. Hand-washing facilities are equipped with hot (>110°) and cold water, soap and sanitary towels.
_____ 9. Water source id safe: hot/cold/good pressure.
_____ 10. Restroom facilities are clean, adequate, accessible, in good repair, and are well-stocked with supplies.
_____ 11. Garbage us contained is covered receptacles, of adequate number, kept away from serving area, with the surrounding area clean and free of insects/rodents.
_____ 12. Vermin such as flies, cockroaches, mice, etc., are controlled.
_____ 13. Food and single-use supplies are stored in a safe manner, and cleaning supplies are stored in separate place, away from food and food serving supplies.
_____ 14. Food carriers used to transport individually portioned meals to homes are insulated, clean, and can be sanitized.

FOOD SAFETY ISSUES

_____ 15. Approved probe thermometer is available and accurate. Temperatures are measured and recorded.
_____ 16. Temperatures of potentially hazardous foods are maintained at minimum temperature requirements; hot, 130 degrees, and cold 45 degrees.
_____ 17. Food is portioned properly, using correct utensils and sanitary food handling techniques.
_____ 18. An approved method of food service is used.
Sneeze guards on display cases, or
Tray preparation in a protected area and handed to clients as they pass through a service window or doorway, or given to a volunteer who takes the tray to the client at the table.
_____ 19. Food is from approved sources.

COMMENTS, NEEDED CORRECTIONS, AND CORRECTION COMPLETION DUE DATE:

_____
_____
_____
_____
_____

	CONGREGATE MEALS (GROUP DINING) **CLIENT INTERVIEWS**	Date:
Greet the client, explain who you are, and then ask the client if they would like to answer a few questions. Explain that you will be writing down the answers, they won't have to write anything. If they don't want to participate, tell them that's okay, then just thank them for talking to you. Note: These questions are meant to be a guide for the interview, other questions may also be asked.		
1	**How many days a week do you come to the meal site to eat a meal?** Response:	
2	**How long have you been coming?** Response:	
3	**Do you ride the van or how do you get here?** Response:	
4	**If you came by van:** (a) Does the van usually come on time? (b) Who helps you get in and out of the van when you need help? (c) Are the drivers courteous? (d) Do you feel safe riding the vans? (e) Are the vans clean? (f) Would you like to see any transportation changes? If yes, what are they?	
4	If you know that you are not going to be coming to eat, what do you do? Who do you call? Do you know what phone number to call to let them know that you can't come? Response:	

CONGREGATE MEALS (GROUP DINING) CLIENT INTERVIEWS	Date:

Greet the client, explain who you are, and then ask the client if they would like to answer a few questions. Explain that you will be writing down the answers, they won't have to write anything. If they don't want to participate, tell them that's okay, then just thank them for talking to you. Note: These questions are meant to be a guide for the interview, other questions may also be asked.

1	**How many days a week do you come to the meal site to eat a meal?** Response:
2	**How long have you been coming?** Response:
3	**Do you ride the van or how do you get here?** Response:
4	If you came by van: (a) Does the van usually come on time? (b) Who helps you get in and out of the van when you need help? (c) Are the drivers courteous? (d) Do you feel safe riding the vans? (e) Are the vans clean? (f) Would you like to see any transportation changes? If yes, what are they?
4	If you know that you are not going to be coming to eat, what do you do? Who do you call? Do you know what phone number to call to let them know that you can't come? Response:

QUESTIONS FOR COA INDIVIDUAL(S) CONDUCTING CLIENT ASSESSMENTS/REASSESSMENTS

May 06

County:	Individual's Name:	Telephone Number:

#	*Items to Check*	*Yes*	*No*	*NA*
1	From the beginning to the end, please explain the complete procedures you use when conducting the "initial" assessment. (1) How are you informed that an assessment is needed? (2) Is the assessment face-to-face? (3) What do you do with the assessment after you received the information? Comments:			
2	For Those Clients Receiving Meals: (1) If the client has a medical condition that might require a special diet (diabetic for example), how do you determine the type of meal that is should be ordered for the client? (2) For those receiving frozen meals: (a) Do you check the freezer for available space and if it working properly? (b) Do you check to see if the stove or microwave is working properly? (c) Do you check to see if the client is able to operate the equipment? Comments:			
3.	What are the complete procedures for "reassessments? (1) How often do you accomplish the reassessments? (2) How do you know it's time to accomplish one? (3) Are the reassessments face-to-face or by phone? (4) Do you get an updated Doctor's approval statement for the regular meals if the client has a diet restriction? Comments:			

Interviewers Name:	Date:

Santee-Lynches Area Agency on Aging P.O. Box 1837 Sumter, SC 29154 (803) 775-7381	QUALITY ASSURANCE (QA) MONITORING REPORT
Date(s) of Visit:	Council on Aging/Contractor:
QA Team/Reviewers:	
Area Monitored: GROUP DINING PROGRAM	

#	Summary of Findings and Recommendations	*Place "X" in Box* Yes	No
1	STANDARD 1.2: The contractor assures that all personnel providing group dining services shall receive initial and ongoing training. Indicator: 1. Personnel who interface with participants shall receive training to recognize major physical and emotional needs of the aging or special needs participants, including observation and recognition of signs of trouble or emergency. 2. Within three months of hire, new dining center staff and all volunteers who handle food receive training in portion control and safe food handling procedures. 3. Dining center staff complete a course in First Aid and CPR within twelve months of employment and a refresher course every three years. 4. Dining center staff receive four hours of training in *nutrition education and/or health education* and recreation programming each year. 5. Within three months of hire, and annually thereafter, all dining center staff receive training in the use of fire safety equipment and proper evacuation procedures. Comments:		

	STANDARD 1.3: The contractor provides adequate supervision of all personnel, paid and volunteer. **Indicator 3 thru Indicator 5** 3. All dining center staff shall have a designated supervisor with whom they have routine contact. 4. There shall be a designated supervisor available during all hours the group dining centers are open. 5. All staff receive and understand the contractor's policy on confidentiality regarding service recipients. **Comments:**		
#	Summary of Findings and Recommendations	Yes	No
3	**STANDARD 3.3:** The contractor assures that participants are provided information and/or referral for other benefits to which they may be entitled. **Indicator:** 1. At each assessment or reassessment of participants, those who meet eligibility criteria are provided information about programs such as Food Stamps, Home Energy Assistance, Caregiver Assistance, and Medicaid. **Comments**		

3	STANDARD 3.2. The contractor uses a priority system to assure that those most in need receive Group Dining services. Indicator #2 – Applicants determined to be at nutrition risk must be given first priority for services. Individuals referred to the program because of inadequate nutrition receive services within two-week referral, if possible. (Also reference Scope of Work, Documentation Section, #3, which states: "Provide documentation of initial participant registration and annual information updates, nutrition risk assessment, and termination forms when applicable.") Comments:		
	STANDARD 3.5: The contractor assures that the termination of group dining services shall be a carefully planned process. Indicators: 1. When it becomes necessary to terminate an individual who poses a threat to the health and/or safety of others or who repeatedly fails to follow program guidelines, the contractor follows clearly defined criteria to plan for that termination. 2. Prior to making a decision to terminate an individual, the contractor staff may try decreasing service levels or other alternatives to service termination. 3. As appropriate and feasible, the participant, or their responsible party, shall be involved in planning for the termination of services. 4. All notices of service termination shall include written procedures to be followed if the service needs to be reinstated. Comments:		

4	**STANDARD 4.2.** The contractor arranges for the provision of modified meals and/or therapeutic diets, where feasible and appropriate. **Indicator #4** – Established procedures assure that each participant requiring therapeutic or modified meals receives only the meal ordered for the individual. **Comments:**	X	
5	**STANDARD 4.3.** The contractor assures that all food service operations follow applicable DHEC procedures and requirements. **Indicator #1** -- Staff and volunteers handling food follow appropriate DHEC hygienic techniques and practices. **Comments:**		X
#	Summary of Findings and Recommendations	Yes	No

Indicator 2

All foods used and served meet those standards of quality, sanitation and safety that apply to foods that are purchased commercially. Only commercially prepared or commercially canned foods may be used.

Indicator 3

Potentially hazardous foods are held, delivered and served at temperatures above 135 degrees F. or below 40 degrees F. Procedures are in place to document delivery times and temperatures.

Indicator 4

Just prior to panning food, temperatures are taken and recorded to ensure proper temperatures at time food leaves kitchen.

Indicator 5

All food delivery carriers and vehicles used to transport food and supplies to dining centers are clean and able to maintain proper hot and cold temperatures, as necessary, until delivery is completed.

Indicator 6

Every effort should be made to limit the time from delivery to serving the food to no more than three hours.

Indicator 7

If used, frozen meals shall be brought to serving temperatures in a way that ensures palatability and safe temperature.

The following two indicators apply to all group dining contractors:

Indicator 8

If group dining centers use permanent tableware or flatware the contractor follows DHEC manual for mechanical cleaning and sanitizing procedures and storage methods.

Indicator 9

Just prior to plating food, temperatures are taken and recorded to ensure proper temperatures at time food is served.

:

Comments

6	**STANDARD 4.5**: The contractor has appropriate and adequate procedures to handle participant, facility, and service emergencies. **Indicator #2** – Participants needing special assistance during declared emergencies issued by the National Weather Service, the Governor, or any emergency announced on the Emergency Broadcast Network, are identified and a plan for meeting their needs has been developed. **Comments**	X	
7	**STANDARD 4.6:** The contractor assures that participants have social, recreational, or educational activities each day. **Indicator #3** – Pre-planned events are scheduled to provide a maximum variety of activities to participants each month. **Comments**		

Other Information/comments

AAA Staff Member:	Date:

NUTRITION PROGRAM
QUALITY ASSURANCE OBSERVATIONS

Nutritional Site:	Date(s) of Visit:
AAA Monitor(s):	

#	***GROUP DINING MEAL COUNTS***
1	Number of Meals Ordered for Day:
2	Number Signed In:
3	Actual Head Count:

Comments

#	***OBSERVATIONS - Standard 4.3, Indicator #1***		
1	Observe nutrition staff plating the home delivered meals and serving the group dining participants to ensure they are practicing good hygienic techniques.		
	As a Minimum Look for These Practices	***YES***	***NO***
	Are staff members wearing gloves, hat/hairnets/other head covering, and aprons?		
	Comments:		
2	***OBSERVATIONS – Standard 4.3, Indicator #4***	***YES***	***NO***
	Observe nutrition staff taking temperatures of the hot and cold items. Temperatures per standard are: Above 130 degrees (hot) and Below 45 degrees (cold)		
	Record the following times and temperatures		
	Meal Arrival: What time did the food arrive from the Caterer: _____ What were the Arrival Hot Temperature Readings: _____ What were the Arrival Cold Temperature Readings: _____		
	Home Delivered Meals: What time were the hot home delivered meals plated: _____ What were the Plated Hot Temperature Readings: _____ What were the Plated Cold Temperature Readings: _____		
	Group Dining Meals: What time were the group dining room meals served: _____ What were the Served Hot Temperature Readings: _____		

	What were the Served Cold Temperature Readings: _____		
3	If the temperatures were outside the acceptable limits (130 degrees F for hot and 45 degrees F for cold), were second temperatures taken with the back up thermometer?		
4	Are pre-plated frozen meals stored at 0 degrees F or lower and delivered in a frozen solid state?		
	SHORTAGES AND OVERAGES		
5	What procedures are taken if there are shortages? Do you get reimbursed? How often does this occur? Comments:		
6	What do you do with excess food? Why are there extras (from caterer, wrong spoons, missing clients? How often does this occur? Who you have written procedures that I can have and do you make your clients aware of them? Is food taken out of the site? Comments:		
	OTHER OBSERVATIONS		
7	Are food delivery carriers clean and able to maintain proper hot and cold temperatures? Comments:		

Site Manager: _____

NUTRITION PROGRAM
QUALITY ASSURANCE OBSERVATIONS

Nutritional Site:	Date(s) of Visit:
AAA Monitor(s):	

GROUP DINING MEAL COUNTS & SERVING PREPARATION

#					
		C1 (Group Dining)		C2 (Home Delivered)	Frozen
1	Number of Meals Ordered for the Day				
		Yes	No	Comments	
2	Was food counted by site personnel when it was delivered?				
3	Number of Group Dining Clients Who Made Reservations:				
4	Number of Group Dining Clients Who Signed In:				
5	The Actual Head Count as Meals were served:				
6	Did the site personnel prepare to serve using the correct utensils for proper plating of the food? (The utensils are specifically listed on the Food Delivery Sheets – this ensures each client gets the correct food portion and it helps eliminate overages/shortages) Yes _____ No _____				
7	Does the site have 2 thermometers? (They should have one primary and one backup) Yes _____ No _____				

RECORDINGS OF TEMPERATURE

#	
1	***Meal Arrival*** What time did the food arrive from the Caterer: _____ What was the Arrival Hot Temperature Reading: _____ What was the Arrival Cold Temperature Reading: _____
2	***Home Delivered Meals:*** What time did the site begin plating the hot home delivered meals: _____ What was the temperature reading of the selected hot food item: _____ What was the temperature reading of the selected cold food item: _____ Do the home delivery containers appear to be able to hold the meals at a safe temperature? Yes_____ No: _____ Are the containers used to hold these meals clean? Yes_____ No_____

Group Dining Meals:

What time did the site begin plating the group dining room meals: _____

What was the temperature reading of the selected hot food item: _____

What was the temperature reading of the selected cold food item: _____

Important Notes on Food Temperatures

If the temperatures were outside the acceptable limits (135 degrees F for hot and 45 degrees for cold) were second temperatures taken with the back-up thermometer:

Yes _____ No: _____ Not Applicable: _____

Are pre-plated frozen meals stored at 0 degrees F or lower and delivered in a frozen solid state? (Only way to check this is to check to see if the frozen meals are frozen hard before they leave the site and that the containers they are placed in for delivery appear to be adequate to keep them frozen)

Yes _____ No: _____ Not Applicable: _____

SHORTAGES AND OVERAGES

1	What procedures are taken if there are shortages? How often does this occur in a month? Does the site have any written procedures on this?
2	What procedures are taken when there are food overages? How often does this occur in a month? What do you do with the extra food – do they ever: Feed the volunteers? Allow the dining-in clients to have extra servings? Throw it away? Let clients take the food home for themselves or their animals? Freeze or refrigerate it for later?). Does the site have any written procedures on this?

Important Note: Extras may be the result of the staff not using the utensils identified for serving, caterer gave them too much, clients with reservations didn't show, or site didn't know how many to order and ordered to much.

Volunteers may be served if they have worked at least 5 hours per week. Clients are usually not given another serving as they may have health problems that would prevent this, and food is never taken out of the facility unless if is an approved home delivered or frozen meal. The food cannot be saved or held for another time either.

NUTRITION SUPERVISOR INTERVIEWS		County	Date
1	What training have you received concerning Group Dining or Home Delivered Meals Supervision? Who trained you? Response:		
2	How many days a week do you work? What are your hours? Response:		
3	Do you assess Group Dining Meal Clients and/or Home Delivery Meal Clients? How Often? Where is the assessment /reassessment conducted? Response:		
4	How many clients do you have on a waiting list for HDM and Group Dining Meals? Response:		
5	Approximately what time does the food arrive each day? Approximately what time dose the staff/volunteers begin to plate the meals? Response: HDM: _____ Group Dining _____		
6	What do you do if a group dining client fails to come when they have made a reservation? Response:		
7	What are your procedures if a client becomes ill at the site? Are the procedures in writing? Did you train your staff on the procedures? Response:		
8	What are your procedures if you find that the client does not come to the door for his/her home delivered meals? What if he/she is found ill, injured, or deceased? Response:		

9	What are the Councils on Aging procedures for weather-related emergencies, disasters, or situations that interrupt the meal service? Are these procedures in writing at this site? Response
10	Does the weather-related plan, identified above, include anything about meeting the needs of the client? Response
11	Do you have procedures in place to start up HDMs if a regular group dining client cannot continue with the group dining arrangements? .
12	Do you visit assigned sites no less than quarterly to observe there operations? Are these trips recorded anywhere? Response:
13	Do you solicit participants' menu input while visiting the sites? Response:
14	Are nutritional and health information provided to clients on a monthly basis? Response:
15	Describe the activities that are conducted daily/monthly (social, recreational, and educational)? Get schedule for last 3 months or get examples of each: Social: _____ Recreational: _____ Educational: _____
16	Who plans the programs and activities? Response:

GROUP DINING MEAL COUNT		
Today's Date:	Site:	Name of Site Manager or Individual Contacted:
1	Number of Meals Ordered for Day:	
2	Number Signed In:	
3	Head Count:	
Comments:		
Name of AAA Monitor:		

GROUP DINING MEAL COUNT		
Today's Date:	Site:	Name of Site Manager or Individual Contacted:
1	Number of Meals Ordered for Day:	
2	Number Signed In:	
3	Head Count:	
Comments:		
Name of AAA Monitor:		

GROUP DINING MEAL COUNT		
Today's Date:	Site:	Name of Site Manager or Individual Contacted:
1	Number of Meals Ordered for Day:	
2	Number Signed In:	
3	Head Count:	
Comments:		
Name of AAA Monitor:		

QUESTIONS FOR COA INDIVIDUAL(S) ESTABLISHING CLIENT PRIORITY

May 06

County:	Individual's Name:	Telephone Number:

#	*Items to Check*	*Yes*	*No*	*NA*
1	From the beginning to the end, please explain the complete procedures you use when establishing the client's priority (1) Is this done during the initial assessment (2) Do you use a computer? (3) Do you update annually? (4) What do you do with the priority paperwork after you are done with your input collection and calculations? Comments:			
2	How often do you update the priority of a client? Comments:			
3	How do you terminate services – why and what procedures do you use? Comments:			
4	What do you do when a client, doctor, or family member says client needs a modified or therapeutic meal? Are these procedures in writing?			

SANTEE-LYNCHES AAA QUALITY ASSURANCE VISIT

Items needed to have ready or information to be supplied before visit. Those identified with an "*" should be faxed as soon as possible. Also please ensure your staff and the volunteers are aware of this visit.

1	AIM reports listing the names of all ACTIVE clients receiving the following services from your COA: a. Home Delivered Meals – Hot b. Home Delivered Meals – Frozen c. Group Dining Meals d. Transportation Services e. Home Care Level I f. Physical Fitness g. Other service(s) you provide	Please have one report for each activity. Please include only those that are paid from funds received from the AAA – not CLTC. As a minimum, please ensure each report includes client's full name, home phone, address, and city.
2	AIM report listing the name of all INACTIVE clients within the last year	This can be one listing of those former clients who received services from AAA funding
3	AIM Report SC 22, which provides a listing that includes (as a minimum) the name, address, phone number, and date of next reassessment	
*4	Please provide name and phone number of each activity supervisor: Home Care Level 1 Supervisor Transportation Supervisor Hot Home Delivered Meals Supervisor Frozen Home Delivered Meals Supervisor Group Dining Supervisor	
*5	Reconfirm all locations where you are serving meals (hot HDMs, frozen HDMs, group). Provide current listing of each site managers, telephone numbers and fax numbers. Other than the supervisors listed above, are there any other assigned managers that oversee more than one site?	
*6	a. How many COA vehicles/vans do you have? How many of them are handicapped equipped? b. If you are contracting any of the transportation services, please provide a current copy of the contract and your primary point of contact for these services (name and telephone number).	Please ensure contractors are aware of this visit and that we will need to contact them.

*7	How many COA drivers (paid and volunteer) do you have? What are their names and when is the best time to talk with them on the date of our visit?	
*8	a. How many home care workers do you have (paid and volunteer)? What are their names and when is the best time to talk with them on the date of our visit? b. If you are contracting the services, please provide a copy of the current contract and your primary point of contact for these services (name and telephone numbers).	Please ensure contractors are aware of this visit and that we will need to contact them.
*9	Who is responsible for conducting your Assessments/Reassessments?	
10	Blank copies of the following forms that you are using: - Service Plan - Quick Reference Sheet (if used) - Assessment/Reassessment - Consent Form - Priority Rating Forms - Home Care Level 1 Client Service Record - Other forms or form letters you use to simplify your work (for example client waiver forms for meals, physician form letters, etc)	Consent forms were already received under separate cover
*11	Number on waiting list for each service you provide	

Note: Kathy Richardson will be contacting you, under separate letter, with the items she will need for her review.

Thank You!!!

MONTHLY ACTIVITIES OF GROUP DINING SITES				Date:
Nutritional Site:				
Point of Contact at Site:				**QA Reviewer:**
#	***Area of Review***	***Yes***	***No***	***Number of Events Per Month***
1	Besides the group dining meals, is the nutritional site offering a variety of programs (listed below) that appeal to a wide-range of clients?			
	a. Social Events (birthday or holiday celebrations, picnics, etc.)?			
	b. Educational Programs (computer classes, writing workshop, etc)?			
	c. Recreational Program (games, arts and crafts, etc)?			
	d. Cultural Programs (book club, poetry, theater/plays)?			
	e. Musical Programs (choir, dance, musical entertainment, etc)?			
	f. Health and Wellness Programs (exercise classes, nutrition training, medication management, etc)?			
2	Are the offered programs rotated or repeated sufficiently so each group attending the site has an opportunity to experience the program?			
3	Are the clients asked for input when developing the schedule of events?			
4	Are the events scheduled one month in advanced?			
5	Are the clients aware of the scheduled events (i.e., scheduled posted, announcements made, etc)?			
6	Is a copy of the schedule maintained for at least one year?			
7	Is the number that attended each of the scheduled events recorded and kept on file?			
8	Is the schedule and number of attendees available for review by Santee-Lynches AAA?			
Comments:				

NUTRITIONAL RECORD'S CHECK - WORKSHEET

County		Monitor(s)							
#	Item to Monitor	Worker 1	Worker 2	Worker 3	Worker 4	Worker 5	Worker 6	Worker 7	Worker 8
1	Has the COA established a record for each Nutritional Worker?								
2	Does Group Dining Site Manager have High School/GED Diploma and min 1 year experience in health, nutrition, or human services?								
3	Is the nutritional worker trained to recognize major physical/emotional needs of the aging/special needs, including observation and recognition of trouble or emergency								
4	Has worker completed course in First Aid and CPR within 12months of employment and a refresher course at least every 3 years?								
5	Has site staff received 4 hours of nutritional education and/or health education and recreation programming each year?								
6	Has staff received training in the use of fire safety equipment and proper evacuation procedures, within 3 months of hire and annually thereafter								
AAA Monitor Signature							Date		

Santee-Lynches Area Agency on Aging P.O. Box 1837 Sumter, SC 29154 (803) 775-7381	**QUALITY ASSURANCE (QA) MONITORING REPORT**
Date(s) of Visit:	Council on Aging/Contractor:
QA Team/Reviewers:	
Area Monitored: **HOME DELIVERED MEAL (HDM) PROGRAM**	

#	*STANDARD AND INDICATORS*	*Place "X" in Box* Yes	No
1	**STANDARD 1.2**: The contractor assures that all personnel (paid and volunteers) providing HDM services shall receive initial and ongoing training. **Indicator #1** – All personnel who interface with participants are trained to recognize major physical and emotional needs of the aging or special needs participants, including observation and recognition of signs of trouble or emergency. ***(Verify by interviewing site manager, volunteers, and review personnel files)*** Comments:		
	Indicator #2 Within three months of hire, meal deliverers are instructed in reporting special request of participants, meals uneaten, and observations of the physical and mental conditions of the participants and the physical and social environment. ***(Verify by interviewing site manager, volunteers, and review personnel files)*** Comments:		
	Indicator #3 - All appropriate staff receive training in the use of fire safety equipment and proper evacuation procedures within three months of hire and annually thereafter. ***(Verify by interviewing site manager, volunteers, and review personnel files)*** Comments:		

2	**STANDARD 2.2:** The contractor assures that the HDM program and caterer facilities are in compliance with applicable Department of Health and Environmental Control (DHEC) requirements, as published in Food Service Establishments Regulations-61-25, local occupancy and fire safety requirements, and have adequate security. **Indicators.** 1. All facilities where meals are assembled for delivery are clean and sanitary and have the necessary equipment to keep food items free of contamination and at proper temperatures. 2. Food service items and cleaning supplies are stored in separate storage areas. 3. All facilities are equipped to limit the theft of food items, supplies and equipment as much as possible. 4. There is periodic inspection to verify that all facilities used in the operation of the HDM program meet local fire and occupancy ordinances. 5. All the facilities used in the operation of the HDM program have installed smoke alarms and the number and type of fire extinguishers required. Fire evacuation procedures are posted and fire extinguishers have current inspection tags. Comments:		
3	**STANDARD 3.1:** The contractor assures that HDM services are provided to eligible individuals who are at nutrition risk and have the greatest economic, social, and/or health need. **Indicators:** 1. Those eligible for HDM services are individuals who are: (a) age 60 or over and *homebound*; (b) spouses of eligible service recipients, regardless of age; (c) disabled persons under 60 years of age that reside with a homebound older recipient if it is in the best interest of the older person; and (d) individuals of any age who volunteer to deliver meals on a daily basis, if allowable in the RFP issued by the AAA. 2. Priority for this service shall be given to eligible individuals who meet one or more of the following conditions: (a) at high *nutritional risk*; (b) unable to prepare meals without assistance; (c) unable to shop for food without assistance; (d) unable to eat without assistance; and (e) lack adequate support from relatives or other caregivers.		

3	**Indicators:** 3. Those eligible for HDM services are individuals who are: (a) age 60 or over and *homebound*; (b) spouses of eligible service recipients, regardless of age; (c) disabled persons under 60 years of age that reside with a homebound older recipient if it is in the best interest of the older person; and (d) individuals of any age who volunteer to deliver meals on a daily basis, if allowable in the RFP issued by the AAA. 4. Priority for this service shall be given to eligible individuals who meet one or more of the following conditions: (a) at high *nutritional risk*; (b) unable to prepare meals without assistance; (c) unable to shop for food without assistance; (d) unable to eat without assistance; and (e) lack adequate support from relatives or other caregivers. 5. Applicants determined to be at high nutrition risk must be given first priority for services. 6. When individuals referred to the program because they are at high nutritional risk cannot be provided services within two weeks the contractor shall notify the referring entity of a projected date that service will be available. 7. Outreach activities are conducted in the communities served by the contractor to inform older persons and others in the community of the availability of the HDM program. *Provide documentation of service management activities including an individual participant file and initial assessment, annual reassessment, nutrition risk assessments (priority rating), meal service plan, appropriate progress notes, and termination forms when applicable.* Comments:		

4	**STANDARD 3.2**: The contractor assures that participant assessments are performed promptly and thoroughly. **Indicator #1** The face-to-face assessment is completed within 30 days of service initiation in the home with the participant and the participant's personal Representative if needed. Participants are reassessed annually unless more frequent reassessments are required. The assessment includes uniform criteria. Comments: **Indicator #2** A written *meal service plan* is developed for each service recipient that indicates: 1. the type of meals to be served (hot, frozen, shelf stable); 2. any dietary restrictions; 3. the days of the week and number of meals per day that will be provided; 4. the need for meals in emergency situations; 5. the individual's ability to attend congregate dining events on occasion; and 6. referrals to other service providers if all elements of the plan cannot be met by the HDM contractor. Comments:		

5	The contractor assures that the participant's rights regarding the provision of home delivered meal services. ***(Not a Standard But needs to be reviewed)*** **Indicator #1** - Prior consent to provide HDM services is obtained from the participant or personal representative except in emergency and/or protective services cases. Comments:		
6	**STANDARD 3.5:** The contractor assures that the termination of HDM services shall be a carefully planned process. **Indicators:** 1. When it becomes necessary to terminate an individual's participation in the HDM program the contractor follows a clearly defined criteria to plan for that termination. 2. Reasons for termination may include failure to follow program guidelines. 3. Prior to making a decision to terminate an individual, contractor staff may try decreasing service levels or other alternatives to sudden service termination. 4. The service recipient or caregiver, if appropriate and feasible, are involved in the planning for the termination of services. 5. All notices of service termination shall include written procedures to be followed if the service needs to be reinstated. Comments:		

7	**STANDARD 4.3 & STANDARD 4.4:** The contractor assures that all food service operations follow applicable DHEC procedures and requirements. [OAA Sec. 339(2)(F)]. 1. Staff and volunteers preparing food follow appropriate DHEC hygienic techniques and practices (proper hand washing procedures and put on gloves immediately before handling food items when plating meals). 2. *Potentially hazardous foods* are delivered, held and served at temperatures above 135 degrees F. or below 45 degrees F. 3. Just prior to portioning food for delivery to meal service centers, hot and cold temperatures are taken and recorded to ensure proper temperatures. Procedures are in place to document delivery times and temperatures at the meal service centers. 4. All food delivery carriers and vehicles used to transport food and supplies to meal service centers are clean and able to maintain proper hot and cold temperatures until delivery is completed. 5. Every effort should be made to limit the time from delivery of food at the meal service center to plating it for delivery to recipients to no more than three hours. 6. Pre-plated frozen meals are stored at 0 degrees F or less. *(Interview driver and staff to find out how food is maintained at that temperature)* Comments:		
8	**STANDARD 4.6:** The contractor has appropriate and adequate emergency arrangements. Indicator #3 – Participants needing special assistance during declared emergencies are identified and a plan for meeting their needs is developed. Comments:		
9	**STANDARD 4.7:** The contractor assures that nutrition and health information is provided. Indicator #1 – Pre-planned nutrition and health information or handouts are provided to participants at least monthly. Comments:		

Other Information/comments

Signature of AAA Staff Member:	Date:

VEHICLE DRIVER QA MONITORING	COA:	Driver's Name: _____

#	*Items to Check or Questions to Answer*		
	Driver's Information	*Yes*	*No*
1	Does the driver have a current SC driver's license and is it current?		
2	Does the driver have less than 6 points against his/her record? If no, how many does he/she have? _____		
	Frozen Meals Delivery	*Yes*	*No*
3	Do you deliver frozen meals? If so, how do you keep the frozen meals frozen and the cold foods (milk, fruit cocktail, etc) cold? *Comments*:		
4	Do the frozen meals stay frozen to the touch when they arrive at the clients' homes?		
5	Are the cold items (like milk, fruit cup, etc) still cold when they arrive at the clients' home?		
6	Do the clients ever ask you how to cook the frozen meals?		
7	Do the clients seemed confused about using a stove or microwave?		
8	Do you ever deliver any educations pamphlets or brochures to your frozen meal clients?		
	What do you do with the frozen meals and cold food if the client doesn't answer the door?		
	a. Leave the food at the door if you think they are at home?		
	b. Leave the food with a neighbor/family member?		
	c. Call them or a family member on the phone?		
	d. Bring the frozen/cold food back to the kitchen and tell the supervisor?		
	(Is the food still frozen/cold by the time you get back to the kitchen?)		
	Hot Meal Delivery	*Yes*	*No*
10	Do you deliver hot meals? If so, how do you keep the hot meals hot and the cold foods (milk, fruit cocktail, etc) cold? *Comments*:		
11	Do the hot meals stay hot to the touch when they arrive at the clients' homes?		
12	Are the cold items (like milk, fruit cup, etc) still cold when they arrive at the clients' home?		
13	Do you ever deliver any educations pamphlets or brochures to your hot meal clients?		
	What do you do with the hot meals and cold food if the client doesn't answer the door?		
14	a. Leave the food at the door if you think they are at home?		
	b. Leave the food with a neighbor/family member?		
	c. Call them or a family member on the phone?		
	d. Take the hot and cold foods back to the kitchen and tell the supervisor?		
	(Is the food still at a good temperature by the time you get back to the kitchen?)		
	e. Just throw away the food since no one is home and the food will spoil?		
15	Do any of the clients that you deliver to cook (on their own) all the time?		

Thank you for your time!!!

Santee-Lynches Area Agency on Aging P.O. Box 1837 Sumter, SC 29154 (803) 775-7381	**QUALITY ASSURANCE (QA) MONITORING REPORT**
Date(s) of Visit:	Council on Aging/Contractor:
QA Team/Reviewers:	
Area Monitored: **TRANSPORTATION SERVICES**	

#	*STANDARD AND INDICATORS*	*Place "X" in Box* Yes	No
1	**STANDARD 1.1:** Transportation Services shall be provided by appropriately qualified personnel. **Indicator:** All drivers have a valid South Carolina driver's license of the appropriate class, driving records with no more than six points in violations at any time, and comply with any and all restrictions placed on their driver's license. *(Review personnel records of drivers and interview drivers to determine if they have any violations)* Comments:		

2	**STANDARD 1.2**: All drivers shall receive appropriate initial and on-going training 1. All drivers have successfully completed the National Safety Council 8 hour Defensive Driving Course or an equivalent course pre-approved by the AAA within six months of date of hire. 2. All drivers have successfully completed an approved course in first aid, CPR, and universal safety precautions within six months of employment and a refresher course according to the applicable certification guidelines. 3. All drivers have successfully completed a course in *passenger assistance techniques* within twelve months of employment or prior to driving a handicapped accessible vehicle. 4. All drivers, whose job involves transporting people with disabilities, have received training in the use of vehicles with specialized equipment. 5. All drivers receive a minimum of eight hours of training each year. Comments:		

	STANDARD AND INDICATORS		
3	**STANDARD 2.2:** Any vehicle used in the delivery of transportation services shall be adequately insured, fully equipped for safety and mechanically sound. **Indicator #1** – For all vehicles used to provide transportation services, the contractor adheres to a written preventive maintenance schedule recommended by the vehicle manufacturer for the type of driving undertaken. *(Inspect maintenance records of each van)* Comments:		
	Indicator #2 – All contractor-operated vehicles have, at a minimum, the basic safety equipment in good working condition as listed in Standard 2.2. • Power-driven windshield wipers and washers • Brake system maintained according to manufacturer safety standards • All lights are operational and of proper brightness and focus • Interior and exterior mirrors of such dimension and placement to enable the driver, from the driver's seat, to see not only the occupants of the vehicle, but also the road to the left, right and rear of the vehicle for a proper distance to adequately observe traffic conditions. • Stocked First aid kit with no items showing an expiration date that has passed. • Fire extinguisher(s) displaying current inspection date and capable of extinguishing both electrical and petroleum based fires. • Emergency road kit ◦ UPC kit • Working flashlight with charged batteries Comments:		

3	**STANDARD 2.3:** Transportation Service vehicles shall be clean. **Indicator:** The interior and exterior of all vehicles are cleaned as needed, to maintain a clean appearance. Comments:		
Signature of AAA Staff:		Date:	

DRIVERS RECORD'S CHECK - WORKSHEET

County		Monitor(s)							
#	Item to Monitor	Driver	Driver	Driver	Driver	Driver	Driver	Driver	Driver
1	Has the COA established a record for each driver?								
2	Do drivers have current SC driver's license?								
3	Do they Indicate an appropriate class?								
4	How many point violations do they each have, if any?								
5	Does the driver have any accident or incident reports on file								
6	Any driver restrictions?								
7	Did all drivers receive a copy of the COA policies regarding driver requirements and alcohol & other drug usage policies?								
8	Did all drivers complete an 8 hour initial National Safety Council Defensive Driving Course (or equivalent) within 6 months of hire?								
9	Did all drivers complete an Initial Course in First Aid, CPR, & Universal Safety Precautions (within 6 months of hire)?								
10	Enter the Last Date of Initial or Refresher Course in First Aid, CPR, & UPC?								

VEHICLE QA MONITORING

COA

Vehicle # _____

#	*Items to Check*	*Yes*	*No*
1	Are the windshield wipers and windshield washers working?		
2	Are there any problems with the brakes and is brake system maintained according to the manufacture's safety standards?		
3	Are all lights operational and have proper brightness?		
4	Are the interior and exterior view mirrors adequate to view all surrounding vehicles? Can they also see the passengers?		
5	Does the vehicle have a first aid kit? Are the items current with not expiration dates?		
6	Is there at least one fire extinguisher in the vehicle that can put out electrical and petroleum-based fires? Does it have a current inspection date?		
7	Does the vehicle have an emergency road kit?		
8	Does the vehicle have a Universal Precautions Kit (UPC Kit)?		
9	Does the vehicle have at least one working flashlight with charged batteries?		
10	Is the interior of the vehicle clean?		
11	Is the exterior of the vehicle clean?		

Comments:

		Date:
	CONGREGATE MEALS (GROUP DINING) **CLIENT INTERVIEWS**	

Greet the client, explain who you are, and then ask the client if they would like to answer a few questions. Explain that you will be writing down the answers, they won't have to write anything. If they don't want to participate, tell them that's okay, then just thank them for talking to you. Note: These questions are meant to be a guide for the interview, other questions may also be asked.

1	**How many days a week do you come to the meal site to eat a meal?** Response:
2	**How long have you been coming?** Response:
3	**Do you ride the van or how do you get here?** Response:
4	**If you came by van:** (a) Does the van usually come on time? (b) Who helps you get in and out of the van when you need help? (c) Are the drivers courteous? (d) Do you feel safe riding the vans? (e) Are the vans clean? (f) Would you like to see any transportation changes? If yes, what are they?
4	If you know that you are not going to be coming to eat, what do you do? Who do you call? Do you know what phone number to call to let them know that you can't come? Response:

5	**Does this senior center/site have programs on nutrition?** Response:
6	**Have you ever been here when they have had a fire drill? When was the last time you participated in a fire drill?** Response:
7	**Are you ever <u>asked</u> to give the staff suggestions about food you would like to have or activities that you would like to do? If so, have you ever given them <u>your</u> suggestions?** Response:
Other Comments:	
Please thank the client for assisting in this survey.	

QA MONITORING FIRE SAFETY		COA:		
#	Items to check	Yes	No	N/A
1	Are quarterly fire drills conducted? If yes, provide the dates of the last three fire drills: Date of Fire Drill # 1 _____ Date of Fire Drill # 2 _____ Date of Fire Drill # 3 _____			
2	Were any problems noted during the drills?			
3	How many of the above fire drills contain information on operation of fire equipment (particularly the fire extinguishers)?			
4	How many of the above fire drills followed the evacuation plans?			
5	Do you get regular fire inspections by the fire department? What was the last date of their fire inspection: _____			
6	How many fire extinguishers do you have in the building? _____ List #			
7	Are all fire extinguishers full and have current dates?			
8	How many smoke alarms do you have in the building: _____ List #			
9	Are the smoke alarms working (check to see if working/if batteries are low)			
10	Are their any other fire protection devices in the building? If so list:			
Comments:				

Service(s) Proposed:_____ Organization:_____

Reviewer:_____ Date:_____

Evaluation Factors and Summary of Certifications and Organizational Information

(Sections 6.2-6.11)

Tab #	Requirement/Evaluation Factor	Max Score	% of Org. Total	Primary Reference(s) /Comments	✓ = Yes X = No
6.2	Completed, Signed Cover Page	0	N/A	Required; Form Provided	
6.3	Certification of Agreement to Terms and Conditions	0	N/A	Required; Form Provided	
6.4	Certification of Non-Collusion	0	N/A	Required; Form Provided	
6.5	Certification – Debarment	0	N/A	Required; Form Provided	
6.6	Service(s) & Location(s) Being Proposed	0	N/A	Required; Form Provided	
6.7	**Executive Summary**	**60**	**16%**		**Actual Score**
a	Mission statement/philosophies/principles	25		Offeror Response	
b	Business Plans and Goals	15		Offeror Response	
c	Experience providing similar services	10		Offeror Response	
d	Relationships with Community/other Service Providers	10		Offeror Response	
6.8	**Organizational Capacity**	**115**	**32%**		**Actual Score**
a	Appropriateness of Business/Org. structure /Background	25		Offeror Response	
b	Adequacy/Experience of Admin/Mgmt Staff	15		Offeror Response	
Section 8, 8.11	Business References	50		**Required; Section 8, 8.11**	
d	Adequacy of Emergency/Disaster Plan	25		Offeror Response	

6.9	**Financial Management and Strength**	**125**	**34%**		**Actual Score**
a	Adequate financial reserve or plan to develop	25		Offeror Response	
b	Past Contract Performance	25		References, canceled contracts	
Section 8, 8.7	Audit findings/Financial statements	50		**Required; Section 8, 8.7**	
d	Additional resources to lower unit cost	15		Offeror Response	
e	Confidence in organization's ability to ensure that public funds received are adequately safeguarded.	10		Offeror Response	
6.10	**Quality Management/Improvement**	**65**	**18%**		**Actual Score**
a	Ability/plan to address and remedy problems	15		Offeror Response	
b	Confidence that quality meets requirements	15		Offeror Response	
c	Ability to identify/utilize areas of strengths and opportunities for improvement	20		Offeror Response	
d	Ability to utilize data and improve service provision/quality assurance.	15		Offeror Response	
	Max Organizational Strength Points	**365**	**100%**		

Organization: _____

Reviewer:_____ Date:_____

7.5 HDM TECHNICAL EVALUATION CRITERIA & Budget 8.1

Home Delivered Meal (HDM) Services		Max Score	% of Service Total	Reference(s)/ Comments	Actual Score
7.1.HDM	**Staffing**	**165**	**15%**		
a	Adequacy of Staffing Patterns for Service Provision	50		Offeror Response	
b	Qualifications/Experience of Service Delivery Staff	25		Offeror Response	
b	Qualifications/Experience of Svc. Mgmt. Staff	25		Offeror Response	
c	Staff Training	30		Offeror Response	
d	Use of Volunteer Staff	35		Offeror Response	
7.2.HDM	**Experience/Past Performance**	**150**	**13%**		**Actual Score**
a/c/d/e	Experience in same or similar services	100		Offeror Response	
Section 8 8.10-8.11	References/Recommendations	50		**Required; Section 8; 8.10-8.11**	
7.3.HDM	**Service Delivery Plan**	**165**	**15%**		**Actual Score**
a/d	Client Eligibility, Determination and Registration	15		Offeror Response	
b	Client Assessment Method	20		Offeror Response	
c	Client Prioritization Plan	15		Offeror Response	
e	Obtaining client feedback	10		Offeror Response	
f	Describe barriers of service delivery	25		Offeror Response	

g	Suitability of Location (Site of Service delivery)	35		Offeror Response	
h	Follow-up for services/termination	20		Offeror Response	
i	Adequacy of Client Rights policy	10		Offeror Response	
j	Follow-up for Complaints	15		Offeror Response	
7.4.HDM	**Community - Expansion of Services**	**150**	**13%**		**Actual Score**
a	Cooperative relationships/agreements	25		Offeror Response	
b	Expansion of services with other resources	25		Offeror Response	
c/d	Participant contributions	50		Offeror Response	
Section 8, Form 8.1	Matching Requirement - Minimum Exceeded	50		**Required Budget, Budget detail**	
8.HDM	**Budget and Cost Proposal**	**150**	**44%**		**Actual Score**
Section 8, Form 8.1	Operating Budget/Unit Cost Calculation	0		**Required; Form**	
Section 8, Form 8.1	Matching Requirement - Minimum Met	0		**Required; Form 8.1 line 41 Y/N**	
Section 8, Form 8.1	Strength/Confidence in Match Requirement source(s)	100			
Section 8, Form 8.1	Adequacy of cost sharing plan/policies for this service	50			
Section 8	Charts, forms and documentation required in Section 8	0		**Section 8.5-8.9, 8.12-8.14 Y/N**	
	Max Provision of Services Points	**775**	**100%**	Unit Cost Proposal 350 points (1125 points total)	
	Max Organizational Strength Points	**365**			

	Max Total Points for HDM Services	***1490**			

Organization: _____

Reviewer:_____ Date:_____

7.5 GDS TECHNICAL EVALUATION CRITERIA & Budget 8.1

Group Dining Services (GDS)		Max Score	% of Service Total	Reference(s)/Comments	Actual Score
7.1.GDS	**Staffing**	165	15%		
a	Adequacy of Staffing Patterns for Service Provision	50		Offeror Response	
b	Qualifications/Experience of Svc. Mgmt. Staff	25		Offeror Response	
b	Qualifications/Experience of Service Delivery Staff	25		Offeror Response	
c	Staff Training	30		Offeror Response	
d	Use of Volunteer Staff	35		Offeror Response	
7.2.HDM	**Experience/Past Performance**	150	13%		Actual Score
a/c/d/e	Experience in same or similar services	100		Offeror Response	
Section 8 8.10-8.11	References/Recommendations	50		**Required; Section 8; 8.10-8.11**	
7.3. GDS	**Service Delivery Plan**	165	15%		Actual Score
a/d	Client Eligibility, Determination and Registration	15		Offeror Response	
b	Client Assessment Method	20		Offeror Response	
c	Client Prioritization Plan	15		Offeror Response	
e/i	Obtaining client feedback	10		Offeror Response	
f	Describe barriers of service delivery	25		Offeror Response	
g	Suitability of Location (Site of Service	35		Offeror Response	

	delivery)				
h	Follow-up for services/termination	20		Offeror Response	
j	Adequacy of Client Rights policy	10		Offeror Response	
k	Follow-up for Complaints	15		Offeror Response	
7.4. GDS	**Community - Expansion of Services**	**150**	**13%**		**Actual Score**
a	Cooperative relationships/agreements	25		Offeror Response	
b	Expansion of services with other resources	25		Offeror Response	
c/d	Participant contributions	50		Offeror Response	
Section 8, Form 8.1	Matching Requirement - Minimum Exceeded	50		**Required Budget, Budget detail**	
8. GDS	**Budget and Cost Proposal**	**150**	**44%**		**Actual Score**
Section 8, Form 8.1	Operating Budget/Unit Cost Calculation	0		**Required; Form**	
Section 8, Form 8.1	Matching Requirement - Minimum Met	0		**Required; Form 8.1 line 41 Y/N**	
Section 8, Form 8.1	Strength/Confidence in Match Requirement source(s)	100			
Section 8, Form 8.1	Adequacy of cost sharing plan/policies for this service	50			
	Max Provision of Services Points	**775**	**100%**	Unit Cost Proposal 350 points(1125 points)	
	Max Organizational Strength Points	**365**			
	Max Total Points for GDS Services	***1490**			

Organization: _____

Reviewer:_____ Date:_____

7.5 TSP TECHNICAL EVALUATION CRITERIA & Budget 8.1

Transportation (TSP)		Max Score	% of Service Total	Reference(s)/ Comments	Actual Score
7.1.TSP	**Staffing**	210	16%		
a	Adequacy of Staffing for Service Provision	50		Offeror Response	
b	Qualifications/Experience of Service Delivery Staff	50		Offeror Response	
b	Qualifications/Experience of Svc. Mgmt. Staff	25		Offeror Response	
b	Use of Volunteer Staff	25		Offeror Response	
c	Staff Training	25		Offeror Response	
d	Licensures	25		Offeror Response	
e	Back-up policies/plans	10		Offeror Response	
7.2. TSP	**Experience/Past Performance**	175	14%		Actual Score
a/b	Experience in same or similar services	100			
Section 8 8.10-8.11	References/Recommendations	50		**Required; Section 8; 8.10-8.11**	
c	Participant satisfaction	25			
7.3. TSP	**Service Delivery Plan**	300	23%		Actual Score
b	Outreach efforts	50		Offeror Response	
c	Methods you will use to assess and prioritize the needs of individual participants	50		Offeror Response	
d	Adequate number of transportation routs	100		Offeror Response	
e	Policies for vehicle maintenance	50		Offeror Response	
f	Van accessible for people with physical disabilities	50		Offeror Response	

g	Proof of minimum insurance (s)	0		Offeror Response; Is it at the minimum requirement Y/N	
7.4. TSP	**Community - Expansion of Services**	**100**	**8%**		**Actual Score**
a	Cooperative relationships/agreements	25		Offeror Response	
b	Expansion of services with other resources	25		Offeror Response	
Section 8, Form 8.1	Matching Requirement - Minimum Exceeded	50		**Required Budget, Budget detail**	
8. TSP	**Budget and Cost Proposal**	**150**	**39%**		**Actual Score**
Section 8, Form 8.1	Operating Budget/Unit Cost Calculation	0		**Required; Form**	
Section 8, Form 8.1	Matching Requirement - Minimum Met	0		**Required; Form 8.1 line 41 Y/N**	
Section 8, Form 8.1	Strength/Confidence in Match Requirement source(s)	100			
Section 8, Form 8.1	Adequacy of cost sharing plan/policies for this service	50			
	Max Provision of Services Points	**935**	**100%**	Unit Cost Proposal (350 points) (1285 points total)	
	Max Organizational Strength Points	**365**			
	Max Total Points for TSP Services	***1650**			

Organization: _____

Reviewer:_____ Date:_____

7.5 HLS TECHNICAL EVALUATION CRITERIA & Budget 8.1

Home Living Support (HLS)		Max Score	% of Service Total	Reference(s)/Comments	Actual Score
7.1.HLS	**Staffing**	**200**	**17%**		
a	Adequacy of Staffing for Service Provision	50		Offeror Response	
b	Qualifications/Experience of Svc. Mgmt. Staff	50		Offeror Response	
b	Qualifications/Experience of Service Delivery Staff	25		Offeror Response	
c	Staff Training	25		Offeror Response	
d	Licensure	25		Offeror Response	
e	Back-up policies	25		Offeror Response	
7.2. HLS	**Experience/Past Performance**	**150**	**13%**		**Actual Score**
a	Currently providing the service	50		Offeror Response Y/N	
Section 8 8.10-8.11	References/Recommendations	50		**Required; Section 8; 8.10-8.11**	
b/c	Experience in same or similar services	50		Offeror Response	
7.3. HLS	**Service Delivery Plan**	**185**	**16%**		**Actual Score**
a	Providing Service to Eligible Seniors	35		Offeror Response	
b	Method Used to Assess Seniors	25		Offeror Response	
c /d	Waiting List/Prioritization	25		Offeror Response	
d	Method used to target individuals	25		Offeror Response	
g	Response to Participants Request for Change	25		Offeror Response	

h	Participant Satisfaction	25		Offeror Response	
I	Providing client follow-up	25		Offeror Response	
7.4. HLS	**Community - Expansion of Services**	**125**	**11%**		**Actual Score**
a	Cooperative relationships/agreements	25		Offeror Response	
b	Expansion of services with other resources	25		Offeror Response	
Section 8, Form 8.1	Matching Requirement - Minimum Exceeded	50		**Required Budget, Budget detail**	
c/d	Participant contributions	25		Offeror Response	
8. HLS	**Budget and Cost Proposal**	**150**	**43%**		**Actual Score**
Section 8, Form 8.1	Operating Budget/Unit Cost Calculation	0		**Required; Form**	
Section 8, Form 8.1	Matching Requirement - Minimum Met	0		**Required; Form 8.1 line 41 Y/N**	
Section 8, Form 8.1	Strength/Confidence in Match Requirement source(s)	100			
Section 8, Form 8.1	Adequacy of cost sharing plan/policies for this service	50			
	Max Provision of Services Points	***820**	**100%**	Unit Cost Proposal (350 points) (1170 points total)	
	Max Organizational Strength Points	**365**			
	Max Total Points for HLS Services	***1535**			

Organization: _____

Reviewer:_____ Date:_____

7.5 HLS TECHNICAL EVALUATION CRITERIA & Budget 8.1

Home Living Support (HLS)		Max Score	% of Service Total	Reference(s) /Comments	
7.1.HLS	**Staffing**	175	14%		Actual Score
a/b	Qualifications/Experience of Svc. Mgmt. Staff	50		Offeror Response	
a/b	Qualifications/Experience of Service Delivery Staff	50		Offeror Response	
c	Staff Training	50		Offeror Response	
d	Licensure	25		Offeror Response	
7.2. HLS	**Experience/Past Performance**	175	14%		Actual Score
a	Currently providing service	50		Offeror Response Y/N	
b	Experience in same or similar services	50		Offeror Response	
Section 8 8.10-8.11	References/Recommendations	50		**Required; Section 8; 8.10-8.11**	
c	Participant satisfaction	25		Offeror Response	
7.3. HLS	**Service Delivery Plan**	245	20%		Actual Score
a	Evidenced Based Experience	100		Offeror Response Y/N (If no provide research documentation)	
b	Research that supports program	35		Offeror Response	
c	Objectives and Outreach to Promote Service	35		Offeror Response	
d	Location Description	25		Offeror Response	
e	Adequate Number of Classes	50		Offerer Response Y/N	

7.4. HLS	**Community - Expansion of Services**	**130**	**11%**		**Actual Score**
a	Cooperative relationships/agreements	25		Offeror Response	
b	Expansion of services with other resources	25		Offeror Response	
Section 8, Form 8.1	Matching Requirement - Minimum Exceeded	50		**Required Budget, Budget detail**	
c/d	Participant contributions	30		Offeror Response	
8. HLS	**Budget and Cost Proposal**	**150**	**41%**		**Actual Score**
Section 8, Form 8.1	Operating Budget/Unit Cost Calculation	0		**Required; Form**	
Section 8, Form 8.1	Matching Requirement - Minimum Met	0		**Required; Form 8.1 line 41 Y/N**	
Section 8, Form 8.1	Strength/Confidence in Match Requirement source(s)	100			
Section 8, Form 8.1	Adequacy of cost sharing plan/policies for this service	50			
	Max Provision of Services Points	***870**	**100%**	Unit Cost Proposal (350 points) (1220 points total)	
	Max Organizational Strength Points	**365**			
	Max Total Points for HLS Services	***1585**			