Waccamaw Area Agency on Aging
Area Plan
2014 - 2017

Region VIII
Serving Georgetown, Horry and Williamsburg County

Waccamaw Area Agency on Aging
1230 Highmarket St
Georgetown, SC 29440
843-436-8502
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I. INTRODUCTION

A. Purpose

The Older Americans Act (OAA) of 1965, as amended in 2006, requires that each state submit a State Plan on Aging in order to be eligible for federal funding under the OAA. In South Carolina, the Lieutenant Governor's Office on Aging is designated as the State Unit on Aging (SUA) and is responsible for administering and carrying out requirements of the OAA.

The State Plan on Aging is made up, in part, from the four-year Area Plans on Aging submitted from the 10 Area Agencies on Aging (AAA) across the state of South Carolina. These plans are blueprints for the planning, management, coordination and delivery of OAA programs, services and activities through the time period of 2013-2017

This four- year Area Plan for Waccamaw, Region VIII, includes Georgetown, Horry and Williamsburg County in its service territory. As a sub-agency of the State Office on Aging, the Waccamaw Area Agency on Aging is responsible for administering and fulfilling the requirements of the Older Americans Act of 1965, as amended in 2006.

The plan will detail the Waccamaw Regional AAA goals and objectives to grow, improve, modernize and change the way that we deliver services, on the local level, in order to achieve cost effectiveness while maintaining the quality of care that is so important to our constituency and their families.

B. Verification of Intent

To be delivered after COG Board Meeting

C. Verification of AoA and LGOA Standard Assurances

To be delivered after COG Board Meeting

II. EXECUTIVE SUMMARY

In order to receive Older Americans Act (OAA) and State funding for 2014 through 2017, each AAA/ADRC is required to submit an Area Plan following the process stipulated by the LGOA. It is the responsibility of the AAA/ADRC to prepare an Area Plan document which accurately reflects the goals of the aging network within its planning and service area, while also taking into account the directives set by the Older Americans Act (OAA), the

2012 State Plan, the terms and conditions set by the Multigrant Notice of Grant Award (NGA), and the South Carolina Aging Network's Policies and Procedures Manual. Per the new policies and procedures manual the 2014 – 2017 Area Plan is an innovative, forward-thinking document that provides a clear blueprint and guide for the AAA/ADRC over the next four (4) years.

In addition to being a blueprint for addressing the new paradigm set by the AoA and the LGOA, the Area Plan is a document which provides best practices for service delivery, accountability, and transparency, not only within the structure of the AAA/ADRC, but within the entire aging network. Through the Area Plan, the AAA/ADRC provides clear monitoring protocols, verification of services provided, and verification of service units earned, as well as the many assurances required by these instructions. The Area Plan demonstrates that the PSA and AAA/ADRC has a clear understanding and knowledge of all activities and services provided throughout its region.

The document addresses the AAA/ADRC Operational Functions and Needs which include the assessment of regional aging needs, program development, program coordination, long term care, advocacy, priority services, priority service contractors, transportation, nutrition services, training and technical assistance, monitoring, contract management, grievance procedures, performance outcome measures, resource development, cost-sharing and voluntary contributions, confidentiality and privacy.

The Area Plan also addresses direct service programs which are provided internally by Council of Governments directly and includes staff qualifications, goals and objectives, strengths and weaknesses, and operational procedures for each of our internal programs. These internal programs include Long-Term Care Ombudsman, Information Referral and Assistance, Family Caregiver Program, and Insurance Counseling and Senior Medicare Patrol.

Finally, the plan addresses changing demographics and the impact on our service delivery system using intervention and prevention plans, senior center development plans, plans for families facing Alzheimer's disease, and legal assistance.

III. OVERVIEW OF THE AREA AAA/ADRC

A. Mission Statement

The Waccamaw Area Agency on Aging/Aging and Disability Resource Center (AAA/ADRC) is dedicated to improving the quality of life for

seniors, adults with disabilities, and their family care partners, by helping them to achieve optimal health, independence and productivity in, both the community, and the long term care setting.

B. Vision Statement

The Waccamaw AAA/ADRC envisions adequate, just and equitable services for ALL. These services will honor and respect differences. They will be: delivered with integrity: offer responsible choice; enable personal empowerment, and growth to area seniors, disabled individuals and their family care partners.

C. Organizational Structure

Waccamaw Regional Council of Governments, a regional agency serving county governments, municipalities, and citizens of Georgetown, Horry and Williamsburg Counties, offers a wide variety of planning, economic development and social services to aid in the orderly growth and development of the area.

Created in 1969, Waccamaw Regional is one of ten such regional agencies in the State, together making up the SC Association of Regional Councils. The Council provides in-depth assistance to local government serving as the technical planning staff for numerous planning and zoning commissions, assisting in securing and administering grant funds for local projects and services, as well as coordinating varied social services for the economically deprived.

Waccamaw Regional operates under the guidance of a twenty-five member Board of Directors comprised of elected officials and citizens-at-large from the tri-county area. Waccamaw Regional's professional staff is engaged in four basic areas of activity: planning; economic development; human resources; and finance. The agency is organized into four separate departments according to those activities.

The AAA/ADRC is one of the four separate departments within the agency. The AAA Director supervises all direct service employees of the department with oversight by the Executive Director of the Council.

D. Staff Experience and Qualifications

Kim Harmon, BA - AAA/ADRC Director – Kimberly Harmon acts as the Waccamaw unit director and financial officer. She earned a Bachelor's degree in Business Administration from Francis Marion University. She has been employed by the AAA for 12 years, and has work experience in

the following areas: COA Finance Director; Interim COA Executive Director.

Danita Vetter, BA, MA, CGC – Waccamaw Aging Programs Coordinator – Danita Vetter has been employed by the Waccamaw COG for nearly 5 years. She brings 28 years of experience, in the field of aging, to the job. Related work experience includes: adult day service director; supervisor of Senior Adult Services for the Archdiocese of Philadelphia; program director and, later, the vice president of the Alzheimer's Association/Delaware Valley Chapter.

Arnold Johnson, Waccamaw COG Finance Director – Arnold Johnson has earned a Bachelor's degree in Business Administration from the University of South Carolina. He is pursuing a master's degree from Walden University. He has served the COG, for 19 years, in various capacities including: Human Resources and Workforce Finance Director.

E. Regional Aging Advisory Board

The Waccamaw AAA/ADRC has for the last several years, while building our ADRC, used our community advocacy group, S.A.G.E.S (Senior Advocates Growing Elder Services) to serve as our advisory council. Our original advisory council was made up of members serving on boards of our contractors and after the many changes that the procurement process brought to our programs we did not believe this to be in our best interest. This S.A.G.E.S group of leaders and advocates became our base for growing our ADRC. Because of recent changes to our focus and mission, harkening back to a more formal and service specific mission we are reconstituting a more formal advisory council. This council will be made up of seniors and advocates that have been involved in each of the areas our ADRC serves. We will have representatives from each county representing, Ombudsman (LTC services), Information/Referral services, Family Caregivers, Assisted Rides Volunteers and Riders, ICARE volunteers and recipients, and Community Advocacy Leaders. We are currently recruiting these positions and should have a full slate by mid-June, 2013.

We have utilized our direct service staff to recruit members that are using our services and/or have family members who are using our services. We believe that keeping this advising body fully engaged is the only way to ensure that the community has an understanding of the services available and for our staff to make informed decisions regarding provision of those services with consistent input from our consumers and advocates.

F. Current Funding Resources

The Waccamaw AAA/ADRC currently has very limited resources for planning and administration within our organization. We worked for over

a year with Georgetown Hospital System to apply for the Care Transitions Grant with no success with regards to funding. This project took much of the staff time allocated to seeking additional resources but we have recently ventured into a contract with a nationally recognized fiscal partner to promote a fiscal concierge bill paying service that we are hopeful will bring in additional revenue for our ADRC programs.

Resource	Program	Amount
LGOA/SCDOT 5317 – Urban and Rural	**Assisted Rides Program(seniors and disabled adults needing transport)(Volunteers)**	**$20,799**
Fiscal Concierge	**Bill Pay Services (private pay clients)**	**$15.00 per client per month**
VISTA Program – United Way	**Assisted Rides Program(seniors and disabled adults needing transport)(Volunteers**	**One full time position to assist with our program for one year. Value = $20,800**
Waccamaw Sports Classic	**Physical Fitness/Socialization**	**$13,083.42 over the last four years(all proceeds used directly for program expenses) In-kind donations towards the program are valued at $52,900**

G. Written Procedures

The Waccamaw Area Agency on Aging has in the past followed as closely as possible the State Office Policy and Procedures Manual along with the Waccamaw Regional Council of Governments Internal Policy and Procedure Manual. We are currently rewriting and updating a manual that will take into account the new policies that affect both our internal operations as well as the operations of our service providers. We will have our new manual completed in the first quarter of the new fiscal year and it will be presented for adoption by our Council of Governments Board of Directors when completed.

The goals of the Waccamaw AAA/ADRC are the same as the goals set forth in the SC State Plan for Aging:

1. Empower older people, those with disabilities, and their family members to make informed decisions about, and have easy access to: health services and the long term care system.

2. Enable seniors, and adults with disabilities to remain living independently, in their own homes for as long as possible through the provision of home and community-based services, including supports for family caregivers

3. Empower older adults, and disabled adults to stay healthy and active through OAA services and Medicare preventive health programming

4. Ensure the rights of older people, and those with disabilities and to prevent abuse, neglect and exploitation

5. Maintain effective and responsible program management. Be transparent and responsive in complying with FOIA requests, as set forth in the Waccamaw COG Policy and Procedure Manual

Through participation, and expenditure, the following service areas have been identified as priorities for the Waccamaw AAA/ADRC: Group Dining; Home Delivered Meals; Health Promotion/Nutrition Education; Home Living Support; Transportation; Family Caregiver Support Program; Information and Referral; Insurance Counseling and Senior Medicaid Patrol.

The Waccamaw AAA/ADRC is organized to fulfill the following nine service objectives that are related to the programs listed above:

- Maintain and improve the nutritional and health status of older adults
- Maintain personal independence and improve quality of life
- Provide assistance for older adults, and those with disabilities, and their family caregivers to overcome barriers to maintain, strengthen and strengthen functioning at home
- Protect the rights of vulnerable adults, residing in congregate settings and to prevent abuse, neglect and exploitation
- Achieve recommended nutritional requirements
- Health promotion
- Disease prevention
- Prevention of institutionalization
- Enhance the quality of life

H. Sign-In Sheets

During the formal congregate meal monitoring process, the monitor observes the sign-in/reservation process that takes place, daily, at each senior center. The monitor asks the center manager to describe how closely the numbers, on the reservation sheet, match the actual numbers of participants that attend the following day, and throughout the week. The monitor stresses, to the manager, the importance of working toward improving the process so that waste is minimized *and* everyone, in

attendance, is served a meal. In cases where there is an obvious variation in the numbers, the monitor asks the manager to demonstrate how he/she talks to the group about the issue. The monitor also offers to make the presentation, to the group, as a way of modeling a "best approach" to the manager.

Congregate meal contractors will be emailed reminders that an accurate reservation system, with consistent consumer participation will be a "focus area" for the next four years, and beyond. Contractors will be asked to: educate their managers about a standardized approach to improve the process; regularly addresses meal participants about their role in an accurate count; have their managers closely monitor the results of the reservation process, and to follow up with clients with an aim toward assuring that the reservation numbers are as close to real attendance numbers as possible. The AAA/ADRC will offer technical assistance or staff orientation/education as requested, and when necessary.

I. Activity Calendars

Calendar Standardization and Quality Assurance - The Waccamaw program coordinator attended LGOA calendar training and brought the information back to the local level. Congregate meal contractors, and their staff members, underwent an orientation, and training process, that was focused on: producing a monthly, standardized calendar with: required content and format elements; attendance counts for each daily activity; adherence to the required nutrition and health education programming; consistent provision of a variety of activities, on a rotating time/day-of-the-week basis; obtainment of client input when planning the calendar; requirements for posting the calendar/maintaining copies for review; reporting requirements (sending copies of activity calendars, with attendance numbers, to the COG with their daily meal vouchers, so that calendar compliance can be monitored on a monthly basis.)

J. Service Units Earned

The Waccamaw Area Agency on Aging is currently using the AIM report LG97c to review assessment dates and ensure they are current for all clients served during a month for which reimbursements are sought. This report is then cross-referenced with AIM report LG45d to ensure that any client without a current assessment did not receive a service. If a service was received without a current assessment the agency is notified and the units are disallowed prior to request for payments to the state office. In the coming year, as prescribed by the changes to the Policy and Procedure Manual, our staff will be making monthly visits to observe the service

delivery of our contractors as well as continuing to monitor the AIM reports.

K. Reimbursement for Services

During our last procurement process we did not require that offerors provide a detailed breakdown of the cost of each service, only the total cost for which they could provide the service for our region. In the upcoming procurement cycle, we will ask for this information. In the meantime, we have asked that our current providers submit to us a breakdown of unit costs for the upcoming fiscal year. These are provided in the charts below:

Georgetown						
	HDM	Cong	Trans	Homecare	Health promotion	Med Trans
Reimb. Rate	3.4602	5.0318	.66	15.1277	2.55	1.0401
Personnel	.78	1.82	.30	5.75	1.27	1.0401
Transportation	.72	0	.28	5.49	0	.47
Supply/Facility	.12	1.16	0	.33	1.18	.03
Admin Support	.67	1.52	.26	4.90	1.09	.44
Food Cost	2.43	2.43	0	0	0	0
Unit Cost	4.72	6.93	.84	16.47	3.54	1.46

Assessment cost for Georgetown is included within personnel/admin

Horry						
	HDM	Cong	Transp	Homecare	Health Prom	Med Mgmt
Assessment Cost	.35	.35	.35	1.25	.35	.35
Activity Cost	0	1.20	0	2.00	.85	.80
Product Cost	2.70	2.70	0	10.25	.20	0
Admin Cost	2.00	1.75	.15	2.75	.35	.25
Insur/Maint/ Fuel	.60	1.25	.62	7.75	.20	.15
Unit Cost (FY 12-13)	4.409	4.75	.95	18.00	1.35	1.35
Unit Cost (FY 13-14)	5.65	7.25	1.12	24.00	1.95	1.55

Williamsburg						
	HDM	Cong	Transp	Homecare	Health Prom	Med Mgmt
Assessment Cost	.20	.20	.16	.38	.21	.21
Activity Cost	0	2.92	.10	4.02	.60	.60
Product Cost	2.64	2.43	0	7.30	0	0
Admin Cost	2.02	.99	.08	2.55	.12	.12
Fuel/Maint	.82	0	.58	.75	0	0
Unit Cost (FY 12-13)	5.6402	6.48	.75	15.009	.9302	.93
Unit Cost (FY 13-14)	5.68	6.54	.92	15.009	.9302	.93

The AAA/ADRC will verify unit cost rates during annual fiscal monitoring with each provider of service and as stated will require the breakdown of all unit costs during the procurement cycle.

L. Client Data Collection

Providers: The Waccamaw Area Agency on Aging is currently using the AIM report LG97c to review assessment dates and ensure they are current for all clients served. This report is then cross-referenced with AIM report LG45d to ensure that any client without a current assessment did not receive a service. If a service was received without a current assessment the agency is notified and the units are disallowed prior to request for payments to the state office. In the coming year, as prescribed by the changes to the Policy and Procedure Manual, our staff will be making monthly visits to observe the service delivery of our contractors as well as continuing to monitor the AIM reports. This process ensures that all clients are entered into the AIM system prior to seeking reimbursement from the AAA. All reports with certifications from the Executive Directors of the provider agency are due to the AAA office by the 10th of each month.

Internal: All client calls and/or walkins for the IR&A and SHIP programs are entered into the OLSA system either by the staff member taking the information or by our data entry specialist. Each month the IR&A Specialist provides to the AAA Director reports chronicling each call by employee with specifics as to the call taken. We are able to monitor types of calls, resolution, and improvement needed. The Ombudsman provides reports to the state office when requested and also copies the AAA Director at that time. The Ombudsman reports are in aggregate data as to not divulge confidential information. These reports help us to gauge the

number of open cases and assist in showing what types of topics should be covered in trainings for LTC staff and families.

M. Client Assessments

Description of the Assessment/Reassessment Process - Prospective clients undergo a face-to-face intake process, preferably, in their own home, that results in the generation of the initial client assessment, prior to the provision of services. Client eligibility will be determined by the AAA/ADRC when the assessment is entered into the AIM system and we are notified by the provider that an assessment has been completed. The client will be deemed appropriate by using the following protocol: the client is prioritized according to his/her situation, and needs, during the intake process by using the standard priority scores recorded by the AIM system. A standard client assessment includes: qualification of a client; determining their unique needs (including DETERMINE score, level of function; family structure, health status, mental status, financial/housing status; existing supports etc) as well as, the level of service necessary to meet those needs; matching the availability/appropriateness of the funds to provide service to the client; explaining and obtaining: consent forms; signed client responsibility forms; agency responsibility forms; cost-sharing responsibilities; emergency contact information; physician notification of participation; liability release; explanation of grievance policy and termination processes. The client is also oriented to the program, and associated services. Referrals for other beneficial programs from community partners are also made at this time, and throughout the relationship between the client and the service entity. Client service plans are built upon the information obtained in the initial assessment. Service plans are modified when a client's health, social or mental status changes, at any time throughout the year, or on an annual basis, when re-assessment occurs. Client eligibility will be determined by the AAA/ADRC when the assessment is entered into the AIM system and we are notified by the provider that an assessment has been completed. The client will be deemed appropriate by using the following protocol: the client is prioritized according to his/her situation, and needs, during the intake process by using the standard priority scores recorded by the AIM system. Once a client is deemed to be next in line for service, the AAA will contact the provider with an authorization for service.

Reassessments are conducted, for each client, at least annually, across the Waccamaw region. Standard, LGOA-approved, data sets are collected and entered in a timely fashion, into the A.I.M. system to create an electronic record for each program client. Paper copies assessments/re-assessments are, also, maintained in the contractor's office for a minimum of five years.

Those conducting the assessments, and re-assessments, are qualified to do so, and have been oriented, trained, and provided with "refresher" opportunities, by the Waccamaw Programs Coordinator, over the last four years. Contractor administrators, site managers/HDM drivers and contractor social work staff have attended these educational sessions. New staff members are trained, incrementally, as their service tenure unfolds. Materials used in the training include: Legislated program standards; Scope of the Work documents; monitoring tools; DETERMINE Tool; Assessment form; Site Managers Manual; COG contact information.
Client assessments and re-assessments are monitored annually by the Waccamaw Programs Coordinator. Following a monitoring visit, client files are randomly selected from contractor files, and these are subjected to a standardized review process that focuses on: funding source; client qualification; client prioritization; quality and continuity of assessment/reassessment; the inclusion of the required: consent forms; service plan; progress/critical event notes; client/agency responsibility forms; blank termination forms; consecutive, comparable DETERMINE scores.

Client Prioritization – The initial, standardized intake/assessment process is key to client prioritization. As the interviewer moves through the process a check list of qualifiers is generated. Prioritization is based on these factors: advanced age (75+); # of ADLs and IADLs that require assistance; mental disability; the prevention of institutionalization; lack of support system; below poverty level; needing assistance to eat; other non-medical/non-economic factors that are not listed. The more of these factors that are indicated, through the interview process, the greater the client's priority for service. The AIM system then generates a priority score which will be used to enroll new clients into services. These point values are assigned to the prioritization factors, as a numeric score is deemed more desirable.

Low Prioritization Scores and Termination – When necessary, in times of scarce service resources, clients with the lowest prioritization scores may be relegated to a waiting list for services. The length of time that the client might wait to be served, will be estimated. The client may also be informed as to where they rank on the waiting list, as well. Clients/family caregivers are instructed to call if a change in the status of the prospective client occurs, or if they would like an update on the fulfillment of the service list.

Termination – It is true that every client that is served will be terminated at some time during service relationship. Every client file contains a blank termination form. Some terminations occur spontaneously, like death or the worsening of a serious illness. Some terminations are generated by the client's choice: client chooses against service; client moves from the service area; client is institutionalized.
The most difficult type of termination is one that is unwanted by

the client or his family member(s). This type of termination is usually surrounded by safety issues. In the congregate setting: deepening dementia; wandering; inability to care for oneself in the bathroom; a pattern of choking when eating; danger to self or others; repeated refusal to follow agreed upon program/social rules.
In the HDM program: not equip, or able to store, or prepare foods; unable to chew and swallow; end stage disease
The parameters for termination are set forth at forth at intake and signed/dated documents, agreeing to the terms, are on file. This discussion is re-visited annually. Termination policies are integral to a quality service plan. It is easier to implement a necessary, but unwanted, service termination when the proper preparation, and care, have been taken.
In the case of a contested termination, the contractor will discuss the situation with the client, and their family caregiver. Excluding imminent danger to self or others, a thoughtful plan including parameters, and a timeline, will be agreed upon. Appropriate referrals will be made to programs/services that offer a higher level of care. Grievance procedure will be offered. Administrators of the service contract will be involved in contested terminations. The AAA/ADRC will offer technical assistance and properly execute their role in a grievance process.

N. General Fiscal Issues

The AAA/ADRC agrees to the following assurances as written below with a checkmark as the indicator:

- ✓ AAA will expend prior year's funds first
- ✓ Planning and admin funds for: Title III-B; III-C-1; 111-E be expended before program development funds are spent for program activities thru OAA
- ✓ Federal share of funds is utilized only when cost has been incurred and state and local matches have been contributed – The AAA only pays the percentage of the unit costs that are federal and state, the provider certifies the local match has been applied monthly and this will be monitored in the annual fiscal monitoring process.
- ✓ Financial and program reports are submitted in the format provided by LGOA and on schedule. Invoice and financial reports are submitted to Accounting and Finance Division, while programs reports are submitted to the appropriate program manager.
- ✓ Invoice to LGOA include: a breakdown of the provider unit cost and units earned. The units cost breakdowns are given in section k.

- ✓ Payment Requests for internal, and flow thru expenditures must be submitted monthly. AAA/ADRC keeps all invoices in case of mid-year budget cuts or reductions. All invoices will be submitted by the 21st of each month.
- ✓ AAA/ADRCs expending $500,000 in Federal awards must monitor delivery and have an audit that complies with OMB Circular A-133. The audit must be submitted within 9 months after the close of the organization's fiscal year.

O. General Provisions for AAA/ADRC in the Area Plan

Federal, State, LGOA Guidelines

The administration of the Waccamaw Council of Governments, the administrator of the AAA/ADRC and program staff have access to the federal and state legislation, and LGOA policies and procedures, that pertain to the provision of aging services offered by the Waccamaw AAA/ADRC , also, through our service contractors. This information is on the web and written copies are available at the office. Staff has been oriented to their roles, and the expectations that define their roles, by reading these documents, and referring to them, as necessary, during the course of their work. Trainings have been provided by LGOA to reinforce the written guidelines. Ongoing training will be provided for changes and updates to any and all regulations.

Contractor Compliance to Guidelines - The administration of service contractors and their front line staff members, who deliver direct care, are oriented and trained for their roles using these documents. All program monitoring processes are directly based on legislation and policy and procedure and program instruction documents. The AAA/ADRC will train all staff as well as providers on all SC Policy and Procedures changes and any Program Instructions that are issued during a program year.

GIS Mapping and Planning – The utilization of GIS mapping allows the AAA/ADRC to literally visualize their service territory. With the insertion of the points of service, the resulting map allows the agency to assess: service/program coverage; inventory local, surrounding resources; identify service gaps; envision the engagement of local partners. It has been especially helpful in the area of mobility management in which, positive outcomes are measured by successfully making remote "matches" between those needing transportation service and trained volunteers who are willing to provide a transport. The AAA/ADRC has provided in this area plan the current service recipients as derived from AIM data across our region. We will use our Planning Department within the COG to help us update these maps on an as needed basis but no less than yearly.

Limited English Proficiency – Waccamaw AAA has identified two volunteers that are willing to assist our staff members in interacting with Spanish speaking individuals and families that seek services in our region.

The SC 211 system has a language translation line with the capability to implement three way conference calls between a client, our staff member and a certified translator. The Alzheimer's Association also has a similar 24/7/365 language line for use with families who are experiencing the challenges of dementia and/or care for someone with dementia.

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

AAA/ADRC maintains an on-going, professional working relationship with all contractual service providers. Orientation, training, refresher courses, technical assistance services; written manuals, standard form utilization; frequent contact; scheduled monitoring visits, voucher audits and an open door policy for unannounced visits to program sites all play a part in assuring contractor compliance with OAA legislative parameters and LGOA's mandatory procedures and policies that are based on legislation.

The Waccamaw Program Coordinator maintains, and shares, the findings/ outcomes of detailed program monitoring reports with staff members of the contracting service agency. A verbal discussion of strengths and weaknesses takes place, at the close of each monitoring visit, first, with front–line staff and then with agency administrative staff/supervisors. A written summary of findings are provided, if requested.
When corrective action is necessary, a plan is developed with the contractor, to improve the program parameters that are found to be out of compliance. The plan includes: specific steps for correction; a timeline for accomplishment; who is responsible to take action; an appointment date for a re-check of compliance. Technical assistance is offered to address: staff re-education; revisions to procedures; review of expectation etc.

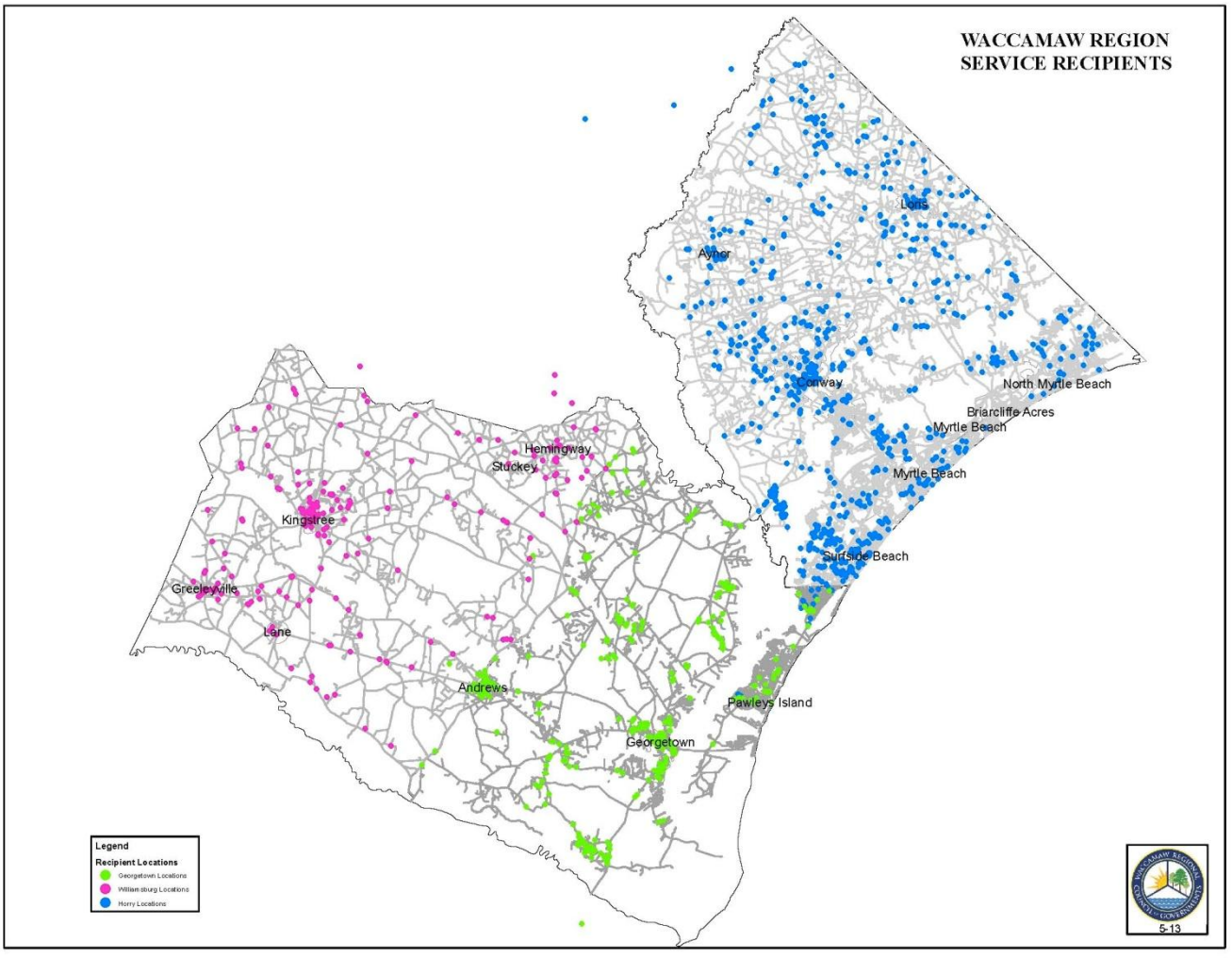
De-Designation – Contractors will be de-designated for: no attempt to take corrective action; a pattern of non-compliance, over time, that designates a disregard for the terms of the agreement and/or corrective action; willful abuse, neglect or exploitation of clients/volunteers/staff; willful misappropriation of funds.

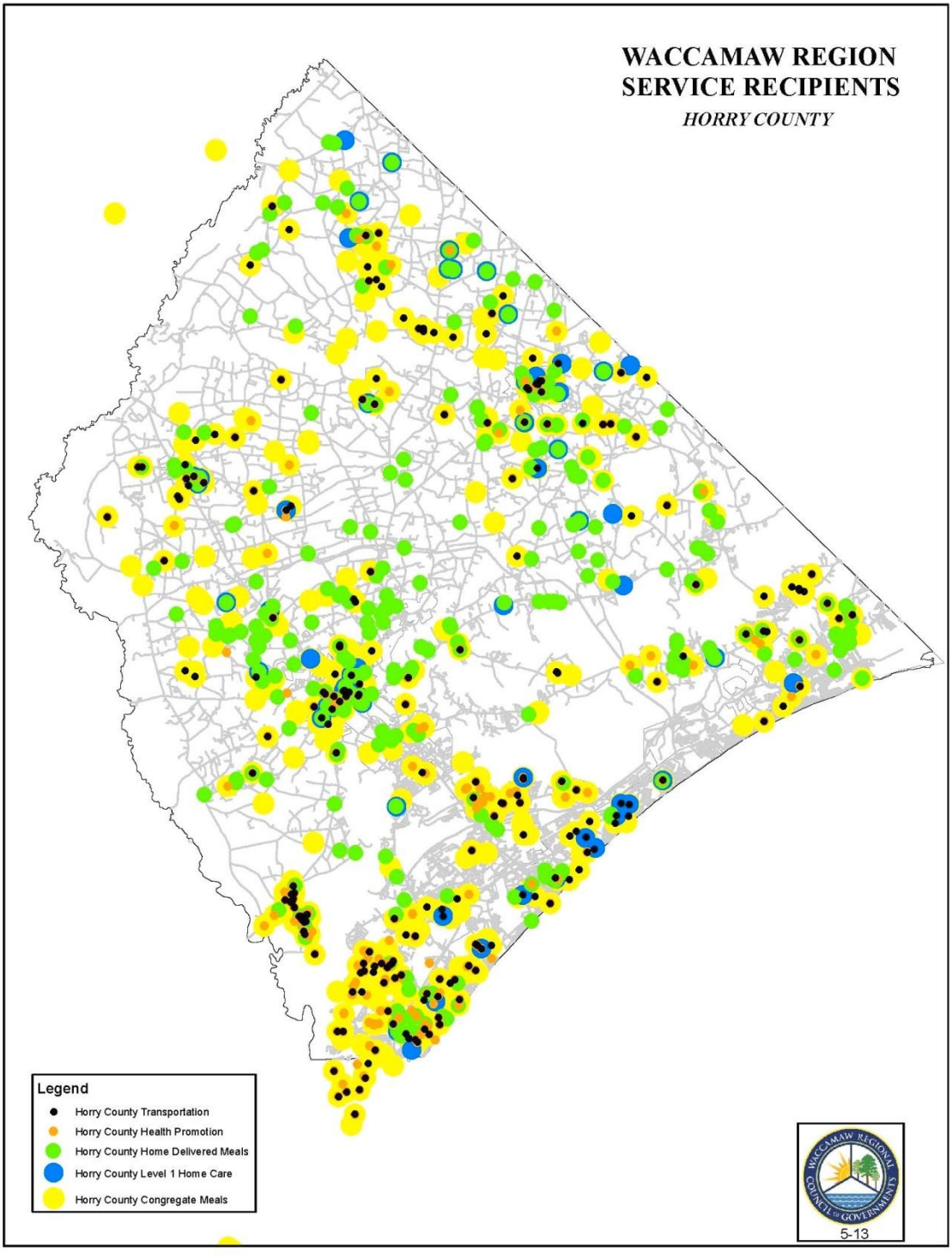
The programs coordinator will report documented, egregious non-compliance, or dangerous practices, to the Aging Department Director and COG Executive Director. These administrators will inform LGOA of the issues. LGOA will inform Federal officials.

IV. OVERVIEW OF THE PLANNING AND SERVICE AREA/REGION

A. Service Delivery Area (SDAs)

The maps on the following pages were created by our GIS personnel based on service data obtained from the AIM system. Each service recipient is shown by service for each individual county as well as a look at our region as a whole. As you will see when reviewing the maps our providers are doing an excellent job of reaching out to all areas in our region. Please note that some counties have data options for obtaining specific address locations that others do not possess, therefore, the mapping varies.




WACCAMAW REGION
SERVICE RECIPIENTS
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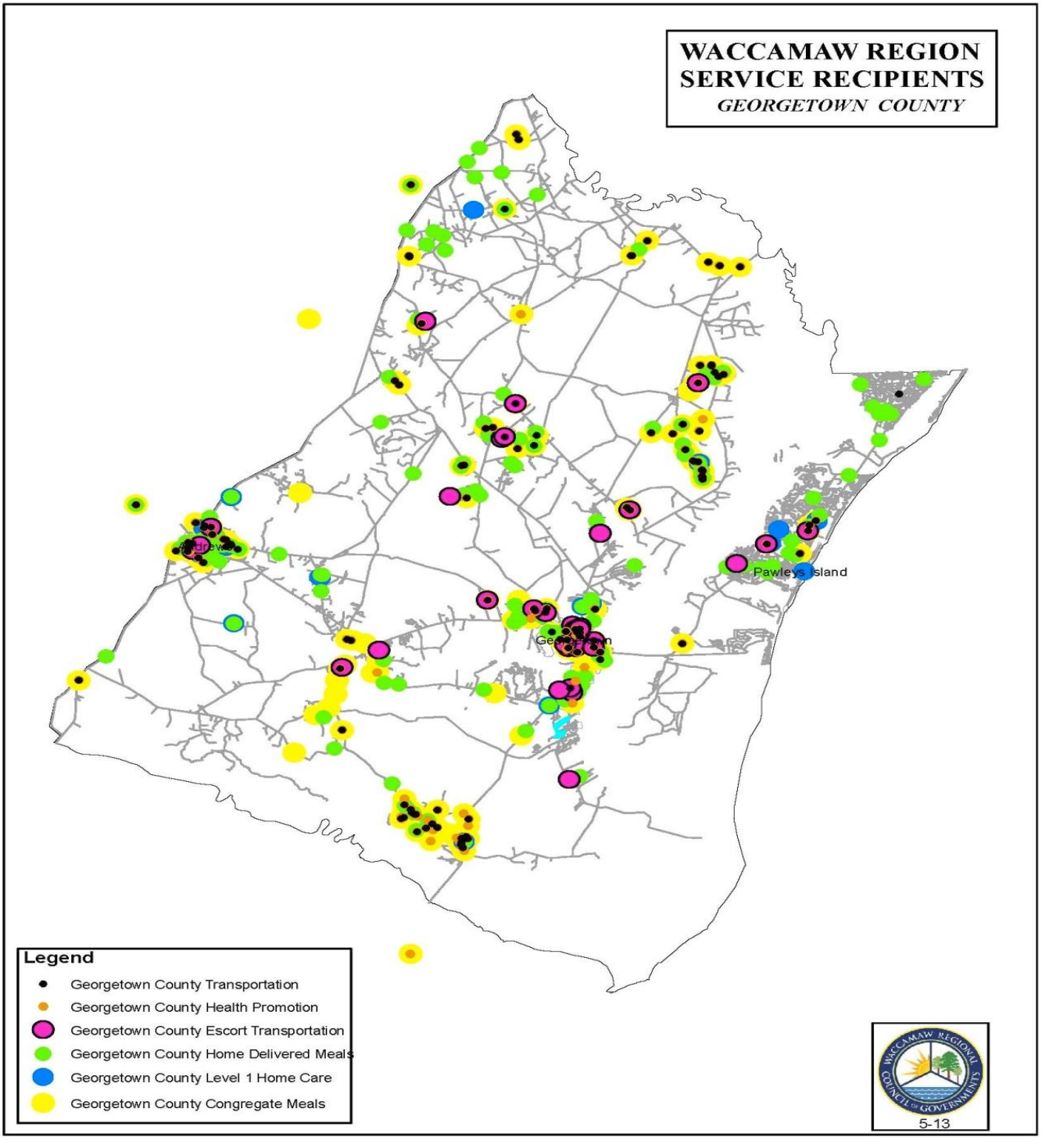
Legend
Horry County Transportation
Horry County Health Promotion
Horry County Home Delivered Meals
Horry County Level 1 Home Care
Horry County Congregate Meals
5-13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SERVICE RECIPIENTS
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Pawleys Island
Legend
Georgetown County Transportation
Georgetown County Health Promotion
Georgetown County Escort Transportation
Georgetown County Home Delivered Meals
Georgetown County Level 1 Home Care
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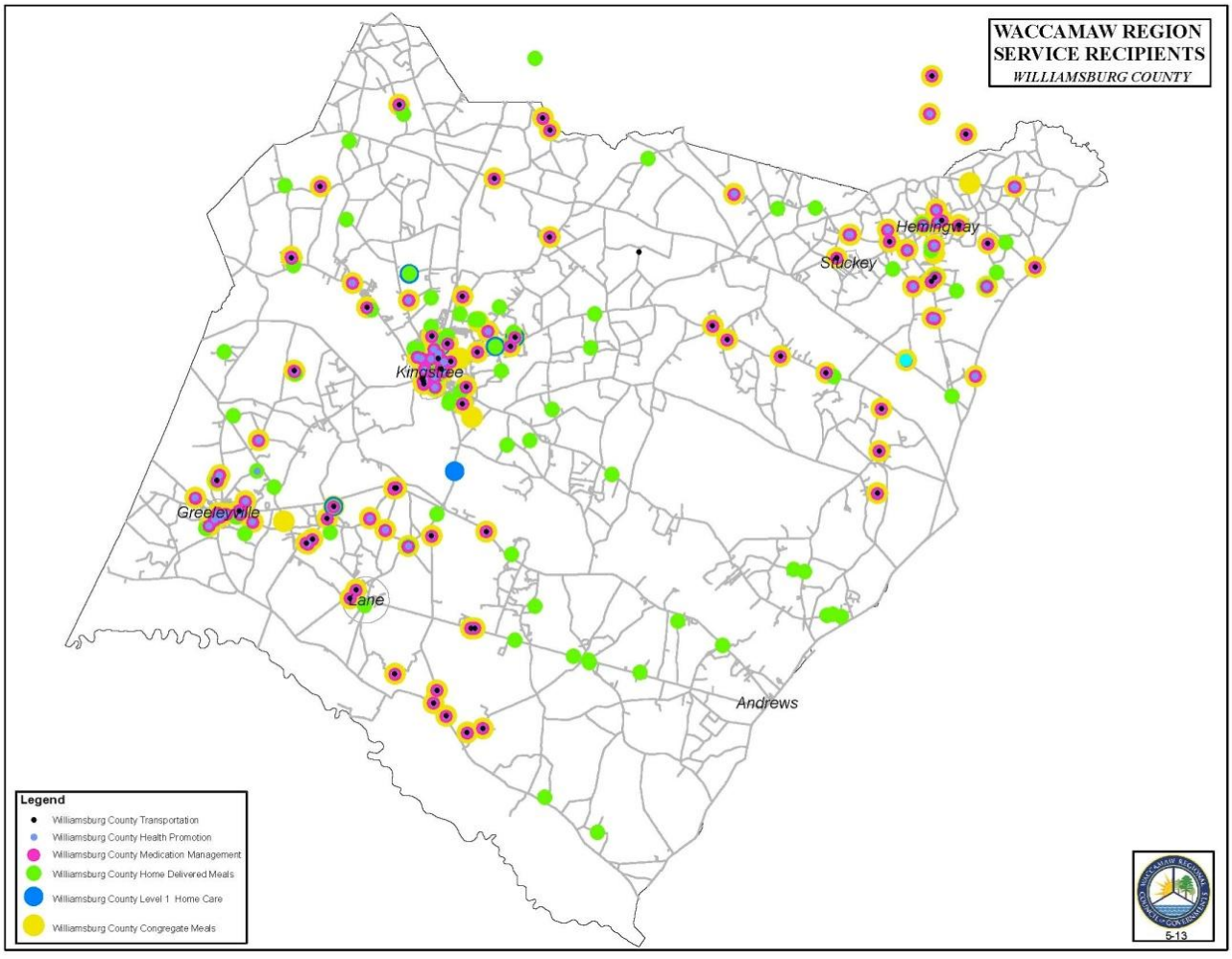


GIS mapping will be used on an annual basis to properly align clients to ensure target populations are being served. We will also use AIM report HHS 51 to identify those clients we are serving who are rural, in a minority class and under the threshold for poverty.

B. Objectives and Methods for Services to OAA Targeted Populations

The growth of South Carolina's 60 and over population will continue to increase significantly over the next twenty-five years. Overall, persons 60 and above are anticipated to increase from 651,482 in 2000 to 1,450,487 in 2030 for a 123% increase. The fastest growing segments of our senior population will be in the 75+ and 85+ age categories.

The US Census Bureau states, Horry and Georgetown counties are among South Carolina's top seven counties in the growth of their senior populations. Horry County, the most populous, was rated 2nd with a growth rate of 54.8%. Georgetown was the 5th fastest growing county at 20.5%. Comparatively, Williamsburg County grew a modest 9.4%.

The Waccamaw region has the highest ratio of senior/general population in South Carolina at 21.8%.

The national trend of unprecedented growth in the cohort group of those 85 years and above is also evident in South Carolina. This group, the oldest of the aged, grew 35% from 2000-2006 according to the US Census Bureau. This is especially important since this age group is the most vunerable in terms of their propensity to experience chronic conditions and Alzheimer's disease. The growth in the projected rate of those with AD will be exceedingly costly, state-wide and to individuals, families, caregivers, businesses and our government. The expected prevalence of this disease, alone, could bankrupt the medical and social services delivery systems across South Carolina.

In South Carolina, the change in demographics of the aging population is from two sources: seniors who age in place within the state and seniors that in-migrate into the state to retire. Williamsburg's modest growth in the number of seniors residing in the county is a result of seniors aging in place. Horry and Georgetown's dramatic growth is attributed to a combination of aging in place, coupled with the high rate of senior in-migration into South Carolina. Net in-migration represents 92.2% of this growth rate. These rising aging statistics are expected to continue over the next four years and well beyond that time frame into the future.

C. Ten Year Forecast for Planning and Service Area Region -

The economy has improved since the last Waccamaw Area Wide Plan was submitted. Our service constituency is forecast to grow considerably, especially along the coast in Georgetown and Horry County, where seniors come from all over the nation to retire. Others have second homes here, or visit the area, regularly, for three to six months a year. As the average life span increases, and the population along coastal areas grow, the agency can expect to serve more individuals and families.

The historic and cultural differences that exist between the indigenous seniors of the Waccamaw region and in-migrating seniors will continue to exist in terms of: personal finance; education levels and expectation with regard to the types and number of services to be offered. The agency will continue to strive to serve the diverse needs of our constituency via the: increased development of a volunteer pool and partnerships with other service providers that demonstrate the intersection of shared mission.

Cultural Diversity – Maintain a culturally diverse staff and seek volunteers to provide language translation, service access and to advise staff members regarding: cultural customs; trends; expectations and appropriateness of services/programs

Alzheimer's Disease – Maintain and grow our partnership with the local and state chapter of the Alzheimer's Association: continue to have A.A. literature on hand; speak at support groups; provide dementia-specific education professionals and families; raise community awareness about the Alzheimer's Association's 24/7/365 Telephone Helpline so our constituents have access to appropriate care and support every hour of every day.

Transportation – Continue to grow volunteer based transportation services across all three counties of the service area via: Waccamaw Assisted Rides Program and through partnership with GRACE Ministries' Neighbor to Neighbor Program (N2N). Continue to meet with community coalitions to identify transportation "gaps" and devise plans to address those gaps in partnership with: area hospitals; SCDOT; Medicaid: COAST RTA; American Cancer Society; Veteran's Administration; local medical clinics; other service providers.

Nutrition- Continue to work with sub-contractors to monitor, improve, and expand, congregate and home delivered meal programs. Continue to develop partnerships with community coalition members, with shared mission, to ameliorate hunger: Georgetown Community Coalition Partnership's program: "What's Cooking?"; Diabetes Association; Mended Hearts ; Food banks; Soup Kitchens; Helping Hand; Friendship Place; Homeless shelters and others.

I&R – Reorganize, update, and distribute the Regional Resource Directory to our constituents, volunteers and community service partners. Cross train all aging staff members to conduct effective interactions with callers and walk-in clients. Raise community awareness of the AAA/ADRC's I&R services through community presentations; health fairs; and print articles.

Housing- Continue to work with the COG's housing department, and community partners, to support programs and service related to the availability and rehabilitation of the area's aging housing stock. Maintain and enhance working relationships with: Ramp It Up!; housing corporations; senior congregate housing projects; assisted living and long term care facilities**.**

Medical- Continue to maintain, and grow, relationships with local medical clinics, pharmacies; physician practices, disease related support agencies and hospitals such as: Health Coach; Family Caregiver Training/Support Groups;

Alzheimer's Association**;** Diabetes Association; Mended Hearts; expansion of dental services across the region; coalition work groups for better mental health care

Distribution of Resources – Maintain, strengthen and extend the reach of the AAA/ADRC's Family Caregiver Support Program and S.H.I.P. programs. Continue to train staff and maintain a working relationship with: The Benefits Bank; Farmer's Market; local medical clinics; hospitals; pharmacy assistance programs; work force agencies; Social Security; Medicare; Medicaid.

Creation of New Resources - Through partnerships, and collaboration, continue to create new resources such as: Waccamaw Sports Classic; Care Transitions Community Collaborative; Health Coaches; Family Caregiver Training Educational Series; Family Caregiver Support Groups; Benefits Bank Workshops; Ramp It Up!; What's Cooking?; Assisted Rides Program; Neighbor to Neighbor Transportation; bill paying services

Legal Assistance – Maintain and grow relationships with area elder law attorneys; legal aid organization; SC Bar Association; SC Legal Services; local law enforcement and victim's advocate program thru I&R and joint educational programming

Multi Purpose Senior Centers – With the help of P.I.P. funding, Waccamaw sub-contractors are planning, or have recently opened, new and/or improved senior center facilities: Pawley's Island/Georgetown County opened May 1, 2013. Hemingway/Williamsburg County has a multi-purpose senior center in the planning stages.

Emergency Preparedness – See below

D. Emergency Preparedness

The Waccamaw programs coordinator has been working, in partnership, with county EOC officials, and local collaborative service provider

groups/partners to address the issue of public emergency preparedness since 2010. Milestones in making these connections and building a viable disaster plan include:

Educational Initiatives

- Completion of C.E.R.T. Training (County Emergency Response Team Training) 18 hours - June 2011
- Completion of Salvation Army Disaster Response Volunteer Training 10 hours– October 2012
- Completion of SAFE SERV – food safety/preparation course (preparation for post disaster community feeding) – 4 hours – October 2012

Developing a Long Range Emergency Preparedness Plan/Partnerships

- Active partner in V.O.A.D./Georgetown County since 2010
- Active partner in Horry County Access to Functional Needs Emergency Planning Committee – February 2013
- Prospective partner – Williamsburg EOC Community Partnership for Emergency Preparedness (meetings have been planned for same time as Horry County mtgs.)
- Planning committee partners include: EOC staff; Red Cross; Salvation Army; GIS/City and Community Planners; Schools; Police; SC DHEC; Commission for the Blind; SC Vocational Rehab; ADA Consultant; Home care agencies; County Rec personnel; media representatives; DSS; Disabilities and Special Needs Organizations; health care providers; CCU faculty; Coast RTA; constituents/residents

Work, to date, has been divided county-by-county, with the hope of eventually developing a regional approach to disaster preparedness. Across the service territory, the work is shaped by the following process:

EDUCATION: Understanding the importance of preparedness; knowing your community partners with a shared interest of surviving and rebuilding a community after a disaster; understanding the functions/responsibilities of the local EOC; knowing how local EOC functions with: state & federal responders; local relief organizations; faith based organizations; health care providers;

INVENTORY of COMMUNITY NEEDS: Hearing from various community constituent groups what special needs the populations they

serve will have with respect to: notification of impending disaster with advanced warning i.e. hurricane, flooding; notification of a sudden, unexpected disaster (i.e. wild fire, explosion; terrorism; flash flood); mandatory evacuation; sheltering in place; surviving a disaster; communication of instructions following a disaster; re-building after a disaster and re-opening of businesses, services, program

INVENTORY of COMMUNITY RESOURCES: What goods/services are, locally, on- hand in preparation for, during and following a disaster? Who is in charge of leading the community through a disaster? What outside agencies will assist in a disaster? How do they function? How will we communicate in an emergency without power, phone lines; computers? How will people be fed, hydrated, clothed, housed, given medical care in an emergency? How will mass casualties, or deaths, be dealt with? How will the community work together?

BUILDING a VIABLE PLAN – work is not at this point yet.

The Waccamaw region has worked through most of the first three steps of the process above. We are building relationships with one another, discovering what we have to work with in case of an emergency, and defining gaps that need to be addressed. The next few months will begin the development of a plan to face disasters as a community. It is a BIG process, and takes time. The ultimate goal is take the county processes and create a regional response plan, that includes drawing up plans for special populations i.e. the aged and disabled – blind, deaf; cognitive disabilities, mobility issues.

Annual Review Process – Every year the AAA/ADRC reviews the list of staff members, COG leaders, contractor leadership and local emergency officials contact information for accuracy. Changes are made. The information includes contact information related to the office and at home. The information is distributed to those listed above. Recipients are asked to keep a copy at their desk and in their home. Information will be conveyed via these contact numbers. TO date, information about how to interface with LGOA in an emergency has not been listed. WE hope to add that information this year. We would welcome training from LGOA on this subject.

Emergency Contact Information Distribution

Office/home/cell numbers are shared with: AAA/ADRC and COG administrators; AAA/ADRC staff members; contractor administrators; EOC leaders in each county.

Responsible Parties in an Emergency

- Waccamaw COG – Sarah Smith E.D. – *on call*
- AAA/ADRC – Kim Harmon – *on call*
- County Office on Aging Executive Directors – Georgetown, Horry and Williamsburg
- County EOC Directors – Georgetown, Horry and Williamsburg

Maintaining Operations in a Disaster

How operations are maintained, in a disaster, depends upon what type of disaster will occur or has occurred. Variables that are pertinent to developing a response include: Do we know that the disaster is coming...is there warning and preparation time (hurricane, winter storm)? Or, is the disaster an unexpected one (wild fire, explosion, chemical spill)? How wide-spread is the disaster (one town, one community or region-wide, national)? Has a mandatory evacuation been imposed or has the community been told to shelter in place? What is the duration of the disaster? How many people are likely affected? What we need to do to serve them before during and after a disaster? Who are our partners in recovery?

Creating a meaningful disaster plan means having a plan that is matched to each of these scenarios. Also, the plan must be in writing; include MoU with partners; have necessary survival supplies on hand; include plans to assure that our families will be safe; have office equipment in other areas; etc. The Waccamaw AAA/ADRC, and frankly, our region, has not yet developed viable working plans to survive and recover from a disaster. We are working on this, and it will be a focus area for the next four years.

Protocols for Congregate and HDM Clients

Currently, before hurricane season, center managers, across the service area, run educational programs about preparing for a hurricane. Center participants are refreshed about: having a portable emergency kit that will sustain them for three days without assistance including: food that does not have to refrigerated or heated; a three-five day water supply 1 gallon per person per day, including pets; extra medications on hand both

prescription and over the counter; first aid kits, sealable plastic bags, bleach; wipes, warm clothing, comfortable shoes, assistive devices etc. A three-day supply of shelf -stable meals are provided to program participants. Center clients are to take the meals home and save them for a possible emergency. HDM clients have their shelf stable meals delivered to the home with instructions.

Contractors have lists of clients that have declared that they will need assistance in evacuating. Home bound clients have priority status in an evacuation. Contractors will provide transportation to shelters for seniors, and disabled citizens, and their family members, in the case of an emergency that comes with warning time.

Contractors keep their vans in several locations to assure that the entire fleet will not be wiped out at once, in a disaster situation. Contractors that utilize blast frozen meals have offered to share their product with the community, should a power outage begin to thaw the frozen meals.

Electronic Record Backup

Data is backed up daily onto a portable data drive and the records are stored off-property to assure that operations will be restored as quickly as possible following an emergency.

MoUs with Service Partners

Memorandums of Understanding with service partners have not been developed or signed, at this point. We are working through a committee process to get to this point in the planning process.

E. Holiday Closings

The following shows the holiday closing schedule for Waccamaw for FY 13-14:

Independence Day	July 4, 2013
Labor Day	September 2, 2013
Thanksgiving Day	November 28, 2013
Day after Thanksgiving	November 29, 2013
Christmas Eve	December 24, 2013

Christmas Day	December 25, 2013
Day after Christmas	December 26, 2013
New Year's Day	January 1, 2014
Martin Luther King Day	January 20, 2014
President's Day	February 17, 2014
Good Friday	April 18, 2014
Memorial Day	May 26, 2014

V. AAA/ADRC Operational Functions and Needs

A. Assessment of Regional Need

Our constituents' viewpoint regarding their self perceived needs were uncovered in the Aging Needs Assessment/SWS Inc. Plan/October 2012 will be incorporated into the Waccamaw AAA/ADRC Area Plan for 2013-2017 in the following ways:

Transportation – The SWS INC. Needs Assessment/2012 corroborates the fact that having access to affordable, reliable transportation is a top priority for several constituent groups across the service area including those whose living situations are characterized by: living in a rural area; being of advanced age; living alone; disability; living in poverty. The Waccamaw AAA/ADRC will continue to grow our Assisted Rides Program and to work in collaboration with GRACE Ministries N2N volunteer-based transportation system to spread access to affordable transportation across the service territory.

I CARE & Insurance Counseling -The AAA/ADRC's role in providing insurance counseling and assisting constituents in understanding their coverage and related options remains tantamount in maintaining independence of the agency's client base. All staff members will continue to have a working knowledge of the basics with regard to options and insurance entitlements. Group workshops will extend community outreach

to engage greater numbers of clients. Community service partners and volunteers will be identified, and trained, to assist with program expansion.

Information and Referral (I&R) – The SWS 2012 Survey served to reiterate that AAA/ADRC clients and those not being served by the agency, are equally interested in having additional information about programs and services that might be available to them. The Aging staff members will have a working knowledge of community resources; the agency will continue to compile, and distribute, a Regional Resource Directory; group presentations will be made to senior centers and other community, faith-based and civic groups; culturally and linguistically matched volunteers will be trained to assist in delivering outreach/educational presentations; and agency brochure will be revitalized.

Advocate Services – Protection of rights and having someone to call to report a perceived threat were high priorities for caregivers and those with disabilities. Incorporating these topics into targeted presentations for these groups would improve AAA/ADRC's service to these constituencies. The services of the ombudsman will remain a top priority for those living in congregate setting. Working with DSS to create a more timely, effective response to those, living in the community, who report abuse, neglect and financial exploitation is warranted.

Senior Center Activities – Across the board, those receiving senior center services viewed exercising as the most important center activity, followed by getting counseling (or having someone to talk to).

Exercise - This finding speaks to the need to re-vitalize exercise programs and to keep exercise options "fresh' and interesting. The Waccamaw Sports Classic preparation process is great way to get seniors moving as they improve their skills in: walking; running; horse shoes; spin casting; corn hole; pickle ball and more throughout the year.

Counseling - Training center managers in developing therapeutic listening skills and in making non-judgmental responses during personal discussions with clients might be a beneficial avenue to explore in terms of improving center service. Other ideas include starting informal discussion/ support groups among center participants and seeking volunteer "experts" with professional experience to develop programs to aid center participants to get the most out of their time spent at the center.

Nutrition Information – The fact that SWS 2012 survey indicated that seniors prioritized the need for nutrition education suggests that perhaps bringing the Cooking Matters classes to senior centers might be warranted. Other ideas: cooking demonstrations; recipe sharing and collection; label reading lectures and practice; presentations from dietary and disease management experts.

Family Caregiver Support Program – Caregivers continue to consider respite care options and monetary support to be very important. The FCSP stipend for caregivers is very small compared to the financial obligations that caregiving imposes upon a family. The question remains: How can the AAA/ADRC, and our community partners, work together to build a pool of resources that are more commensurate with the needs of family caregivers? This dilemma is one that will require a community response and will be put before collaborative work groups in order to begin the process of creating an appropriate response.

B. Program Development

Consumer Choice – It is the prevue of the AAA/ADRC to offer our constituents the greatest amount of freedom, and access to options, that lead to optimal independence and quality of life throughout the life span. Each of our staff members will commit themselves to examining their respective program/service areas of responsibility, keeping this overarching premise in mind. We will continue to bring our community service partners to the table to plan, and implement, a range of service possibilities for our clients. Examples of these efforts that have resulted in positive outcomes include: Volunteer driver transportation programs; Waccamaw Sports Classic; Cooking Matters; Ramp It Up!; Health Coach Initiative; Family Caregiver Educational Series and Family Caregiver Support Groups; dental care imitative. Creating choices for consumers means developing those choices from "scratch" in most cases. The Waccamaw AAA/ADRC will continue to build, and strengthen, these program choices, over the next four years. We will also seek opportunities to build additional programs and services. Possibilities that are underway include: improving community mental health care; providing a program for those who need a wheelchair transport but do not qualify for Medicaid service; end of life care initiatives.

Private Pay – Waccamaw AAA/ADRC recognizes the growing role that private pay services will play as a way to extend the scope, and reach, of our services as government dollars shrink. We have begun the implementation of our first private pay service for consumers: our new bill paying service. The program provides automatic monthly bill paying services for households and small businesses for a reasonable fee. This new addition to our constellation of services will help people to stay in their homes who are experiencing declining mental capacity and/or the declining physical capacity to write checks and manage their budget. Other targeted clients are: snowbirds and people managing two households; busy caregivers managing their own expenses and their parents or grandparents; anyone who wishes to have more time to work or engage in leisure activities; those who need structure in organizing and paying monthly expenses.
The program is offered to people of all ages, and small businesses.

The agency will continue to offer nutrition services to those, with a need for support, but that do not qualify for government-supported programs, on a private pay basis. Sliding fee scales will continue to be implemented for senior center related transportation services.

We intend to look for opportunities to expand fee for service programming throughout the 2012-17 plan period.

C. Program Coordination

The Waccamaw Aging Programs Coordinator has implemented a standard process for contractor administrators and staff members including: orientation, training, refresher education, monitoring and follow up services. Consultation and technical assistance are offered as needed, and when requested. The goal has been, and continues to be standardization of quality services/programs across the region. AAA/ADRC staff members offer their services through the senior center system. Examples include: S.H.I.P. counseling and Part D re-enrollment workshops; The Benefits Bank workshops; special educational presentations on: dental care; diabetes; stroke; dementia; regional social activities such as fashion shows, talent contests,; health and wellness programming – Waccamaw Sports Classic and County

Parks and rec workers providing practice sessions to prepare senior center participants to prepare for optimal performance at the WSC event.

Partnerships have been developed with community service providers to extend service outreach and expand programming for clients. Examples include: Coastal Carolina University faculty, staff and students: Georgetown Hospital System; home care agencies; hospice agencies; disease-related service agencies; advocacy agencies; AARP; elder care attorneys; physicians; dentists; Helping Hands; Dept of Social Services; nursing homes; assisted living facilities; adult day service agencies; transportation providers, and more.

Partnership focus areas include: health and wellness; transportation; meeting medical needs; meeting dental needs; meeting mental health needs; disaster preparedness; dealing with chronic health conditions; nutrition; family care giving education and support; insurance needs; financial and long term care; planning; information and referral. The collaborative community processes that aim to: identify needs; engage active service partners; assess current resources; make plans to address "gaps" in resources; assign responsibility and pilot programs will continue into the future.

D. ADRC and Long Term Care

The Waccamaw AAA would welcome the opportunity to provide more options to its constituents in terms of community-based long term care. At the heart of this effort the AAA has developed an educational program entitled: Family Caregiver Education in conjunction with the area hospital. The Family Caregiver Advocate along with physicians, attorneys, community resource specialists have partnered to present full day Saturday classes to educate the community. These are advertised in newspaper, hospital newsletters, AAA newsletters to increase participation. We were able to hold two of these sessions in fiscal year 2012-2013 and more are planned for the upcoming year. These sessions will be moved around the counties in order to ensure that all interested parties can participate.

Advanced topics will include: Choosing a Quality Service; Working Together: Building Good Family/Staff Relationships; Making the Transition to Long Term Care.

The service territory covered as well as the numbers of trainings offered will grow in planned fashion over the course of this four year plan.

This type of service expansion requires careful and extensive planning and additional resources.

E. Advocacy

Past Advocacy Efforts – The Waccamaw AAA/ADRC staff members have conducted advocacy efforts by: being connected to service organizations and watch dog organizations that keep us informed about pertinent, timely issues pertaining to the field of aging/disability; caregiving; service and program planning/funding; medical research; pharmacology care; insurance changes; long term care issues; safety concerns; social service research; national, state and local policy changes.

We respond to the issues that we aware of via: letter writing; phone calls to legislators; informing our constituents; building awareness among local service partners with shared interests; devising response plans with community partners; writing Op-Ed letters; making visits to legislators in local offices, state offices; federal offices; informing out C.O.G. Board of Directors, many of whom, are legislators and community leaders.

At least once a year, or more as needed, an entire COG Board meeting is dedicated to aging/disability issues.

F. Priority Service

In the past, our region has chosen to adhere to the state prescribed percentages for priority services and used no less than 10% for in-home services, 1% for legal and the remaining 89% was primarily used for transportation services. For the upcoming year, the state has prescribed that the minimum for legal shall be 4% and we will adhere to that policy. Our 2013-2014 budget allocates 96% of our IIIB funding to transportations services and IR&A. We believe that given the current climate as described by the LGOA, we expect to receive additional state funding that will help to backfill any shortfalls in the area of Title IIIB funding and we will revisit the Title IIIB allocation

as soon as we have firm allocations of state home and community based services dollars.

G. Priority Service Contractors

The Waccamaw AAA/ADRC assures the LGOA that it will only enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance. All clients will be determined eligible based on social and economic need and if there are no other appropriate alternatives to furnish their needs. The following issues will be used as priority services under the legal assistance program; income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. This service will be subject to procurement and eligibility will be determined upon successful applications.

H. Transportation

Regional transportation services will continued to be assessed through a ride-along monitoring assessment process, wherein. the monitor: gets to know the driver; observes his/her job performance; considers safety procedures; offers suggestions to improve service delivery; provides written feedback to the sub-contractor administrators; follows up to be sure that necessary corrections have been accomplished in a timely fashion. New drivers are assessed before tenured drivers each year.

Currently, our contractors earn transportation units based on per passenger mile rates. As we entered into new contracts through procurement in 2014, we will transition to the required point-to-point mileage rates as stated in the LGOA Policies and Procedures Manual.

In addition to the transportation services provided via OAA funding, the Waccamaw AAA/ADRC has focused, in the last four years, on filling transportation "gaps" that are experienced throughout the region by seniors, and disabled adults, who no longer drive. Community surveys of consumers, and service providers, have indicated that that lack of transportation is a barrier to: timely and appropriate medical/therapeutic care; access to pharmacy; access to

nutrition; access to social care, worship and other quality of life activities.
The agency has actively partnered with GRACE Ministries to provide more than 5,000 free rides to senior/disabled individuals. Most recently, the agency has entered into a contract with LGOA to initiate the Assisted Rides Program in our service territory. The program is off to an excellent start.

I. Nutrition Services

Changes in the Last Four Years - In the last four years, the nutrition program, both the congregate and the HDM programs in the Waccamaw area, have grown. The agency has worked to grow positive working relationships with our contractors and especially with the front-line staff of sub-contracting agencies. The following changes have been implemented: orientation and training of front-line staff; pre- and post monitoring meetings with site/program managers; written follow-up monitoring summaries to sub-contractor administrators; compliance deadlines for corrections.
In the future, we expect that as the area's population ages that the number of people seeking nutrition services will rise. This is an especially challenging prospect in light of the shrinking budget trend. We also expect to find a growing number of Spanish speaking citizens seeking services. We are planning to address this issue with volunteer translator and 211 language line utilization. Our providers currently earn units based on meals served to each client in the group dining centers based on requirements as stated in the Older Americans Act.

25 or More Clients -The annual monitoring process has confirmed that congregate dining sites do have the appropriate number of clients (25 or more) unless they have been granted a formal waiver. Even those with a waiver, have average attendance number close to, or exceeding, 25.

Activities - Congregate activities are monitored, monthly, because activity calendars are included with each month's food vouchers that are returned to the AAA/ADRC office. AAA staff can see what activities have been provided, how many clients participated in each activity and how long those activities were performed. PIP funded

sites are required to have longer activity schedules. The AAA/ADRC knows which sites have been PIP funded.

Services to Rural and Low Income Clients - Except along the coast of our service territory, most congregate nutrition sites and HDM routes are rural, and the majority of the clients who are served in these programs, fall with the low to moderate income categories. The evidence leading to this conclusion comes from: observations collected during ride-along monitoring of at least 1/3 of all HDM routes and face-to-face monitoring sessions of at 1/3 of congregate meal sites; client record review.

It has been observed that our sub-contractors are not serving many people that have English as a second language; this is most likely because outreach has not been conducted to these populations, nor have culturally/linguistically-matched staff members been hired. This is an area to be addressed.

Client Prioritization - Clients are prioritized for services through an intake interview, and by the utilization of standardized intake forms that list all the legislated avenues to qualification, as well as, those factors that determine who is MOST qualified to receive services. The list of qualifiers, and prioritization factors, are presented to the interviewer in a check box format. The more boxes that are checked the greater the priority level of the prospective client. Re-assessments are conducted annually, for each client, and this provides a continuous record of prioritization that is reviewable via case file monitoring. The AAA/ADRC monitor takes random samples from the entire caseload of the subcontractor and reviews each "pulled" file for qualification and prioritization.

Cost Sharing - Cost sharing is discussed on intake and during re-assessment, on a one-to-one basis, and is presented to the group throughout the year, as a group reminder. Sites generally, have an envelope and collection jar system that is always in a prominent location in a center. Center managers count, and record, funds that are collected and turn them into the office of the sub contractor on, at least, as monthly basis. HDM service clients are reminded of the opportunity to cost share via written communications that are delivered with meals.

Menus – Menus posting procedures are taught in staff orientation and training sessions conducted by the AAA/ADRC and/or sub-contractor administrators. The posting procedure is reviewed, through observation, during site monitoring visits.
AAA/ADRC staff members attend quarterly menu planning meetings, in Columbia, and communicate with Senior Catering regarding menu development, and changes to planned menus.
To date, Waccamaw AAA/ADRC has not worked with community partners to encourage meal variety or intergenerational meal programming.
In case of blast frozen meal delivery, menus are delivered with the meals.

J. Training and Technical Assistance

A standardized training and orientation curriculum, based on legislation and LGOA Service Manuals has been developed and implemented across the service territory. Regional training and refresher courses are offered throughout the year, and upon request, of sub-contractors, as new employees are hired. Included in training are: Scope of Service requirements; client intake and prioritization; job safety and expectations; emergency procedures; DETERMINE score forms and training; reporting procedures.
Technical assistance will continue to be offered in terms of planning for new service centers; improving client health and nutrition educational programming; offering of regional health and wellness activities and regional social activities.

K. Monitoring

The Council currently uses the calendar year 2013 edition of Sage 50 Nonprofit Accounting software to account for all fiscal records. In addition to a customized chart of accounts, the Council employs the use of subsidiary ledgers to track revenue and expenditures in connection with all LGOOA and/or AAA funds. The subsidiary ledgers allow for tracking at three (3) successive levels (job, phase & cost code), as necessary and applicable, to account for fund use in compliance with the various, and often unique, grant or contract requirements. Each contract or grant, including any source subset and/or special delineation within a given fund

source, is accounted for separately—to the extent such benefits are derived from a respective fund source. The subsidiary ledgers can be displayed in summary format or detailed format. Both of the aforementioned formats reflect the disposition, nature and amount of expenditures; however, the summary format is most useful for general tracking purposes while the detailed format includes an itemization of all costs under a given general ledger account and a more detailed description of each expenditure. Our accounting system and the tracking methodology employed offers great accountability and transparency. Available for review at our offices are the FY 2013 subsidiary ledger used for tracking all LGOOA funds which pass through our Special Revenue Fund for Aging and a copy of a few of the FY 2013 subsidiary ledgers used for tracking all internal AAA revenue and AAA expenditures incurred in the administration of AAA/ADRC programs, which are recorded in our General Fund on a reimbursable basis.

Describe how AAA/ADRC accounts for matching funds – External -The AAA/ADRC only reimburses the provider 90% of requested funding for units submitted monthly to ensure that the local match is appropriately applied. Internal- The Waccamaw Regional Council of Governments (hereinafter referred to as the Council or COG) receives supplemental funding from member counties pursuant to an Inter-local Agreement. The Inter-local Agreement has been in effect since the inception of the Council. The agreement essentially provides for a mandatory recurring annual supplemental appropriation from member counties (Horry, Georgetown and Williamsburg) to the Council for purposes of meeting match requirements for programs administered by the Council, which necessitate or mandate local match in order to qualify for receipt of such funding. Each fiscal year, a portion of the collective annual supplemental appropriation is obligated to provide the required local match for the LGOOA programs administered by the Waccamaw Area Agency on Aging. The obligated portion of the collective annual supplemental appropriation varies commensurate with variations in the amount of the LGOOA funding (and the related match requirements) from year to year. The Council operates on a cost reimbursement basis. All AAA expenditures incurred in the administration of AAA/ADRC programs are tracked separately and recorded on subsidiary ledgers in our General Fund. At the end of each fiscal reporting cycle (monthly), the Council prepares an invoice for each unique AAA program and/or contract. Prior to invoicing, the Council prepares an adjusting journal entry at the end of

each fiscal reporting period (monthly) to obligate the required match for given AAA program and/or contract, as necessary and applicable, to ensure compliance with matching requirements. The amount invoiced is net of the Council's local match. To clarify, the invoice reflects only the eligible, reimbursable amount for a given AAA program and/or contract. Available for review at our offices are the subsidiary ledgers used for internal tracking which display and denote the required match applied to a given program or contract.

The AAA/ADRC requires a cash match from all of our providers in order to ensure that the required local contributions are applied and local units are served. Again, only 90% of requested funding is reimbursed to allow for local match to be applied. The AIM system also deducts the monthly contributions from service recipients and the AAA/ADRC only pays for units not supplied by the additional contribution of participants.

The AAA/ADRC monitors the MUSR as well as LG97c and LG45d to ensure accuracy of reports as well as ensuring completed assessment data.

The Council has an annual independent audit at the conclusion of each fiscal year. Copies of the annual audit are forwarded to the LGOOA and filed with the Clearing House. The contents are public information and accessible to the LGOOA and the USGOA. The Council assures the LGOOA and the USGOA that related fiscal and programmatic records will be maintained and that such records may be reviewed upon notification. The FY 2012 Annual Audit and our internal Monitoring Policies & Procedures may be viewed at any time as requested.

L. Contract Management

A procurement of services is conducted every four years. In between the formal procurement process, providers are monitored on a yearly basis to ascertain the quality of services provided as well as the level of services performed. Formal monitoring reports are sent to each provider along with any corrective actions that need follow-up. If a provider has no major deficiencies and is serving the required number of clients and continues to provide local support for services (match) then a provider will continue to receive a contract with our agency.

- All procurement documents, contracts and amendments are on file and available for review.

- All procurement contracts are supported by LGOA and adhere to state and Federal policy
- All senior centers in the Waccamaw region will provide monthly calendars of activities that meet requirements. Activity calendars will show variety and that the activities meet the needs of clientele.

M. Grievance Procedures

Client grievance procedures are posted, in a prominent, public location in centers. As per protocol, issues are to be addressed first, whenever possible, at the center-level of the organizational structure. However, if the client is not satisfied with the resolution, or if protocol has not followed, the clients can proceed to grieve their case at the administration-level of the sub-contractor; next to the AAA/ADRC level; finally to the state level. Standard response times will be adhered to at all levels of the process.

N. Performance Outcome Measures

Contractor performance is measured against: the standards that are set forth in the service contract; the Scope of the Work Service documents; the federal legislation associated with the program; the LGOA Service Manual requirements. Outcome measurements are monitored via: service unit utilization; A.I.M. documentation review; monthly voucher audits; monthly calendar review; annual on-site and ride along monitoring process/ follow-up; client record review process; informal survey discussion with clients and family members.

O. Resource Development

The AAA/ADRC consistently encourages its providers to seek additional grant funding and will assist with any efforts. Our providers hold fundraisers throughout the year to support local programs and provide services through organizations such as the Foster Grandparents Program to supplement services and staffing. The following are services that were provided through grant related income from July 2012 – April 2013 by county and service:

Provider	C1 Meals	C2 Meals	Health Promotion	Home Care	Transp
Georgetown	204	303			
Horry	190	230	176	20	233
Williamsburg	286	151			5012
Total	680	684	176	20	5245

P. Cost-Sharing and Voluntary Contributions

Local Partnerships - Community service partners are identified through the process of uncovering shared missions that exist because of the needs of the seniors/disabled individuals, and their family caregivers, living in the service area. Examples of programming that have resulted through collaborative service partnerships include: volunteer driver transportation programs; health and wellness programming (Waccamaw Sports Classic); Family Caregiver Education Programs – addressing health; legal/financial issues; and practical care tips and community resources for families; Cooking Matters; Ramp It Up!; Health Coach Program – providing better transitions from hospital to home for seniors/reducing hospital readmissions; Community Care Network – Mental Health – filling the gaps in mental health services; Disaster Response- building a better plan before, during and after a disaster.

Working in partnerships with organizations with shared mission extends the reach and budget of the AAA/ADRC by bring free resources to the problem areas of service delivery. Partnerships provide: collective professional experience; the benefits of divergent educational backgrounds; a variance in point of view/cultural norms; synergy and energy; cost sharing in terms of time/staff budget/volunteerism. The relationships that are built during the community problem-solving process create a foundation of trust that provides a legacy of community infrastructure that is likely to generate additional, future community problem-solving.

Voluntary Contribution System – The voluntary contribution system will continue to be: explained verbally and in writing, at intake and at annual re-assessments; contribution confidentiality will be strictly maintained; the voluntary nature of the contribution will be stressed; these parameters will be addressed in every service contract.

Q. Confidentiality Assurances

Each of our providers must ensure the confidentiality of records and their Executive Directors much sign assurances in their contract with our agency. They each must provide their internal confidentiality policy as a part of the required documentation of their contract. The AAA/ADRC will ensure that these policies are on file for review.

VI. AAA/ADRC DIRECT SERVICE DELIVERY FUNCTIONS

A. Staff and Qualifications

Valerie Gonzalez, Family Caregiver Advocate – Valerie has earned a Bachelor of Science Degree with a concentration in Gerontology. She has served for fifteen years in the aging field as Family Caregiver Advocate, Waiver Care Manager, CareManager II, Ombudsman, Protective Services worker, and Guardianship CareManager. She holds certificates in Family Dynamics and Social Work, Grief and Loss, Stress Management and ICARE.

Amanda Stoveken, Information and Referral Specialist – Amanda has earned a Bachelor's Degree in Criminal Justice and a Masters Degree in Social Work with a Specialist in Aging certificate. She is a licensed social worker as well as a certified Benefits Bank and SHIP counselor. She has been in the field of aging for two years.

Tasia Stackhouse, LTC Ombudsman – Tasia has earned a Bachelors of Science Degree in Government and International Studies/Sociology. She has served for fifteen years in an advocacy role with the last eight years as Waccamaw's Long Term Care Ombudsman.

Trina Cason, Mobility Manager – Trina is currently enrolled in Horry Georgetown Technical College – Associate of Arts program in the Communications, Humanities, Behavioral and Social Sciences department. She has six years military service and is certified in the following areas: First Responder, and System Support. She has also worked as a licensed realtor.

Brenda Blackstock, SHIP/SMP Coordinator – Brenda has earned a Bachelor's Degree in Religion from Allen University and a Masters Degree in Social Work from Ashely University. She is a Certified IR&A Specialist in Aging and has served as the ICARE/SMP Program Coordinator for eight years.

B. Long Term Care Ombudsman Services

The Ombudsman program in the Waccamaw service area is seamless and quite responsive to the needs of the population in which it is serves. The local ombudsman has become an excellent resource for information and help and is a trusted resource in mediating complaints or concerns that may arise for anyone living in long term care environment (nursing homes or residential care facilities). We are called upon daily to mediate for residents and have become a knowledgeable resource in the long-term care community.

The long term goals would be those in branding and marketing. The program is still not well known to those not in long term care facilities. As the baby boomers come of age the need for information is now even more relevant. Many will matriculate into long term care facilities if they armed with the right information and tools to navigate into long term care it will make the transition smooth. Branding of the program is a needed phase in order to proceed forward. Moving forward working with partners, stakeholders to develop a brand that is consistent, easy to remember, and provides a clear identity of the program and the program functions will be required. The branding process should make the information readily recognizable. Tagline will need development one that can be tailored to local networks that facilitate easy identification.

The program as it is today has achieved and is known for its availability to the clients at all times in the region. This level of accessibility has allowed for the provided a way to get complaints and concerns heard and resolved in a timely manner. Residents as well as staff has utilized the ombudsman as a means of ensuring that the wishes and needs are adhered to in a justified manner.

Improvement is needed in the promotion of the Advancing Excellence initiative. This initiative encompasses eight goals;

Goal 1 - Staff Turnover: Nursing homes will take steps to minimize staff turnover in order to maintain a stable workforce to care for residents.

Goal 2 - Consistent Assignment: Being regularly cared for by the same caregiver is essential to quality of care and quality of life. To maximize quality, as well as resident and staff relationships, the majority of nursing homes will employ "consistent assignment" of CNAs.

Goal 3 - Restraints: Nursing home residents are independent to the best of their ability and rarely experience daily physical restraints.

Goal 4 - Pressure Ulcers: Nursing home residents receive appropriate care to prevent and appropriately treat pressure ulcers when they develop.

Goal 5 - Pain: Nursing home residents will receive appropriate care to prevent and minimize episodes of moderate or severe pain. Objectives for long stay and short stay are slightly different.

Goal 5A - Long stay (longer than 90 days) nursing home residents will receive appropriate care to prevent and minimize episodes of moderate or severe pain.

GOAL 5B - People who come from a hospital to a nursing homes for a short stay will receive appropriate care to prevent and minimize episodes of moderate or severe pain.

Goal 6 - Advance Care Planning: Following admission and prior to completing or updating the plan of care, all nursing home residents will have the opportunity to discuss their goals for care including their preferences for advance care planning with an appropriate member of the healthcare team. Those preferences should be recorded in their medical record and used in the development of their plan of care.

Goal 7 - Resident/Family Satisfaction: Nursing home staff will assess resident and family experience of care and incorporate this information into their quality improvement activities.

Goal 8 - Staff Satisfaction: Nursing home administrators will assess staff satisfaction with their work environment at least annually and upon separation and incorporate this information into their quality improvement activities.

The success of the advancing excellence initiative is vastly depended on the partnerships forged with the many participants and long term care providers across the region as well as the state and nation inclusive.

An additional barrier to quality of life and reduction in abuse of long term care residents in facilities at the hands of staff as well as family is regulatory agencies and law enforcement ambiguities as it relates to the laws surrounding the various issues of long term care. Regulatory (DHEC, LLR, LLE) slow responses to complaints makes it harder for the ombudsman program effect positive changes.

The friendly visit program is still active. Recruitment remains to be major barrier. Retention tends to be an additional problem due to fact that participants need a constant contact with supervisor. The volunteer poll has diminished somewhat due current economic environment. Many volunteers need some form of compensation to offset the fuel cost associated with travel to the different locations.

The ombudsman in the Waccamaw region has forged many positive working relationships with long term care administration in the multiple facilities in the region. These relationships has allowed for many different

opportunities of advocacy that had not been afford the program previously. The resident voices through the ombudsman are being heard more frequently and louder than ever before. Contacts are being made through the many county interagency councils that now has started to invite the ombudsman to speak and elaborate on the program, explain its many functions and benefits. The program is open to forging relationship within its ethical boundaries to elevate advocacy. Promoting educational venues will be the focus in the future. The more the information is readily available. The likelihood of misinformation will decrease. Residents or their family will know that the program exists and how it can be utilized which will in turn increase reporting of issues and problems.

C. Information and Referral Assistance Services

Long Term Goals:

- Provide ongoing, one-stop approach for bringing information, education, services and resources to our consumer base
- Maintain a current database of resources to be made available via the WRCOG website
- Reach a wider audience of clients via innovative marketing and outreach options, including online/print/visual media, newsletters and presentations
- Investigate the possibility of creating new programs, including emergency preparedness, telephone reassurance and preventative home maintenance
- Create program literature for distribution

Strengths:

The I&R/A Specialist is a Licensed Master of Social Work (LMSW) with a Specialist in Aging Certificate. This specialized training allows for a unique, compassionate response to clients. The I&R/A Specialist is also cross-trained in ICARE and pursuing CIRS-A Certification (to be obtained after one full year of employment). The I&R/A Specialist has extensive knowledge in database management and report queries.

Weaknesses:

The current configuration of the I&R/A program contains three key weaknesses. The first is the inability to contact I&R/A staff if they are

off-site. Clients have to wait for the I&R/A Specialist to return to the office, leave a message or speak with back-up. This is counter-productive to our efforts to decrease client wait time. The second is that our mobile technology is out-dated and insufficient. The third and final weakness is that contact data is limited to phone calls or in-person conversations. Phone calls to agencies on behalf of the client, the completion and mailing of applications and mailing of information requested by the client do not count as contacts despite doing work directly relating to a specific client.

SC Access and Additional Resources:

SC Access is a state-wide service data base used by workers to find assistance for clients and track the intake of consumers. SC Access is also used in creating reports to determine service areas, referrals and unmet needs. The web address is also given to clients for their own use in finding programs and services. The website also features a monthly calendar highlighting area events. Other resources available for use include the 2-1-1 Information System, ElderCare Locator, SCHousing.org, Medicare.gov, HUD.gov and the resource directory published by the AAA.

Follow-Up Procedures:

There are two avenues for follow up calls. The first is a monthly follow-up of a randomly selected 10 out of every 300 inquiries. Clients who complete an application (Medicaid, QI, SLMB, LIS or Food Stamps) with the I&R/A Specialist will receive a follow-up call within 30-45 days of completing the application.

Delivery Challenges:

Many of the clients in our consumer base are rural, making it difficult to reach certain areas. In conjunction with the long-term goals I&R/A Specialist will work to reach the most rural and vulnerable populations. There currently exists no literature regarding the I&R/A program specific to our region, making mailings difficult.

Funding Stream and Protocols:

The Waccamaw region uses the following funding streams to administer the IR&A program: Title IIIB IR&A is used for the majority of the

expenses. This fiscal year, we will also use 6 percent of our Planning and Administration dollars to fully fund this program.

Employment and Hiring Policy:

The Waccamaw region employs a fulltime IR&A Specialist as directed by the LGOA. Our region is very fortunate to have a LMSW in this position and she is proving to be of great value to our clients as well as our reports and monitoring capabilities.

Program Success Measurements:

The I&R/A Program's success can be measured by a review of the follow-up calls and the monthly reports. When possible, each client should receive three appropriate referrals; comparing the notes and referral sections of the reports will indicate whether this occurred and, if it did not, for what reason three referrals were not given.

Marketing Strategy:

One component of the I&R/A program is Benefits Screenings which have already been performed in two of the three counties served by the Waccamaw region. During these screenings the I&R/A program as well as other programs offered are discussed. Program information is currently being distributed by the Assisted Rides program. The I&R/A Specialist will work to identify media outlets and additional locations for program presentation and information distribution. The I&R/A Specialist will also investigate the possibility of creating a newsletter including information from each program. Three regional events will be submitted one week prior to the start of a new month to the SC Access Program Coordinator.

Partnerships:

The I&R/A Specialist works closely with the Family Caregiver Program and ICARE Program to coordinate referrals and exchange resource information. The I&R/A program works closely with the Assisted Rides Mobility Manager to distribute program information and ensure Assisted Rides clients are receiving all available services. The I&R/A Specialist works with the CDBG department to coordinate the use of a centralized database to enter and track clients requesting home repair funding. The I&R/A Specialist will work to identify potential partnerships with area organizations, faith based groups and community groups.

Interpretation Services: Our region is again fortunate to have recruited a bi-lingual volunteer who has general knowledge about the Hispanic culture as well as specific facts about Hispanic individuals in the local community and will serve as a liaison that will help break down any language barriers between the ICARE/ SMP programs as well at the IR&A program.

Intake & Input:

If I&R/A Specialist is available, the call is to be directed to her. If the I&R/A Specialist is in the office but unavailable the client is given the option of leaving a voice message or leaving a message with front desk staff. If I&R/A Specialist is out of the office, back-up staff (ICARE Specialist) can assist the client or the client can be informed of absence and given the choice to leave a message, speak to alternate staff or call back.

When a client speaks to the I&R/A Specialist, an intake form is filled at. A minimum of date of call, call time, client name, client date of birth and zip code should be filled out. It is best to collect as much demographic information as possible.

Client information should be entered into OLSA as soon as possible. All information is to be entered no later than the 10th day of the following month.

In order to provide the AAA/ADRC Director with accurate and informative reports, as much information as possible should be entered into OLSA including demographic information, financial information, call topics, applications completed and whether or not the call was a SHIP eligible call.

Supervisory Responsibilities:

I&R/A is supervised by AAA/ADRC Director utilizing an "open door" policy. The WRCOG Executive Director is available for consultation in the absence of the AAA/ADRC Director. AAA Director has made her schedule available via online calendar; if AAA Director is off-site but working, staff has her cell phone number to reach her as well as her email.

I&R/A Specialist provides monthly reports to AAA Director. Reports are

created each program that utilizes SC Access (I&R/A, FCP & ICARE) as well as an overall departmental report. Call data is broken down for each program into calls per county, total number of calls, total number of call minutes and total number of SHIP calls (by program and department). A separate report is created to show the percent of calls by topic.

I&R/A Specialist created a "call flow" chart to determine primary, secondary and tertiary responses to calls. If I&R/A Specialist is unavailable the caller is given the option of speaking to her immediate backup (ICARE/SHIP Counselor), leaving a voice mail message or leaving a direct message with the front desk. If I&R/A Specialist is out of the office, back-up staff can assist the caller or the caller should be informed of I&R/A Specialist's expected return.

Crisis Calls:

The IR&A Specialist will take the following steps during the call:

Identify yourself by name and ask the person for his/her name. Calling the person by his/her first name can establish rapport and trust between you, a necessary component for successful crisis intervention. Do not push if he/she refuses to give her name; instead, reassure her you want to listen and help no matter who he/she is.

Ask the person the reason for her call. You need to assess whether the person is suicidal, homicidal or both in the first few minutes of the call. Signs a person is in need of immediate intervention include statements about self-harm or suicide, threats to kill someone, scattered thoughts and statements -- and the inability to calm or focus the person after several minutes.

Alert another employee to call for immediate police assistance, if you believe the person is going to harm herself or someone else. Indicate to the caller your concern for her or another person's safety and tell her you are sending someone to help. Keep the person on the phone until help arrives.

Talk to the caller about why she is feeling down, depressed or upset; if you have previously assessed she is not suicidal or homicidal. Ask open-ended questions and use reflective listening to help understand how and why she is feeling the way she does. For example, you might ask, "What prompted you to make this call...?" and allow her to explain.

Ask the caller to describe coping methods which have worked in the past. The person in crisis can be overwhelmed and forget she has skills to help her through her problems. Talking to her about her coping skills can remind her she has the ability to work through her issue. You can also

suggest coping skills that have worked for other callers or yourself in the past.

Develop a working plan with the caller for when you hang up the phone. You may suggest she write down her plan and share it with family or friends. The plan should have immediate and preventive strategies in it. The immediate plan will get the caller out of the crisis and back to normal functioning. The preventive plan will help prevent an issue from occurring again.

Close the call on a positive note and remind the caller of her strengths. Assure the caller she can call back for more help if necessary. Develop a follow-up plan -- phone call -- to be sure the intervention was successful.

D. Insurance Counseling and Referral Services and Senior Medicaid Patrol

In order to receive the Older American Act and State funding the Waccamaw Regional Council of Governments' Insurance Counseling and Referral Service and Senior Medicare Patrol Programs submits the following document as our 2014-2017 Area Plan. As we move farther into the 21st Century, I have outlined a vision that addresses the following areas:

- Volunteer Efforts
- Part-D Enrollment
- Outreach and Education
- Training
- Data Entry

Insurance Counseling and Referral Services

The primary goal of the ICARE Program is to provide unbiased information through one-on-one personalized counseling, education, and outreach, this network of resources provides accurate and objective information and assistance to Medicare beneficiaries and their families. This allows the recipients to better understand and utilize their Medicare benefits.

In addition, the ICARE Program helps beneficiaries identify and understand programs and plans, including Medicare prescription drug coverage, Medicare Advantage plans, Medicare supplemental insurance

policies, Medicare Savings Programs, Medicare's Preventive Services, long-term care insurance and financing, and other public and private health insurance coverage options. Insurance Counselors also assist eligible participants in enrolling in these programs and plans.

Senior Medicare Patrol

SMP's purpose is to educate Medicare/Medicaid beneficiaries and caregivers about Medicare/Medicaid benefits in order to understand Medicare Statements such as Medicare Summary Notices (MSN), Medicare Part D Prescription Drug Plan (PDP) Explanations of Benefits (EOB) and other related health care statements. Through this knowledge, a person can identify, resolve and/or report possible billing errors, fraud, abuse and waste to the SMP Program.

Volunteer Recruitment/Work force

Studies have shown that because people naturally seek personal development, and are concerned about their community and want to feel better about themselves; they are apt to volunteer for a worthy cause. Our ICARE/SMP program will **recruit** and **train** at least **two** volunteers to provide coverage in Georgetown, Horry and Williamsburg counties to teach and educate Medicare/Medicaid beneficiaries on what to do about discrepancies on their Medicare Summary Notices, assist in the dissemination of outreach and education materials and inputting data into the ShipTalk/SMART FACTS Systems

We will recruit volunteers by the following:

- Word of mouth.
- Direct mail. Have personal letters written by your agency, sent through other organizations such as local civic associations, community groups and faith-based organizations.
- Information tables at community events.
- Presentations to community groups.
- Flyers, posters and brochures.
- Articles or press releases in local and community newspapers
- Other organizations' newsletters.
- Religious institutions—Churches and relevant local agencies and organizations to run your press release in materials they send out to their members.
- Public service announcements (PSAs).
- Web pages—Post on our website.

Our ICARE/SMP program will utilize volunteers to do the following:

- Educating and empowering our seniors to protect themselves against Medicare fraud.
- How to protect their Medicare numbers.
- How to examine their Medicare summary notices to detect discrepancies and report suspicious activity when detected.
- Volunteers will work in their communities to educate Medicare and Medicaid beneficiaries, family members and caregivers about the importance of reviewing their Medicare summary notices, to identify billing errors and potentially fraudulent activity.
- Volunteers will encourage seniors to make inquiries to the SMP program with such issues are identified so that the project may ensure appropriate resolution and referral
- Data entry into a ShipTalk/SMART FACTS National Reporting Database.
- Perform clerical duties as assigned include into but not limited to filing answering phones and preparing mass mailings.
- Assist with presentations and health fairs.
- Assist with customer service satisfaction surveys.
- Other duties as assigned.

Training

Training for our ICARE/ SMP volunteers will be provided through the Lieutenant Governor's Office on Aging in conjunction with the SMP Volunteer Handbook, webinars and conference calls. Ongoing training opportunities and 12 hours of update training will be made available through the Lt. Governors' Office on Aging. In addition, more opportunities for training will be given when there are national changes which are important for SMP volunteers to understand and when changes occur at a local or state level that impact volunteers.

Outreach and Education

In order to build, increase and sustain public awareness through visual cues that represent our message, empower and educate our seniors about Medicare fraud, Medicare Prescription Drug Program, Medicare Advantage Plans, Medicare Supplement Plans, LIS, Medicare Savings Programs, Medicare Preventive Services and other Medicare issues our ICARE/SMP program will disseminate brochures, written materials in large print to accommodate those with visual impairment. Our ICARE/SMP programs will utilize newspaper articles, radio interviews,

public service announcements, community letters, TV and radio stations, and community letters and collaborate with community partners such as:

- The Benefits Bank
- Williamsburg County Inter-agency Council
- Georgetown Assisted Rides Program
- Williamsburg County Disaster Preparedness Council
- Councils on aging
- Social Security Administration
- Georgetown Memorial Hospital Community Awareness Council
- Georgetown Outreach Ministries, Incorporated
- Department Of Health Human Services
- Department of Social Services

2010 Census Data shows that there are at least 19,239 Hispanics in our region, in order to target multicultural populations and expanding our outreach our ICARE/ SMP program has recruited a bilingual volunteer who has general knowledge about the Hispanic culture as well as specific facts about Hispanic individuals in the local community will serve as a liaison that will help break down any language barriers between the ICARE/ SMP programs in the beneficiary. Mapping out trends and learning key players or gatekeepers of neighborhoods, communities and churches is an important concept for effective strategic outreach planning. Moreover, our ICARE/SMP programs will endeavor to provide written materials, brochures and flyers to the Spanish speaking population.

Data Entry

In order to measure our ICARE/ SMP Programs efficiency, monitor performance, to ensure that data is entered into the ShipTalk/SMART FACTS web-data reporting systems in a timely fashion, our ICARE/SMP programs has implemented a performance development plan. This plan states that:

- ICARE/SMP Coordinator returns all calls by the end of the business day.
- ICARE/SMP Coordinator keeps accurate records of all demographic information of beneficiary by using a data intake form.
- ICARE/SMP Coordinator keeps detailed information of client's concerns and issues.
- ICARE/SMP Coordinator records the time spent on each client and beneficiary.

- ICARE/SMP Coordinator keeps duplicate copies of all correspondence sent to beneficiaries
- ICARE/SMP Coordinator inputs data into the Ship Talk/SMART FACTS data systems by the end of the business day.
- ICARE/SMP Coordinator meets once a month with management to discuss progress, concerns and review results.

The Waccamaw AAA/ADRC requires that monthly reports are produced and reviewed by the AAA Director for all direct service programs within our office.

Whenever there is any change in staff that serves in the capacity of ICARE/SMP Coordinator, the LGOA will be notified to ensure that all passwords and access to databases are revoked and assigned to new staff.

During times of high call volume; both the IR&A Coordinator and Family Caregiver Advocate are available to assist the SHIP program, both staff members are ICARE certified.

In order to employ a fulltime staff member in the SHIP Coordinator position, the AAA/ADRC cobbles together funding from the ICARE, SMP, SMP Expansion, and MIPPA to ensure adequate funding.

E. Family Caregiver Support Program

Long Term Goals

- Continue to offer much needed Respite and Supplemental Services/Resources to caregivers. Ensuring priority is given to caregivers providing care to individuals who fall within the following categories: those with Alzheimer's Disease or related disorders; grandparents or relative caregivers who provide care for children with severe disabilities; caregivers with the greatest social need especially low income older adults; and older adults who care for older individuals or adults suffering with severe disabilities. Net-working with agencies like DSS and Disability and Special Needs will serve to get program information out to a greater number of those target populations; as will advertisement through local news media sources like newspapers and radio. Health organizations and school resources will also be explored as possible avenues to identifying caregivers who fall under priority status. The Assessment process is used to determine the eligibility, need, and priority of caregivers applying for assistance through the program. Assessment of caregivers in their home will be used as much as is feasibly possible.

- Increase availability of the program through outreach and net-working to: caregivers/public/staff via face to face presentations or meetings (senior centers, community organizations, senior apartment complexes, health fairs); development of support groups (caregiver and/or condition specific) advertisements in local newspapers and radio programs; partnerships with local hospitals, educational institutes (grade schools, high schools, local colleges, technical schools), and other helping organizations (CLTC, DSS, Adult Day Cares, in-home care agencies, Disability and Special Needs, Aging Services offices, Alzheimer's Group, Stroke Support Groups, Medicare Social Service, Hospice Agencies, Churches). Adequate knowledge of and contact with a variety of referral and resources will lend to providing caregivers with an increased number of service choices and plans.

- Develop a plan of action with the caregiver that best meets the unique circumstances of each caregiver, and encourages choice and empowerment. This can be done through fostering of a team attitude with the caregiver as team leader, and allowing service flexibility and choice to the caregiver to make service decisions that best meet their needs. Providing resource information and referral to programs, conducting or providing education/training on the caregiver role/condition specific seminars that the caregiver/care receiver can access to meet their needs(Alzheimer's Seminars, Caregiver 101, assistance one on one and/or in group situations, consultation, senior centers, community partnerships, local organizational groups), informational brochures/materials (care resources/agencies, caregiver tips, newsletters), can serve through knowledge and insight gained to empower the caregiver and encourage them to believe in themselves and their abilities to make appropriate choices and provide adequate care.

- Regular evaluation of contact/intake procedures, information/ educational materials; and implementation of change as needed in a timely fashion, will be an integral part of the program to ensure communication with potential caregivers and others interested in the program is effective, efficient, and readily understood. Providing up to date, uniform, and comprehensive information and/or referral source procedures are vital aspects of this goal. The Caregiver Advocate will strive to ensure all calls, assessments, and follow-ups are done in a timely and effective manner. In the absence of the assigned advocate agency personnel will be assigned to handle all necessary caregiver business. All procedures concerning these duties are included in agency policy. Regular evaluations by appropriate staff to assess the program and Caregiver Advocate's role in it; and providing caregivers with the

means through evaluation questionnaires or phone contacts where they can express concerns or problems will continue to be an important procedure of the Waccamaw FCGSP. The Caregiver Advocate through attendance of educational seminars, in-services, and relevant programs will maintain an up to date knowledge base about the caregiver field, resources, and educational opportunities that can be used to better serve the caregiver population. Quality and cost effective ways to meet the needs of caregivers in the region will continue to be strived for.

- Continue to strive to develop a volunteer base to assist with dissemination of program information within the Waccamaw region with the goal of increasing understanding and knowledge of FCGSP services and resources.

- Development of a support group services, offering informational materials, net-working with organizations within the community (The Mitney Project, DSS, Disability and Special Needs) for grandparents and/or relatives raising children in the home. Dissemination of program information to relevant relative caregivers will be achieved through advertisement in local newspapers, health/school fairs, and during presentations to various community groups.

Weaknesses

One of the weak areas of the program can be seen in the area of maintaining a volunteer base. Efforts to develop a volunteer core group have shown minimal success. In exploring reasons for this we find that many of those in the area available to volunteer are already doing so in one capacity or another and are not ready to commit to more at this time. Future plans will be to hold informational seminars to recruit potential volunteers and possibly having caregivers speak about what care giving entails and how important support and help from other is in the life of a caregiver. Utilizing advertising resources on a more regular basis, speaking to more local organizations, and developing volunteer flyers or informational pamphlets that can be distributed in a number of different locations within the Waccamaw Region will be explored. Net-working with volunteer organizations like "Neighbor to Neighbor" for suggestions of ways to recruit volunteers is also planned.

One other area of weakness that will be addressed concerns the Seniors Raising Children (SRC) portion of the program. A support group to provide insight and validation into this aspect of care giving will be developed. A survey will be conducted to determine choice as to preferred day, time of day, and what meetings will consist of (support

only, or a combination of support/educational). Net-working with other community groups like the Mitney Project, scout groups, and YMCA groups who work with either the SRC or with the children themselves will hopefully provide not only an avenue to identify potential caregivers but serve to provide a means of meeting unmet needs. Survey and evaluation of those in need will be an integral part of the development of this portion of the program to determine what assistance SRC most find they are in need of and what they feel they would like to see to aid them in meeting this need.

More in the way of development of partnerships with other helping organizations is needed if the program is to reach potential caregivers as well as providing assistance to identified caregivers. Although there have been some recent movement in this area there is more needed. Meeting one on one with the directors or leaders of programs within the area needs to be explored. Partnerships with the local educational organizations as well as helping organizations such as the local Alzheimer's Association and various support groups will be tapped for possible collaboration to provide programs for caregivers.

Strengths

One of the more notable strengths within the region has been in the way of development of a partnership with the local hospital (Georgetown Hospital System) to provide training to caregivers who care for loved ones suffering with specific chronic conditions (HF, COPD) and have shown to be constant readmits to the hospital system. These trainings provided much needed education about the condition, how to manage the condition, support systems, and available resources to caregivers and care receivers. Development of partnerships will be a targeted goal for now and in the future. Within the past year the new advocate has met with numerous care providers and program representatives to provide and give information concerning programs that directly affect caregivers or care receivers. This has been helpful in providing valuable resource information to caregivers; and in providing information to other agencies about FCGSP services and supports.

Strengths come within many of the new additions to the local FCGSP added within the past year as well as the development of new procedures and processes instituted to make the Waccamaw FCGSP a quality program to caregivers within the region. This past year the Waccamaw Family Caregiver Advocate has started three new Family Caregiver Support groups. All three counties covered by the Waccamaw FCGSP have a support group that is easily accessible to caregivers within that area. These support groups have proven to be a valuable resource as is evidenced by caregiver comment. Caregivers in the support group enjoy the availability of access to a setting where they can validate experiences,

gain insight, provide assistance to others, get/give comfort to others experiencing what they are, and reduce the isolation many caregivers experience. The support groups have also served to provide a means of getting information about available program services out to a greater number of people; and identifying caregivers who may be eligible for other services. Support group members were questioned on what day, time of day, and content of meetings they would like to see. From this support group meeting specifics were developed and are continually evaluated for any unmet needs/challenges/changes support group members would like met or identified.

Updating of all brochures, informational/educational material/flyers, assessment instruments, client communication documentation, and program financial forms has also made a difference in the quality of service provided to caregivers and other interested individuals. Improvement in intake and response procedures for all client communications have been given priority and have proven to be successful in providing satisfaction to those accessing caregiver services and/or programs. Caregiver calls and written communication is answered as soon as is feasibly possible and backup assistance if the advocate is not available for an extended period of time is part of agency policy. Expansion of the caregiver library materials have provided information to caregivers giving them more confidence in their ability to care for their loved one thus reducing stress and feeling of inadequacy.

The past year has shown an increase in program presentations by the caregiver advocate to senior groups within the community. This has shown to provide valuable and educational benefit to a large group of caregivers and interested persons who had little knowledge of the program and the services it can provide. Recent increase of new caregivers requesting service is showing positive results from face to face presentations. More in the way of program presentations has been scheduled and will continue to for the future.

Development of a new caregiver newsletter has been very successful as well. This newsletter allows participation by the caregivers as they are encouraged to provide suggestions on topics they would like to see addressed. One section of the newsletter called the "Recipe Corner" features a recipe sent in by a caregiver. The hope is that enough recipes will be collected by the end of the year to allow for a cook book to be published. Caregivers will then decide what if anything they would like to do once the book is published. Caregivers have suggested a fund raiser for something they would like to do as one possible outcome.

Challenges

The biggest challenge for the local FCGSP will be in reaching more of the caregiver population within the region and finding innovative and creative ways to serve that population that will be cost effective and meet the needs of the caregivers. With people living longer and in worse conditions more and more families are forced into the position of deciding if they can provide for their loved ones at home with the resources available to them. Advocates are challenged to provide or find resources to meet the needs of these families. As indicated above increased focus will be on target groups and finding ways to get program services and opportunities out to a greater number through media resources, face to face presentations with individuals and groups, net-working with schools, community and helping organizations like schools, churches, governmental service, and support groups.

Greater numbers of senior relatives are raising children and this requires specific needs that will prove to be a bigger challenge for advocates trying to provide relief to caregivers dealing with their own needs as well as a child/children. For now and in the future the Waccamaw Caregiver Program will focus on partnerships with those resources that can provide direction and assistance to SRC. Providing SRC the opportunity and input into what they feel is most needed in their care giving situations will pay an important part in program development in this area.

F. Disease Prevention Health Promotion

Waccamaw AAA/ADRC will continue to work with health partners to enhance the community's health outcomes for aged and disabled adults. We will work, internally and with community partners to:

- Increase access to medical care; therapies; pharmacies/medicine; groceries by growing volunteer-based transportation systems founded in the region – Intern Resource – Assisted Rides Program; S.H.I.P. Counseling ; Community Partner: GRACE Ministries Neighbor to Neighbor Program – 3 counties

- Strive to ensure that our constituents have a "medical home", and affordable quality health care by working with: Internal Resources: I&R and FCSP; Community Partners: Georgetown Hospital System Community Care Network; Smith Clinic; Choppee Clinic; Santee Health Clinic; Little River Clinics; Black River Clinic – three counties

- Continue to improve transitions from hospital to home for seniors via Internal programs: FCSP – Family Caregiver Community Education Program; Health Coach Program. Community Partners: Georgetown Hospital System ; long term care facilities; home care agencies; volunteer drivers; Café at Home Program

- Continue to work with community partners to develop better ways of managing mental health crises: Community partners: hospital Emergency Dept; DSS; Mental Health agencies; addiction specialists; Alzheimer's Association; Board of Disabilities

- Expand access to dental services through partnerships and support of: Horry Georgetown Technical College's Dental Clinic; Helping Hands Dental Clinic/Georgetown; Healthy Smiles

- Develop greater community awareness regarding end-of life programs all terminal diagnoses. Engage consumers in services designed around the concepts of consumer choice and full palliative care earlier in the process of dying so that the services are more meaningful to the terminally ill and their family caregivers. Internal Programs: I&R; FCSP; Omsbudman. Community partners: hospice providers; hospital social workers; physicians; media partners; home health

VII. Changing Demographic Impact on AAA/ADRC Efforts

A. Intervention vs. Prevention

The AAA/ADRC should explore avenues to assist younger people to plan for their future in a proactive way. Though this has not been a focus area for the AAA/ADRC to this point, the agency understands the trend that the government will not be able to be the sole source of support, in retirement, for an aging society. We also understand that many people fail to plan, adequately, for the longer life span expectations that we enjoy today. Therefore, it is our responsibility to provide information, education and referrals, to the community so that they can experience solvency, and be able to live a long life that is not one of poverty.

The best approach to proactive planning is to change the mind sets of young adults, who find it difficult to project themselves into old age. The

key to their success is to start saving, for retirement, from the beginning of their career, and be consistent in doing. For those who are a bit older, AAA/ADRC can help them to understand that it is never too late to get started in planning, and saving, for the future.

Projecting ahead, the AAA/ADRC will get this accomplished through partnerships with other agencies/companies that share the mission of preparing people financially for the future. We will begin by adding a bill paying program to our constellation of services, for those have difficulty with paying bills because of changes in mental or physical status. This will help people to stay living in the community for as long as possible. We will present education programming, to groups, and begin to have conversation that focus on finance as we become more comfortable, and grow our resources through partnerships, in financial arena.

B. Senior Center Development

Senior Centers as a Focal Point -There are 18 senior centers across the Waccamaw region, many that have been serving rural communities, in a stand-alone posture, for decades. The activities that are offered at this type of center, are evident by their inclusion on the center's activity calendar, and are chosen by the center participants. The activities are appropriate because the participants themselves want to spend their time engaging in them. Center managers work to bring new, creative ideas for programming such as: lectures by experts; musicians; business owners who share their products and processes with center participant (i.e. flower arrangement); talent demonstrations; visits from nursery schools, trips, outings and specials events.

Multi-Purpose Senior Centers -As senior centers are moved, constructed and even re-built, a new type of senior center is emerging. Centers are becoming more a place for the whole community, such as the region's newest center in Pawleys Island. The senior center has a designated space, but, the building in which it is housed, in is a place for the entire community, and every generation, to come to enjoy fitness activities, special educational opportunities and a common place to gather together.

Williamsburg is seeking to move a center to a renovated school that houses a number of non-profit and social service agencies, including a Head Start Program; government offices; social service agencies and the like, This potential approach would allow participants to interact with other generations and take advantages of services not offered by the contractor. Potentially, it could be the beginning of an innovative "one

stop" approach to meeting the needs of rural seniors. What if the barber and a hairdresser could have space in the building? What if the space offered shared space for a podiatrist, therapists a dentist one day a week? What if some fresh vegetables and staples could be offered for sale? What if a small profit margin, from sales/services offered went back into the center coffers? With an approach like this, many of the needs of rural seniors could be addressed through the senior center site, making this approach a multi-purpose approach in a different way. If senior centers were a convenient "one stop approach" to getting the goods, and services, that are hallmarks of quality of life, more seniors would be utilizing the programs, and centers would be perceived as a vital part of community life, a place that seniors choose to go as an essential, life-enhancing place to belong.

Encouraging contractors to build multi-purpose seniors centers is a matter of demonstrating that, with community partners, professional volunteers and vision, that a new senior center model is possible. A pilot program would be an excellent way to demonstrate the possibilities.

Marketing - Senior Centers are currently marketed without any dedicated funds for marketing. As a result, they are marketed in a "grassroots" fashion. Local speaking engagements, flyers, posters, articles, church bulletins, open houses, bring a friend day.

P.I.P. Funded Centers – Centers that have been built, or renovated, using P.I.P. finding are held to different contractual standards than those that built without this type of funding. P.I.P. funded centers have longer activity schedules, as reflected on their calendars and observed during monitoring. Attendance is monitored daily and records are on file at the center.

C. Alzheimer's Disease

Waccamaw AAA/ADRC would like to expand their partnership and strengthen our working relationship with LGOA as it pertains to serving people with Alzheimer's disease and their family care partners.

In the past five years, the department has utilized the professional experience of the Waccamaw Programs Coordinator to enable the agency to: provide dementia-related community education to groups of family caregivers, faith-based service groups; long term care staff members; high school and university classes; home care providers; support groups and callers.

Training Opportunities-Topics provided include: 101Overview of Dementia; Legal Issues and Dementia; Coping with Challenging Behaviors; Enhancing Communication with a person with Dementia; Driving and Dementia; What to Expect at Each Stage of the Disease; Early On-Set Issues: End Stage Issues: Caring for the Caregiver.
Dementia-specific outreach has been conducted via: written articles; presentations; conferences; classrooms; radio, email, TV and blog web programs and mailings following phone calls.
The AAA/ADRC has working relationships with those that share our mission of serving people with dementia and their families Including: Alzheimer's Association – we distribute their literature; raise awareness of their 24/7/365 Helpline (1-800-272-3900); advocate with legislators on their behalf; speak at support groups to families; train professional care staff.

Objectives for Procurement Contracts

- Include dementia education in health presentations at centers – warning signs; how to talk to your doctor; caring for a family member, the importance of early intervention
- Include printed dementia resources, and information, to those along the HDM routes
- Make training available to contractor's staff and administration – center managers; drivers; home service workers; social services

D. Legal Assistance Services

The legal assistance program in the Waccamaw region was initially implemented several years ago with the required one percent of the Title IIIB funding. Due to the change in state requirement, the legal services budget has been increased to the required four percent. The factors outlined in the Older Americans Act were considered and will be evidenced in the creation and marketing of a legal services brochure by the Waccamaw region. The legal services will be marketed using this brochure, outreach will be achieved when all staff conduct presentations, attending health fairs, and through networking and contacts with attorneys and probate court.

Attorneys throughout the region will be asked to participate in the Legal Services Program. Referrals will be made on a rotating basis to those who respond to the outreach for participation. To provide consumer choice, if a

client requests a specific attorney not participating in our program, we will make every effort to accommodate their request. The provisions made for homebound clients will be made on an individual basis. With the limited funding, we will ask all participating attorneys to provide consultations at no charge. The AAA will conduct the assessments and enter data into the AIM system before the client is referred to the local attorney's office. We will require documentation from the attorney as to the type case, number of hours served, action taken and appropriate referral. All cases that can be referred to legal aid will be referred. We will use the bar association for training as well as common issues that can be handled by pro bono attorneys.

VIII. Region Specific Initiatives

Transportation – In Waccamaw AAA/ADRC surveys of senior and senior service providers, transportation was identified as a keystone, regional concern with regard to helping people remain living independently in the community for as long as possible. The lack of transportation is a barrier to: timely, appropriate medical care/pharmacology; nutrition; dental care; shopping; banking; social service and business appointments; worship and quality of life activities. Public transportation across the region is characterized by fixed bus routes that are more prevalent along the coastal area and in the larger towns. A few public bus routes extend to the interior, more rural, parts of the service areas. These are designed to bring workers to the beach, and are, generally, limited to one ride to the coast in the morning and one ride to back to the interior in the evening. Many older people are not fit enough, or well enough, to wait, in all kinds of weather, and board vehicles at cross road/bus stops. Many do not have a way to get to bus stop and/or have difficulty affording the fare.To address these, and other barriers, to accessing reliable transportation the Waccamaw AAA/ADRC partnered with a non-profit transportation agency, GRACE Ministries' Neighbor to Neighbor (N2N) Program. It is a volunteer driver program that matches those with transportation needs with those volunteers that are willing to give rides using their own: vehicle; primary automobile insurance; gas money and their time. The program has provided more than 5,000 transports through the services of 260 volunteer drivers. The Waccamaw AAA/ADRC assisted GRACE Ministries through: grant writing; planning and implementation of special events; recruiting/retaining/training a

VISTA and community volunteers; provided community presentations, Op-Ed submissions; newspaper and newsletter articles; radio and television spots.

In July of 2012, the Waccamaw AAA/ADRC was awarded a contract to become a part of the Assisted Rides Program. This program works, in tandem, with N2N to provide a volunteer-based driver program to seniors and disabled adult in every county of the Waccamaw region. This program is designed to fill the transportation gap currently facing individuals 18 and older with disabilities and individuals 60 and over, in order to enhance their quality of life by enabling them to obtain needed services.

ADRC Assisted Rides Program Overview

The Lieutenant Governor's Office on Aging oversees the Aging and Disability Resource Center [ADRC] Assisted Rides Program [ARP] from the state level. Currently, the Assisted Rides Program is operating in the Santee-Lynches and Waccamaw regions, and it has received endorsements from the State AARP, the State League of Women Voters, the State Chapter of the American Cancer Society, and local and regional stakeholders.

The ADRC ARP utilizes the web-based software Assisted Rides web portal developed by the AlterNetWays Company. Volunteer drivers are given access to Assisted Rides upon approval and choose trips through the web portal or the ADRC Mobility Manager. Each trip helps individuals with disabilities and older adults obtain life-essential and life-enriching activities.

Volunteers with the ARP use their own vehicle to transport passengers needing a ride. We do provide Volunteer Insurance, mileage reimbursement and quarterly volunteer incentives.

Destinations where a passenger could be transported might include non-emergency trips to: hospitals, doctors and dentist offices, pharmacies, assisted living facilities, grocery stores, human service agencies, etc. Based on the need, each passenger will be allowed to have one (1) escort that can accompany her or him to their approved destination. Additional escorts are considered on a case-by-case basis.

Funding

Even though the transportation service is free for the passenger, funding of this program is contingent upon passenger donations, public and private donations, and grant funding.

Assistance is provided via phone, mobile unit, by appointment or by home visit for those in the ADRC Case Management Program.

Passenger Eligibility

Passengers eligible for the ARP are individuals 18 and older with a disability and individuals 60 and over who reside in participating ADRC regions. Program enrollment is done by completing the Passenger Enrollment Form.

Regional Collaboration

To eliminate duplication of services in Horry County and parts of Georgetown County, we have collaborated with Grace Ministries Neighbor to Neighbor Transportation program. Through this collaboration, the ARP is using their portal to the AlterNetWays program. This collaboration allows each organization to utilize each other's volunteers to provide the maximum amount of rides to the entire region.

United Way VISTA Collaboration

The Georgetown County United Way VISTA project has allowed the collaboration between Grace Ministries Neighbor to Neighbor Transportation Program and the ARP to additionally encompass the benefits of having a VISTA to serve both organizations in Georgetown County. The VISTA will provide support in volunteer recruitment, resource development and community outreach for a one year period.

Transportation will continue to be a focus area for the agency well into the 2013-2017 time period. The issue of transportation has been taken up by a community coalition of transportation service providers, who have mapped our resources, identified gaps, and are currently building plans to address the gaps that have been identified. The Waccamaw AAA/ADRC is a part of this collaborative effort.

Waccamaw Sports Classic (WSC): Health, Wellness and Prevention – As a founding entity, the Waccamaw AAA/ADRC has been providing leadership for a region-wide coalition of volunteers who plan, and implement, an Olympic-style sporting competition for people who are 50

years, and better. The event has taken place since 2009, and is hosted by Coastal Carolina University. Under the direction of university faculty, students earn college credits for their role in community event planning/implementation. The students work with a WSC Steering Committee of 35 volunteers that hail from each county of the service territory. Businesses and agencies from the Waccamaw area provide funding by way of annual sponsorships.

This year 350 seniors participated in Waccamaw Sports Classic. County Parks and Recreation staffs work with senior center participants to prepare them to compete in the annual event, creating a year-long opportunity for purposeful exercise and enhanced fitness. Athletes from outside the senior center system are encouraged to participate in the event, this allows them an introduction to the senior center system and other related services/programs.

Seniors also participate in regional social activities, leading up to WSC, such as fashion shows and talent contests that result in the crowning of county senior "kings and queens" who are honored at WSC each year.

WSC is an intergenerational opportunity for the whole community to get involved in senior support and programming including: Offices on Aging; County Parks and Rec; Coastal Carolina University; Georgetown Hospital System; long term care facilities; assisted living facilities; hospices; home care agencies; media outlets; durable equipment companies and others. WSC community partners are more likely to refer to the AAA/ADRC and volunteers are likely to become engaged in other planning and implementation efforts.

Care Transitions – The Waccamaw AAA/ADRC is the identified, lead Community Partner for this pilot program, designed after an extensive examination of issues that lead seniors to be re-admitted, to the hospital, for the same diagnosis over and over again. Care Transitions is a proactive approach to provide better follow-up care to seniors after a hospitalization including: offering screened, trained, volunteer Health Coaches to engage patients in a prescribed process that helps them to understand their condition, medications, physician's orders and enhance their chances of attending follow- up medical appointments. Other strategies for change include: offering free transportation home and to medical appointments, pharmacy and grocery store; offering family caregiver educational programs about specific disease processes that constitute leading cause for repeated readmissions; developing standardized communication processes between the hospital and long term care facilities where a multiplicity of cross referrals are inevitable.

35 Health Coaches have been assigned, to date, and only 2 hospital re-admissions have occurred within 30 days of discharge. 40 Health Coaches have been trained from Georgetown and Horry County.

50 providers of elder care services have signed a charter agreement to support this effort.

Community Care Network – This is a collaborative community approach designed to engage service partners from the general population and the senior care arena, to pool their: time; talent; expertise and resources to create solutions to barriers that diminish the quality of life for the citizens of Georgetown County, Findings and outcomes are transferrable to other geographical areas of the AAA/ADRC's service territory. Active work groups focusing on identified issues include: transportation; mental health services; dental services; medical staff engagement; obtaining medical "homes" for the un/under-insured; health screening committee; indigent pharmacy solutions.

Work groups have identified existing resources related to each work area; recruited partners to create solutions; identified "gaps" in service delivery; begun planning collaborative strategies to address problem areas.

VISTA Volunteer Program – Four years ago, the Waccamaw AAA/ADRC became a founding partner in a coalition that worked to bring AmeriCorps VISTA Volunteers to Georgetown County. The purpose of this effort was, and remains: to build capacity, community awareness and services for partnering non-profit and quasi governmental agencies to achieve identified aspects of their mission. VISTA Volunteers enable program partners to stretch tight budgets, and serve more people with quality programs, because the high-level VISTA volunteers offer their full time services, to a mission, for a nominal stipend. In the Waccamaw region, the VISTA volunteer has been utilized to grow the volunteer-based transportation services that are being built throughout the Waccamaw region. Involvement will continue over the next four years.

The Benefits Bank Partnership – All Waccamaw AAA/ADRC staff have been trained as Benefits Bank Counselors. Select staff members have been engaged in offering Benefits Bank services to the participants in senior centers across the service territory via on-site workshops. The AAA/ADRC has also partnered with medical clinics to offer these services to those who are chronically ill/disabled who are also un/underinsured. In this instance, an average of $2,000 additional dollars were "found" by counselors for those who are experiencing financial insecurity, making it possible for them to achieve a better quality of life.

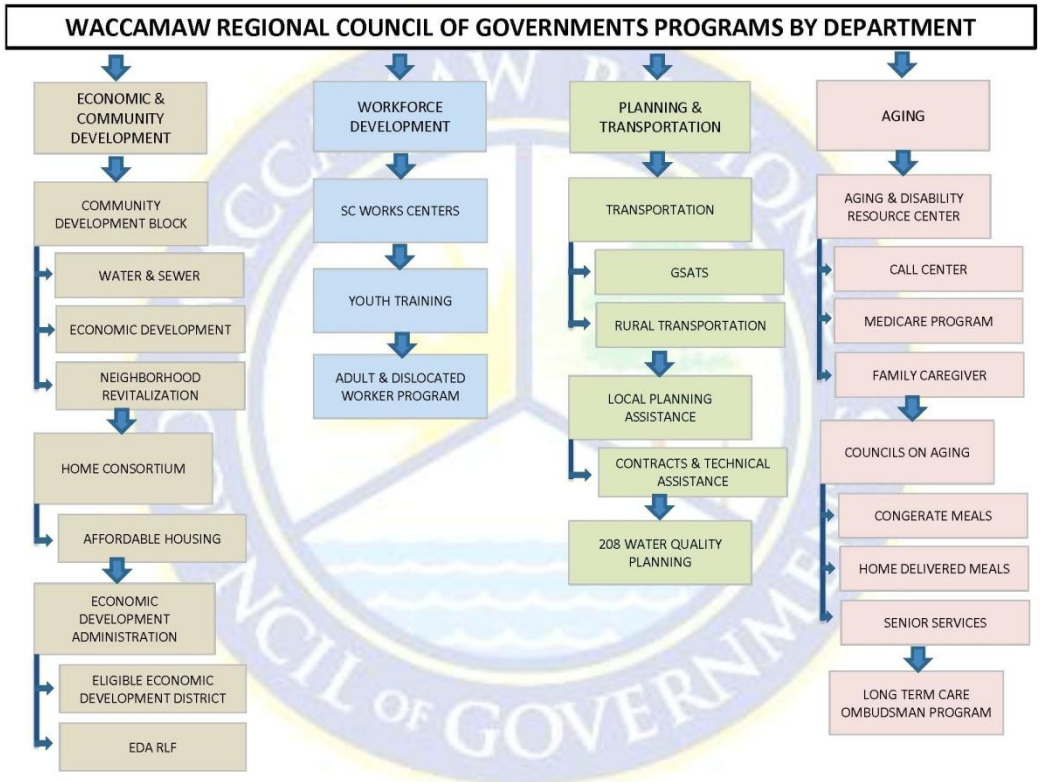
Many report using the extra money to buy medications, food and to pay personal bills.

Bill Paying Services – Many family caregivers, and seniors, with declining health or mental capacity, have increasing difficulty in paying their monthly obligations, as they age. The Waccamaw AAA/ADRC will be partnering with a bill paying service to offer assistance to clients, and perspective clients, who will benefit from an automatic bill paying service. At present, this is a private pay option for those that can afford to purchase this reasonably priced offering. In the future, the agency hopes to negotiated smaller service fees for those with smaller personal budgets.

IX. Area Plan Appendices

A. Appendix A

Waccamaw Region Council of Governments Organizational Chart



B. Appendix B

Regional Needs Assessment

Representation of the Population

A total of 759 surveys were completed in Region 8. 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 759 surveys completed, 610 (80.4%) were categorized as a senior receiving services, 61 (8%) were categorized as a senior not receiving services, 228 (30%) were categorized as being a caregiver, and 562 (74%) were categorized as an individual with a disability.

For Region 8, the confidence interval for the sample of seniors receiving services is 3.36 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 3.36 percentage points). The confidence interval for seniors not receiving services is higher (12.54 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 high (4.2 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 relatively high (3.2 points at a 95% confidence level assuming 50% agreement). (See Table 8-1.)

TABLE 8-1: SAMPLE REPRESENTATION OF POPULATION

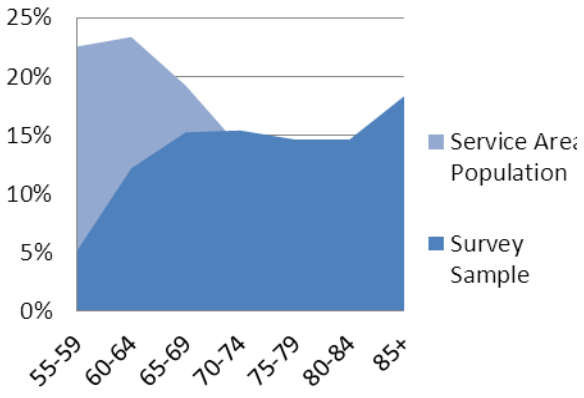
	Population Size	Sample Size	Representation
Seniors Receiving Services	2,138	610	3.36
Seniors Not Receiving Services	71,283	61	12.54
Caregivers	391	228	4.2
ADRC	1,395	562	3.2

Demographic Characteristics of Seniors

Compared to the service area senior population, the survey respondents are older; however, the overall pattern of age distribution is very similar. A small percentage of survey respondents are under 55 (n=30, 4.6%), 55 to 59 years old (n=33, 5.1%), or 60 to 64 years old (n=79, 12.2%), whereas 22.5% and 23.4% of the service area senior population is between these ages, respectively. However, for both the survey sample and the service area senior population, the percentage peaks at 70 to 74 years (n=100, 15.4% of the sample and 13.9% of the population) and stays even until it reaches 85 years and over (n=119, 18.3% of the sample and 6.5% of the population). (See Figure 8-2.) For this reason, further population figures only include seniors ages 65 and older.

FIGURE 8-2: AGE GROUP

	Survey Sample	Service Area Population
Total	**650**	**116,510**
Under 55 years	4.6%	
55 to 59 years	5.1%	22.5%
60 to 64 years	12.2%	23.4%
65 to 69 years	15.2%	19.2%
70 to 74 years	15.4%	13.9%
75 to 79 years	14.6%	9.6%
80 to 84 years	14.6%	6.5%
85 years and over	18.3%	4.9%

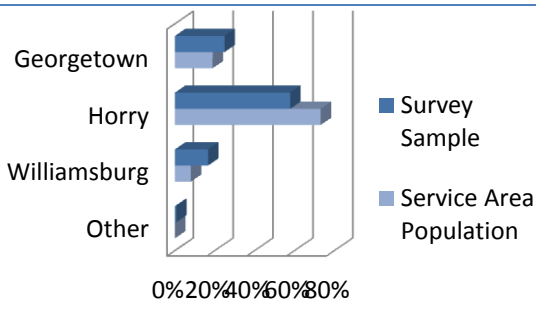


Larger proportions of the survey sample reside in Williamsburg (n=99, 16.6%) and Georgetown (n=148, 24.9%) than in the service area senior population (8% and 18.9%, respectively). Smaller proportions of the survey sample reside in Horry (n=344, 57.8%) than in the service area senior

population (73.1%). This was done intentionally in order to ensure representation from the smaller counties and to increase the power of comparisons by county. (See Figure 8-3.)

FIGURE 8-3: COUNTY OF RESIDENCE

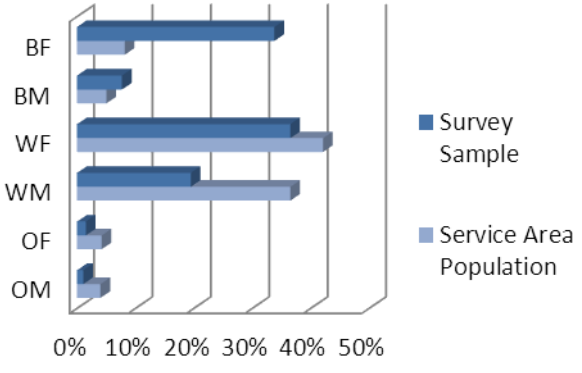
	Survey Sample	Service Area Population
Total	**595**	**63,029**
Georgetown	24.9%	18.9%
Horry	57.8%	73.1%
Williamsburg	16.6%	8.0%
Other	0.7%	--



A much larger percentage of the survey sample are African American female (n=224, 33.8%) or than in the service area senior population (8.1% respectively). Conversely, a smaller percentage of the survey sample are White/Caucasian male (n=129, 19.5%) compared to the service area senior population (36.5%, respectively). Very few respondents were of other races (females: n=10, 1.5%; males: n=7, 1.1%). These populations are also relatively small in the service area senior population (other females: 4.2%; other males: 4.0%). (See Figure 8-4.)

FIGURE 8-4: RACE AND GENDER OF SENIORS

	Survey Sample	Service Area Population
Total	**663**	**63,029**
African American Female	33.8%	8.1%
African American Male	7.7%	5.0%
White Female	36.5%	42.1%
White Male	19.5%	36.5%
Other Female	1.5%	4.2%

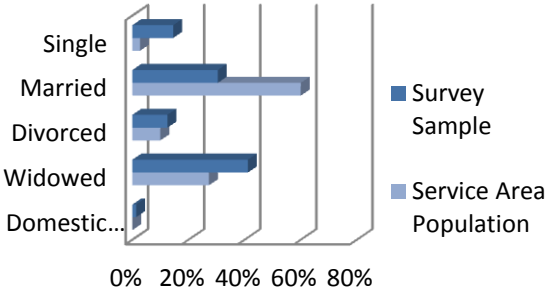


Other Male	1.1%	4.0%

The survey sample has a much larger percentage of individuals who are single (n=99, 14.6%) or widowed (n=280, 41.2%) than exist in the service area senior population (2.7% and 27.3%, respectively). Conversely, there is a much smaller percentage of individuals who are married (n=207, 30.4% of the sample compared to 60% of the service area senior population). A similar percentage of respondents are divorced (n=85, 12.5%) as are in the service area senior population (10%). (See Figure 8-5.)

FIGURE 8-5: MARITAL STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**680**	**57,150**
Single	14.6%	2.7%
Married*	30.4%	60.0%
Divorced*	12.5%	10.0%
Widowed	41.2%	27.3%
Domestic Partner**	1.3%	--



*Individuals in the service area population categorized as "Married, spouse absent, not separated" were excluded from the counts.

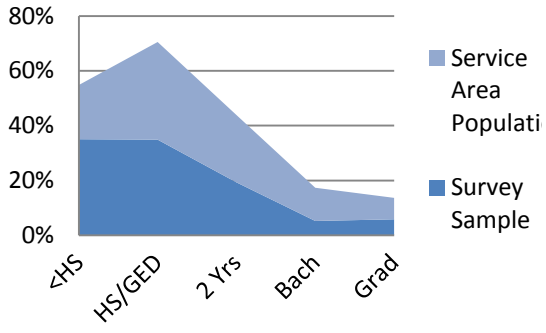
**Individuals who are in a domestic partnership were not included in the population counts as the Census does not include this category in the marital status calculation. Inclusion of this category in the population counts could lead to a duplication of individuals currently classified as single ("never married").

The survey sample has a higher percentage of individuals who have completed less than high school (n=231, 35%) compared to 19.8% of the service area senior population. A slightly lower percentage of the respondents (n=127, 19.2%) attended some college or earned as Associate's degree than the service area senior population (24.6%). The percentage of respondents who earned a Bachelor's degree (n=34, 5.2%) is lower than the service area population (12.1%

respectively) Advanced/Graduate degree (n=38, 5.8%) are similar to the percentage in the service area senior population (7.8%, respectively). (See Figure 8-6.)

FIGURE 8-6: EDUCATIONAL ATTAINMENT OF SENIORS

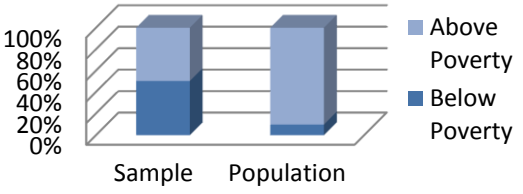
	Survey Sample	Service Area Population
Total	**660**	**58,199**
Less than high school	35.0%	19.8%
High school diploma/GED	34.8%	35.6%
Some college/Associate's	19.2%	24.6%
Bachelor's degree	5.2%	12.1%
Advanced/Graduate degree	5.8%	7.8%



In comparison to the service area senior population, respondents to the survey are estimated to more likely be below the poverty line (n=312, 50.4% compared to 9.9% of the service area senior population). (See Figure 8-7.)

FIGURE 8-7: POVERTY STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**619**	**57,390**
Below Poverty Line	50.4%	9.9%
Above Poverty Line	49.6%	90.1%



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, more likely to be single or widowed, less well educated and more likely to be below the poverty line, as well as more likely to be African American and female.

Demographic Characteristics of Individuals Who Have a Disability

Only 50 survey respondents from this region are considered to have a disabled 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 60% (n=452) 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 5.4% (n=41) 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 comprise 28.4% (n=215) of the sample. Persons with disabilities are the (n=50, 6.6%) and represent 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 141 respondents (18.6% of the sample and 27.9% of those classified). Cluster 2 is comprised of 78 respondents (10.3% of the sample and 15.4% of those classified). Cluster 3 is comprised of 131 respondents (17.3% of the sample and 25.9% of those classified). Cluster 4 is comprised of 156 respondents (20.6% of the sample and 30.8% of those classified). The remaining 253 (33.3%) 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 a little important (*mean=2.24, median=2.11, n=436, sd=0.97*). The most important of these needs are keeping warm or cool as the weather changes (*mean=2.58, median=3.0, n=409, sd=1.33*) and transportation for errands (*mean=2.54, median=3.0, n=406, sd=1.35*), household chores (*mean=2.24, median=2.0, n=462, sd=1.22*). The least important services to seniors who are already receiving services are nursing care/prescription assistance (*mean=1.69, median=1.0, n=403, sd=1.1*) and housekeeping (specifically laundry) (*mean=1.86, median=1.0, n=409, sd=1.17*. (See Figure 8-8.)

Seniors who have not received services view personal and home care needs to be a little important (*mean=2.08, median=1.78, n=40, sd=0.96*). The services deemed to be a little important by most of the respondents are home repairs and maintenance (*mean=2.41, median=2.0, n=37, sd=1.32*) and transportation for errands (*mean=2.41, median=2.0, n=37, sd=1.32*). The least important services to seniors who are home meal service (*mean=1.58, median=1.0, n=38, sd=.86*) and nursing care (specifically assistance with prescription medicine) (*mean=1.68, median=1.0, n=37, sd=1.1*). (See Figure 8-8.)

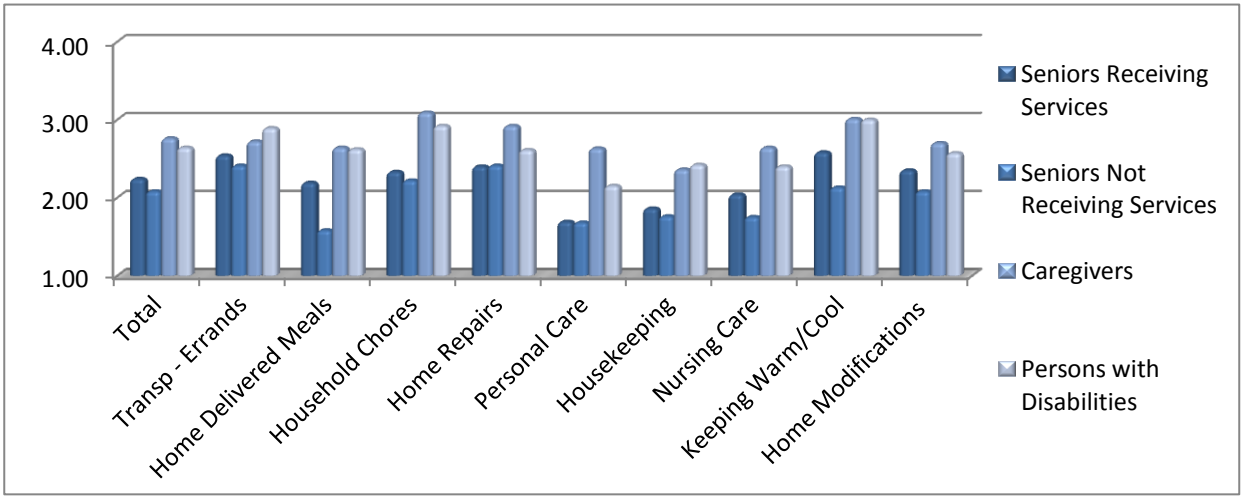
Caregivers view personal and home care needs to be between a little and quite a bit important (*mean=2.76, median=2.78, n=213, sd=0.91*). The most important service to caregivers is household chores (specifically keeping home clean) (*mean=3.09, median=4.0, n=206, sd=1.17*) and keeping warm or cool as the weather changes (*mean=3.01, median=4.0, n=206).* The lest

important service to caregivers is housekeeping (specifically laundry) (*mean=2.36, median=2.0, n=205, sd=1.31*). (See Figure 8-8.)

Persons with disabilities view personal and home care needs to be between a little and quite a bit important (*mean=2.64, median=2.56, n=50, sd=0.88*). The most important service to persons with disabilities are household chores (specifically keeping home clean) (*mean=2.92 median=4.0, n=50, sd=1.26*) and keeping warm or cool as the weather changes (*mean=3.0, median=3.5, n=48, sd=1.17*). The least important services to persons with disabilities is personal care or bathing (*mean=2.15, median=2.0, n=46, sd=1.24*). (See Figure 8-8.)

FIGURE 8-8: 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	**2.24**	**2.08**	**2.76**	**2.64**
Transportation for Errands	2.54	2.41	2.72	2.89
Home Delivered Meals	2.19	1.58	2.64	2.62
Household Chores	2.33	2.22	3.09	2.92
Home Repairs/Maintenance	2.40	2.41	2.92	2.61
Personal Care	1.69	1.68	2.63	2.15
In-Home Housekeeping	1.86	1.76	2.36	2.42
Nursing Care/Prescription Assistance	2.04	1.75	2.64	2.40
Keeping Warm/Cool	2.58	2.13	3.01	3.00
Home Modifications	2.35	2.08	2.70	2.57

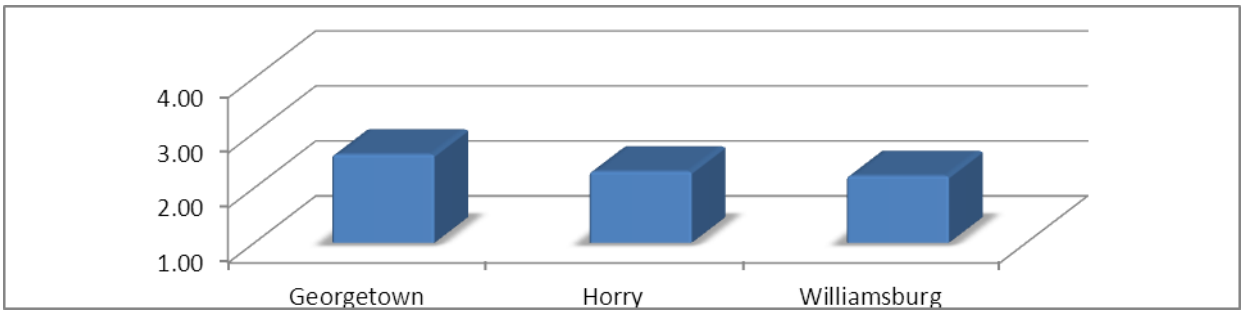


The difference in the personal and home care needs composite is significantly different between the targeted groups (*F=17.15, df=3, p<0.001*). Therefore, caregivers and persons with disabilities view personal and home care needs to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 6.5% of the variability in this composite (r^2*=0.065*).

The age of the respondent has a significant impact on their perceived need for personal and home care needs (*F=8.76, df=4, p<0.001*). This indicates that respondents who are in most need of these services are those who under the age of 55 years old (most of whom are persons with disabilities) and those who are 75 and older. African Americans, those with less than a high school diploma/GED, and individuals below the poverty line also rated these services as being of greater importance to them (*F=30.12, df=1, p<0.001; F=17.49, df=4, p<0.001; and F=32.61, df=1, p<0.001, respectively*). Those who are single or widowed rated these services as being of greater importance to them than individuals who are divorced or married (*F=3.27, df=3, p=0.021*). For seniors, those who have a disability have a significantly greater need (*diff=0.57, t=6.23, df=474, p<0.001*). Individuals residing in Georgetown County had significantly greater personal and home care needs (*F=5.68, df=4, p<0.001*).

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=11.6, df=3, p<0.001).

FIGURE 8-9: 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 between quite a bit important and a little important (*mean=2.69, median=2.9, n=438, sd=0.94*). All but one of the items has a median value of quite a bit important. The most important of these needs are getting exercise (*mean=3.01, median=3.0, n=411, sd=1.09*) and nutrition counseling (*mean=2.83, median=3.0, n=409, sd=1.17)*. The least important service to seniors who are already receiving services is transportation to the senior center (*mean=2.12, median=1.0, n=399, sd=1.31*). (See Figure 8-10.)

Seniors who have not received services view senior center activities to be slightly less than quite a bit important (*mean=2.55, median=2.38, n=40, sd=0.81*). The most important of these needs are getting exercise (*mean=3.08, median=3.5, n=40, sd=1.07*), counseling (having someone to talk to) (*mean=2.73, median=3.0, n=40, sd=1.18).* The least important service to seniors who are not already receiving services is transportation to the senior center (*mean=1.95, median=1.0, n=39, sd=1.19*). (See Figure 8-10.)

Caregivers view senior center activities to be between a little important and quite a bit important (*mean=2.50, median=2.43, n=213, sd=0.88*). The most important of these needs are getting exercise (*mean=2.97, median=3.0, n=205, sd=1.1*), counseling (having someone to talk to) (*mean=2.88, median=3.0, n=205, sd=1.17*), and getting information on eating healthy (*mean=2.78, median=3.0, n=205, sd=1.2*). The least important service to seniors who are not

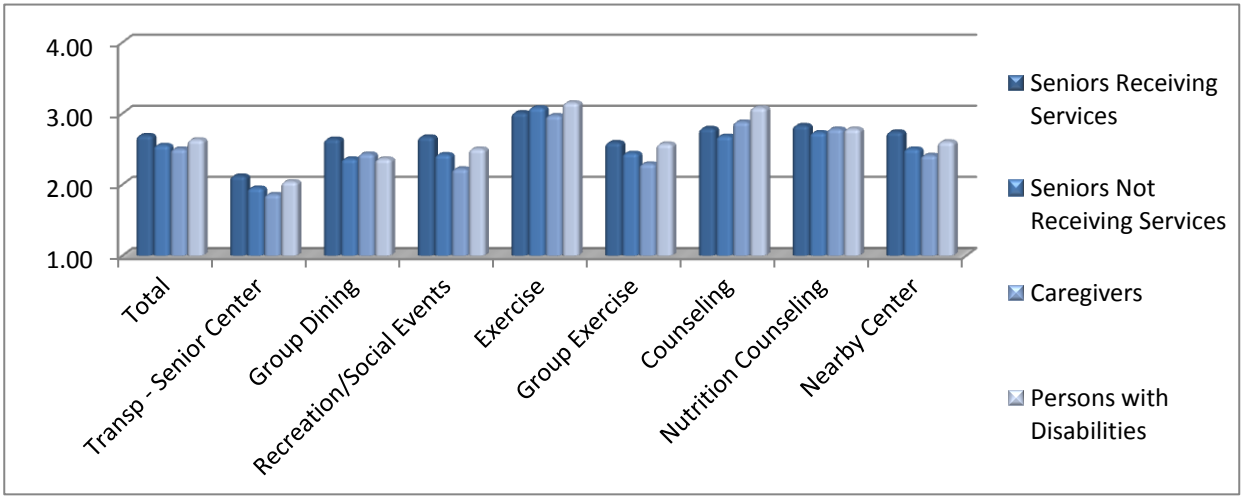
already receiving services is transportation to the senior center (*mean=1.86, median=1.0, n=200, sd=1.21*). (See Figure 8-10.)

Persons with disabilities view senior center activities to be between a little important and quite a bit important (*mean=2.63, median=2.61, n=50, sd=0.84*). The most important services to persons with disabilities are getting exercise (*mean=3.15, median=3.0, n=48, sd=0.97*) and counseling (having someone to talk to) (*mean=3.08, median=3.0, n=49, sd=1.07*). The least important service to persons with disabilities is transportation to the senior center (*mean=2.04, median=1.0, n=47, sd=1.32*). (See Figure 8-10.)

Transportation to the senior center is the least important of all the senior center activities for each of the targeted groups. Of these groups, it is the most important to seniors receiving services and persons with disabilities.

FIGURE 8-10: SENIOR CENTER ACTIVITIES BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Senior Center Activities Composite	**2.69**	**2.55**	**2.50**	**2.63**
Transportation to the Senior Center	2.12	1.95	1.86	2.04
Group Dining	2.64	2.36	2.43	2.36
Recreation/Social Events	2.67	2.42	2.22	2.50
Exercise	3.01	3.08	2.97	3.15
Group Exercise	2.59	2.44	2.29	2.57
Counseling (someone to talk to)	2.79	2.68	2.88	3.08
Nutrition Counseling	2.83	2.73	2.78	2.78
Nearby Senior Center	2.74	2.50	2.41	2.60

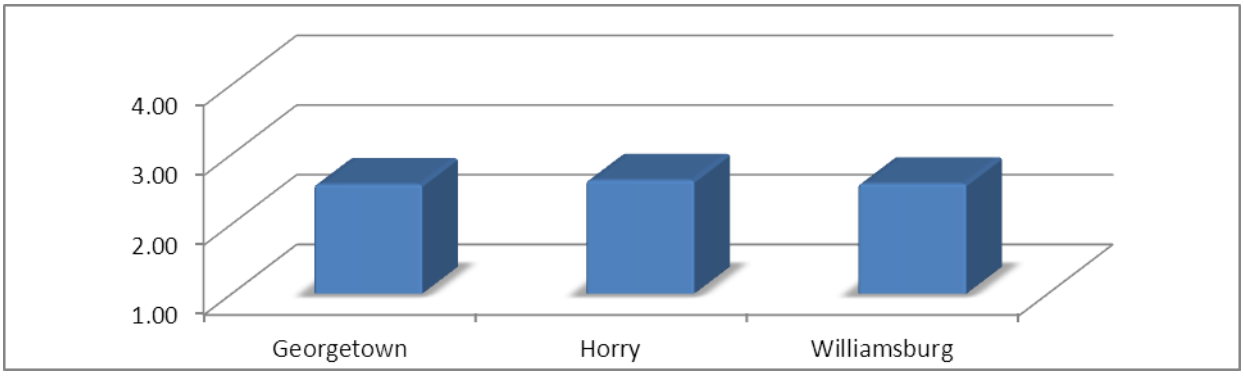


The difference in the senior center activities composite is significantly different between the targeted groups (*F=2.08, df=3, p=0.102*). Therefore, seniors receiving services and persons with disabilities view senior center activities to be more important than do seniors not receiving services and caregivers. However, the target group categorization only accounts for 0.8% of the variability in this composite ($r^2=0.008$).

African Americans and females rated these services as being of greater importance to them (*F=25.96, df=1, p<0.001; F=16.57, df=1, p<0.001, respectively*). Those who are single, widowed or divorced rated these services as being of greater importance to them than individuals who are married (*F=3.58, df=3, p=0.014*).

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), the majority of whom are seniors receiving services.

FIGURE 8-11: 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 between a little and quite a bit important (*mean=2.56, median=2.5, n=425, sd=1.1*). The most important of these needs is having someone to call if feeling threatened or taken advantage of (*mean=2.71, median=3.0, n=408, sd=1.3*). Healthcare directives is the only one considered to be a little important (*mean=2.36, median=2.0, n=403, sd=1.25*). (See Figure 8-12.)

Seniors who have not received services view services to help in maintaining independence to be between a little and quite a bit important (*mean=2.50, median=2.5, n=94, sd=1.03*). The most important of these need are protection of rights (*mean=2.59, median=3.0, n=39, sd=1.21)* and having someone to call if feeling threatened or taken advantage of (*mean=2.54, median=3.0, n=37, sd=1.24).* Preventing falls and healthcare directives are a little important (*mean=2.37, median=2.0, n=38, sd=1.28; mean=2.37, median=2.0, n=38, sd=1.95*). (See Figure 8-12.)

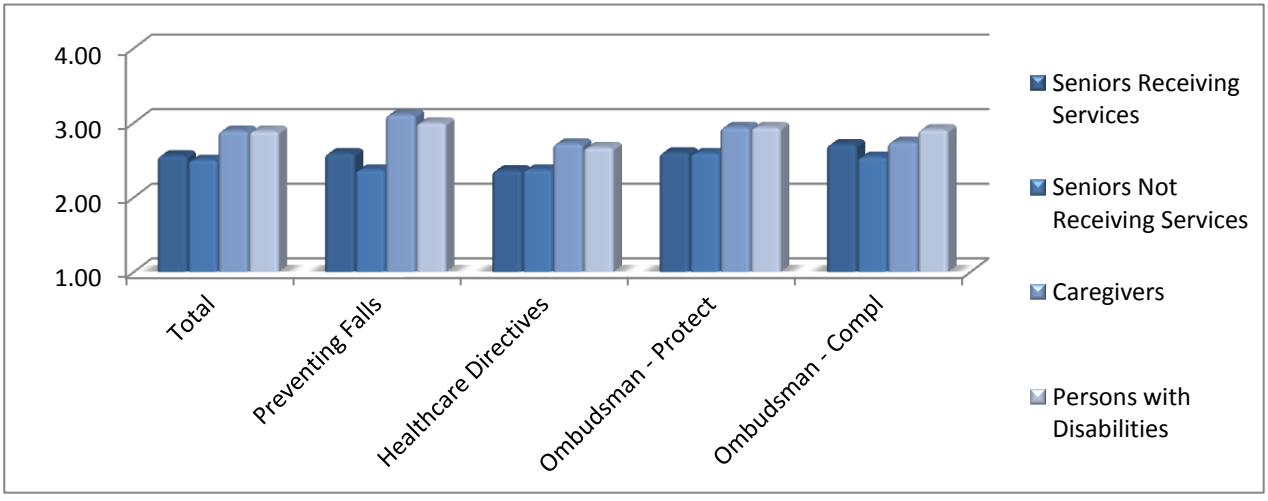
Caregivers view services to help in maintaining independence to be quite a bit important (*mean=2.89, median=3.25, n=211, sd=1.05*). The most important of these services are preventing falls (*mean=3.11, median=4.0, n=207, sd=1.17*) and protection of rights (*mean=2.94, median=4.0, n=208, sd=1.25).* The remainder of the services were deemed to be quite a bit important (healthcare directives: *mean=2.72, median=3.0, n=207, sd=1.27*; and someone to call if feeling threatened or taken advantage of: *mean=2.74, median=3.0, n=207, sd=1.29*). (See Figure 8-12.)

Persons with disabilities view services to help in maintaining independence to be quite a bit important (*mean=2.9, median=3.0, n=49, sd=1.05*). All of the services were deemed to be quite a bit or very important (preventing falls: *mean=3.0, median=4.0, n=46, sd=1.21*; healthcare directives: *mean=2.67, median=3.0, n=48, sd=1.26*; protection of rights: *mean=2.94, median=4.0, n=48, sd=1.25*; and someone to call if feeling threatened or taken advantage of: *mean=2.91, median=3.0, n=47, sd=1.23*). (See Figure 8-12.)

Preventing falls is most important to caregivers and people with a disability; whereas having someone to call if feeling threatened or taken advantage of is most important to seniors not receiving services. . Seniors receiving services perceive the services of the ombudsman to be the most important.

FIGURE 8-12: MAINTAINING INDEPENDENCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Maintaining Independence Composite	**2.56**	**2.50**	**2.89**	**2.89**
Preventing Falls	2.59	2.37	3.11	3.00
Healthcare Directives	2.36	2.37	2.72	2.67
Ombudsman - Protection	2.60	2.59	2.94	2.94
Ombudsman - Complaints	2.71	2.54	2.74	2.91

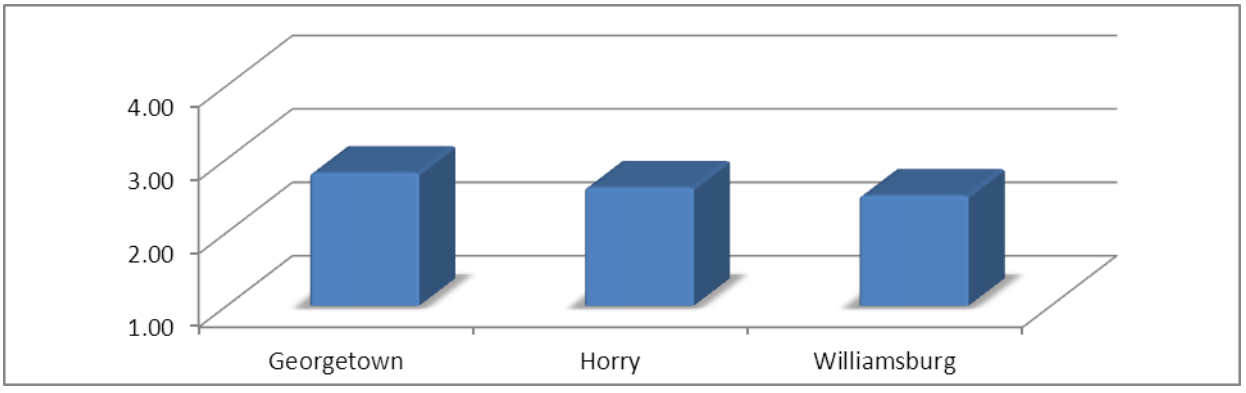


The difference in the maintaining independence composite is significantly different between the targeted groups (*F=5.33, df=3, p=0.001*). Therefore, caregivers and persons with disabilities view services to help maintaining independence to be more important than do seniors receiving services and seniors who have not received services. However, the target group categorization only accounts for 2.2% of the variability in this composite (r^2*=0.022*).

The age of the respondent has a significant impact on their perceived need for personal and home care needs (*F=3.7, df=4, p=0.005*). This indicates that respondents who are in most need of these services are those who are under 55. African Americans, those with less than a high school diploma/GED, and individuals below the poverty line also rated these services as being of greater importance to them (*F=7.4, df=1, p=0.007; F=9.44, df=4, p<0.001; and F=4.7, df=1, p=0.031, respectively*). For seniors, those who have a disability have a significantly greater need (*diff=0.48, t=4.6, df=462, 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 and most likely to be over the age of 85),. *F=3.7, df=4, p=0.005*) This matches the analysis of individual demographics above.

FIGURE 8-13: 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.

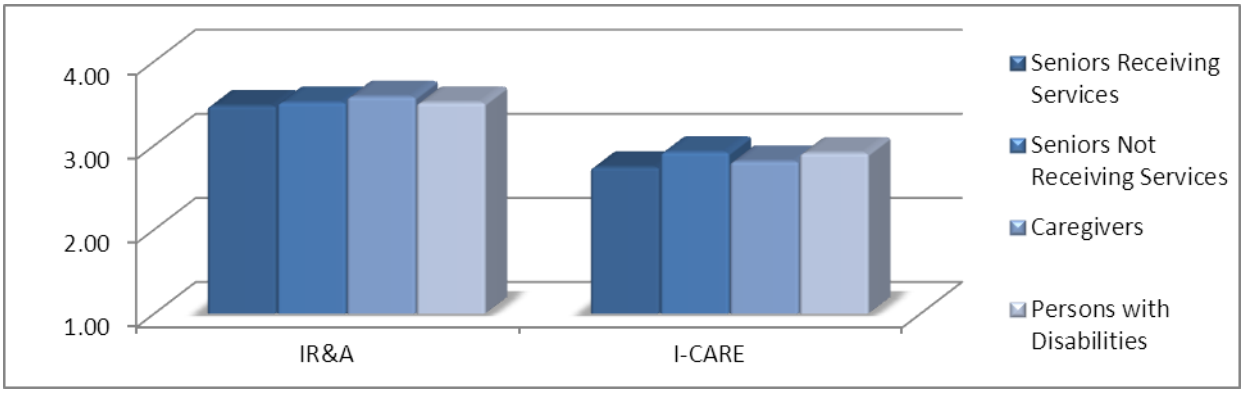
Of the 759 respondents, 705 reported on how important information, referral and assistance services are to keeping them where they are now. All of the targeted groups view IR&A to be very important (*mean=3.47-3.51, median=4.0*). The results of the Kruskal Wallis test indicate that there was no significant differences between the target groups ($X^2_{K\text{-}W}=2.14$, *df=3, p=0.543*). (See Figure 8-14.)

Of the 759 respondents, 696 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 (*mean=2.74-2.92, median=3.0*). The results of the Kruskal Wallis test indicate that there was no significant differences between the target groups ($X^2_{K\text{-}W}=1.77$, *df=3, p=0.623*). (See Figure 8-14.)

FIGURE 8-14: IR&A AND I-CARE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving	Caregivers	People with a Disability

	Services			
Information, Referral & Assistance	3.47	3.51	3.58	3.51
Insurance Counseling (I-CARE)	2.74	2.92	2.81	2.91



Respondents with a Bachelor's degree have a greater perceived need for IR&A ($X^2_{K\text{-}W}$ *=11.5, df=4, p=0.021*). Since most of the respondents viewed this service to be quite a bit to very important, there are no other significant differences by demographics.

The age of the respondent has a significant impact on their perceived need for I-CARE ($X^2_{K\text{-}W}$*=11.29, df=4, p=0.023*). This indicates that respondents who are in most need of these services are those who between 55 and 64 years old. African Americans, those with a high school diploma/GED or less, and individuals below the poverty line also rated these services as being of greater importance to them (*t=21.1, df=1, p<0.001; t=27.22, df=4, p<0.001; and t=17.31, df=1, p<0.001, respectively*).

Overall, the demographic cluster of respondents who reported the greatest need for I-CARE services is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line) ($X^2_{K\text{-}W}$*=19.3, df=3, p<0.001*).

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 slightly more than a little important (*mean=2.45, median=2.5, n=418, sd=1.1*). The most important of these needs are dental care and/or dentures (*mean=2.63, median=3.0, n=389, sd=1.32*) and eye exam and/or eyeglasses (*mean=2.61, median=3.0, n=386, sd=1.3).* The least important services to seniors who are already receiving services are hearing exams and/or hearing aids (*mean=2.22, median=2.0, n=380, sd=1.3*) and health insurance (*mean=2.23, median=2.0, n=370, sd=1.3*). (See Figure 8-15.)

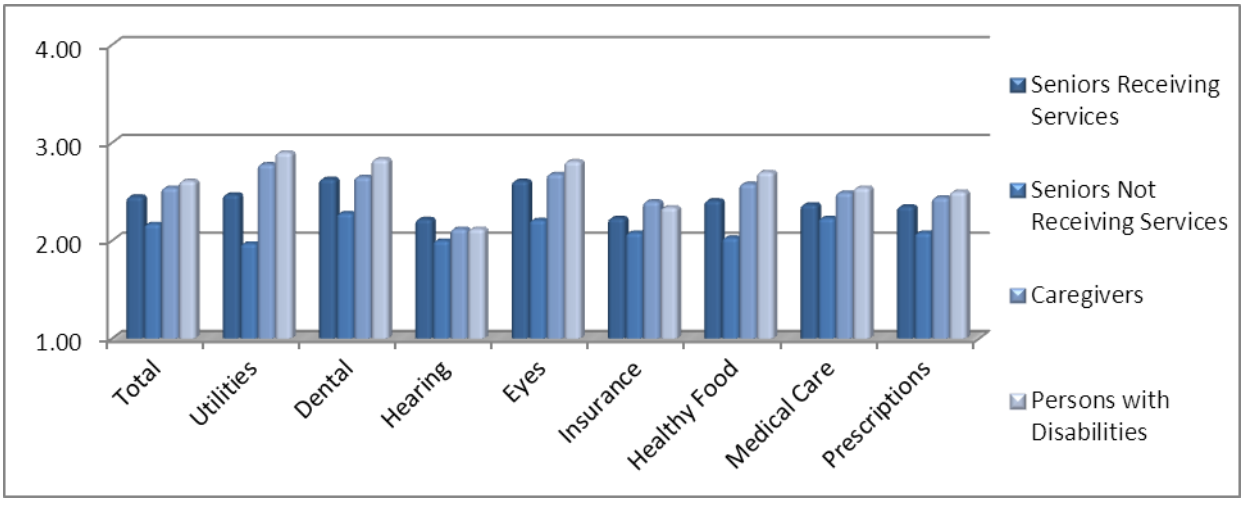
Seniors who have not received services view monetary assistance to be a little important (*mean=2.08, median=2.0, n=36, sd=1.2*). The most important of these needs is dental care and/or dentures (*mean=2.28, median=2.0, n=36, sd=1.21*). The least important service to seniors who are already receiving services is paying for healthy food (*mean=2.03, median=1.0, n=37, sd=1.3*). (See Figure 8-15.)

Caregivers view monetary assistance to be between little important and quite a bit important (*mean=2.54, median=2.5, n=213, sd=0.98*). The most important of these needs are for utilities or an unexpected bill (*mean=2.78, median=3.0, n=203 sd=1.2*) and dental care and/or dentures (*mean=2.65, median=3.0, n=207, sd=1.3).* The least important service to caregivers is help paying for hearing exam and/or hearing aids (*mean=2.12, median=1.0, n=200, sd=1.3*). (See Figure 8-15.)

Persons with disabilities view monetary assistance to be between little important and quite a bit important (*mean=2.61, median=2.71, n=45, sd=0.86*). The most important of these needs are for utilities or an unexpected bill (*mean=2.9, median=3.0, n=41 sd=0.97*) and dental care and/or dentures (*mean=2.83, median=3.0, n=41, sd=1.2*), eye exam and/or eyeglasses (*mean=3.28, median=4.0, n=18, sd=1.07).* The least important service to persons with disabilities is help paying for hearing exam and/or hearing aids (*mean=2.12, median=2.0, n=41, sd=1.25*). (See Figure 8-15.)

FIGURE 8-15: MONETARY ASSISTANCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Monetary Assistance Composite	**2.45**	**2.17**	**2.54**	**2.61**
Utilities or an unexpected bill	2.47	1.97	2.78	2.90
Dental Care and/or Dentures	2.63	2.28	2.65	2.83
Hearing Exam and/or Hearing Aids	2.22	2.00	2.12	2.12
Eye Exam and/or Eyeglasses	2.61	2.21	2.68	2.81
Health Insurance	2.23	2.08	2.40	2.34
Healthy Food	2.41	2.03	2.58	2.70
Medical Care	2.37	2.23	2.49	2.54
Prescriptions or Prescription Drug Coverage	2.35	2.08	2.44	2.50

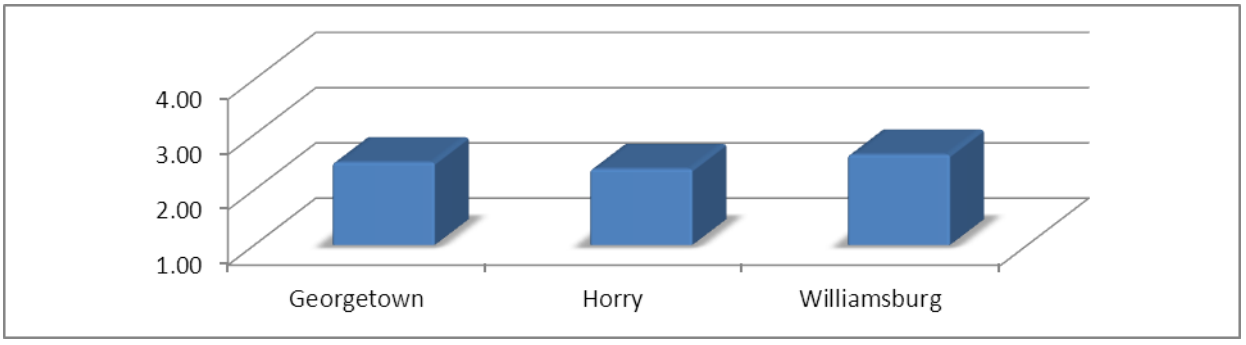


The difference in the monetary assistance composite is not significantly different between the targeted groups (*F=1.71, df=3, p=0.164, r^2=0.007*). The age of the respondent has a significant

impact on their perceived need for monetary assistance (*F=4.31, df=4, p=0.002*). This indicates that respondents who are in most need of these services are those who are under 55 years old. African Americans, those who have received less than a high school diploma/GED, and individuals below the poverty line also rated these services as being of greater importance to them (*F=34.45, df=1, p<0.001; F=23.14, df=4, p<0.001; and F=45.77, df=1, p<0.001, respectively*). Individuals who are divorced rated these services as being of greater importance to them (*F=8.21, df=3, p<0.001*). For seniors, those who have a disability have a significantly greater need (*diff=0.58, t=5.45, df=455, p<0.001*).

Overall, the demographic cluster of respondents who reported the greatest need for these services is Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line) (*F=9.57, df=3, p<0.001*).

FIGURE 8-16: MONETARY ASSISTANCE BY CLUSTER



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; and 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=18, 9.1%*), caregivers of seniors with disabilities (*n=126, 64%*), caregivers of persons with disabilities (*n=37, 18.8%*), and caregivers of children (*n=16, 8.1%*). 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) disagree that caregiver services are necessary to help them care for the individual(s) (*mean=2.38, median=2.6, n=18, sd=.95*). The most important need is for temporary relief from caregiver duties (respite) (*mean=2.8, median=3.0, n=15, sd=1.15*). (See Figure 8-17.)

Caregivers of seniors who do have a disability agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.81, median=2.8, n=126, sd=0.86*). The most important of these needs is for temporary relief from caregiver duties (respite) (*mean=3.07, median=4.0, n=115, sd=1.4*), followed by monetary assistance for acquiring services (*mean=3.01, median=3.0, n=116, sd=1.31*) and information and referral for services (*mean=2.94, median=3.0, n=112, sd=1.09*). (See Figure 8-17.)

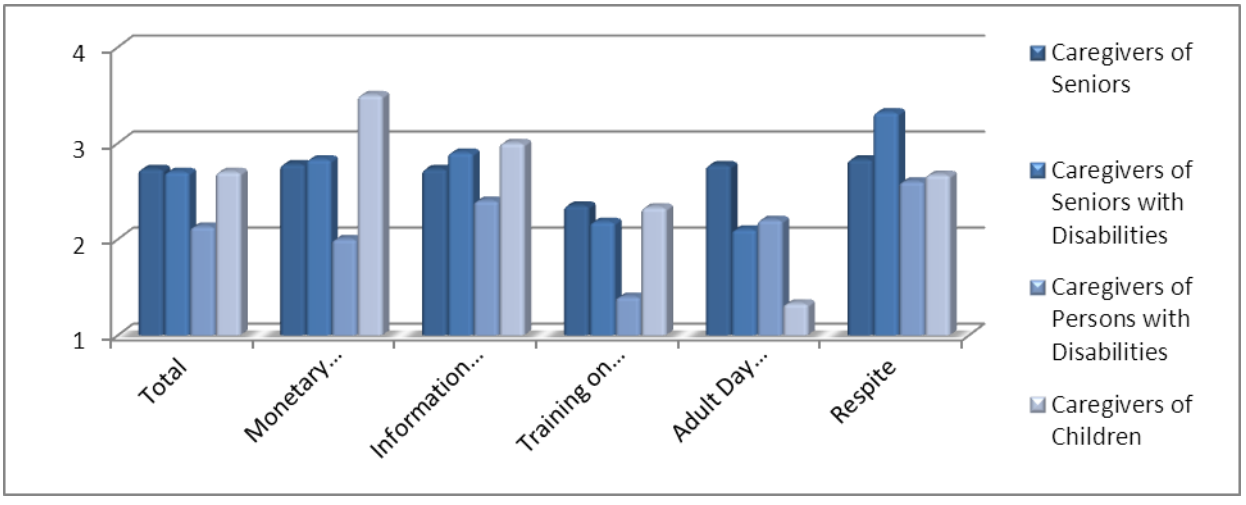
Caregivers of persons who have a disability (and are under 60 years of age) agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.89, median=2.8, n=37 sd=0.73*). The most important of these needs are information and referral for services (*mean=3.26, median=4.0, n=31, sd=.99*), for monetary assistance in acquiring services (*mean=3.21, median=4.0, n=34, sd=1.04*), and temporary relief from caregiver duties (respite) (*mean=2.86, median=3.0, n=35, sd=1.2*). (See Figure 8-17.)

Seniors who are also caregivers of children somewhat agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.5, median=2.6, n=16, sd=0.77*). The most important need is for monetary assistance in acquiring services (*mean=3.0, median=3.0, n=16, sd=1.2*), followed by temporary relief from caregiver duties (respite) (*mean=2.77, median=4, n=13, sd=1.42*). Note that some of these senior caregivers of children also care for other seniors. (See Figure 8-17.)

The difference in the caregiver needs composite is not significantly different between the type of person being cared for (*F=2.34, df=3, p=0.075, r^2=0.035*). Monetary assistance and respite are the services most needed by all types of caregivers, followed by information and referral. There are no differences in the needs of caregivers based on demographics.

FIGURE 8-17: 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	**2.38**	**2.81**	**2.89**	**2.45**
Monetary Assistance	2.61	3.01	3.21	3.00
Information & Referral	2.56	2.94	3.26	2.64
Training on Caregiving	1.47	2.32	2.35	1.93
Adult Day Care	2.00	2.25	2.22	1.86
Respite	2.80	3.07	2.86	2.77



Partner/Professional Survey

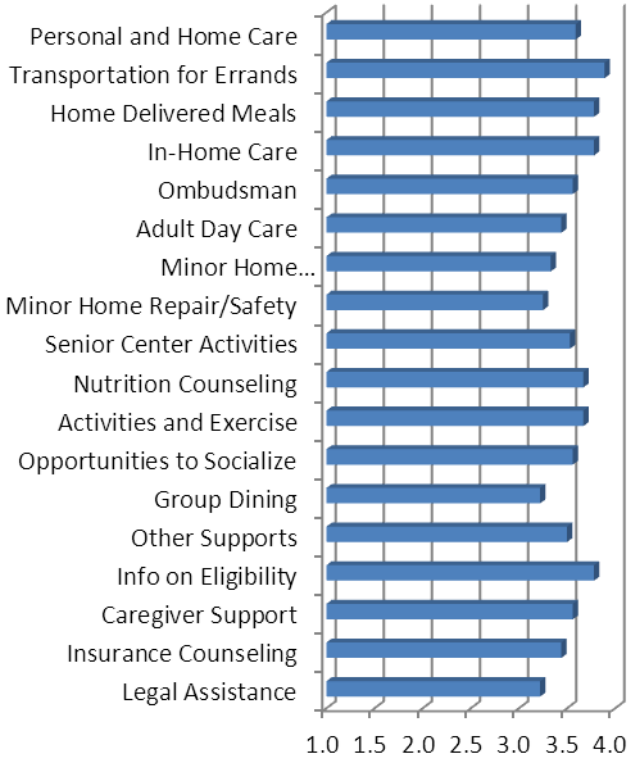
Three composites were created from the questions on the partner survey related to preserving services. These three composites are: Personal and Home Care (which consists of items related to home delivered meals, in-home care, minor home repairs/property upkeep, transportation for errands, adult day care, 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=3.59, median=3.71, n=9, sd=0.46*), senior center activities (*mean=3.53, median=3.5, n=9, sd=0.36*), and other supports (*mean=3.43, median=3.5, n=30, sd=0.44*) are viewed to be equally essential services to helping seniors and those with disabilities in Region 8 to remain independent. The most essential services are transportation for errands (*mean=3.89, median=4.0, n=9, sd=0.33*), information on eligibility for community and other services (ADRC) (*mean=3.78, median=4.0, n=9, sd=0.67*), home delivered meals (*mean=3.78, median=4.0, n=9, sd=0.44*), and in-home care (housekeeping, laundry, personal care) (*mean=3.78, median=4.0, n=9, sd=0.67*). (See Figure 8-18.)

FIGURE 8-18: PARTNER PERCEPTION OF ESSENTIAL SERVICES

	Mean Response
Personal and Home Care	**3.59**
Transportation for Errands	3.89
Home Delivered Meals	3.78
In-Home Care	3.78
Ombudsman	3.56
Adult Day Care	3.44
Minor Home Repairs/Upkeep	3.33
Minor Home Repair/Safety	3.25
Senior Center Activities	**3.53**
Nutrition Counseling	3.67
Activities and Exercise	3.67
Opportunities to Socialize	3.56
Group Dining	3.22



Other Supports	**3.50**
Info on Eligibility	3.78
Caregiver Support	3.56
Insurance Counseling	3.44
Legal Assistance	3.22

Overall, partners' perceptions of how their organization interacts with the AAA are divided; however, the sample size is too small to draw definitive conclusions (n=9). Just over half of the partners are knowledgeable of the services offered (n=6, 66.7%), are aware of the AAA's strategic plan and goals (n=5, 55.6%), know who is eligible to receive services (n=5, 55.6%), and believe that the services are easily accessible (n=5, 62.5%). The majority believe that the AAA is a critical partner for their organization (n=8, 88.9%), and refer clients to the AAA/ADRC (n=8, 87.5%). Most partners disagreed that there are unmet needs for caregivers (n=5, 62.5%), seniors (n=7, 87.5%), and persons with disabilities (n=5, 62.5%). Of concern is that only 44.4% (n=4) understand how the AAA/ADRC sets priorities for which clients receive services. Only 37.5% of partners (n=3) stated that the clients are able to pay part of the cost of their services, and 85.7% (n=6) agreed that the AAA/ADRC should offer providers the opportunity to contract for fixed reimbursement rates. (See Figure 8-19.)

FIGURE 8-19: PARTNER PERCEPTIONS OF INTERACTIONS WITH AAA

	Agree	**Disagree**	**Total Responses**
Knowledgeable of Services	66.7%	33.3%	9
Aware of Strategic Plan	55.6%	44.4%	9
Know who is Eligible	55.6%	44.4%	9
Understand Priorities for Services	44.4%	55.6%	9
Critical Partner	88.9%	11.1%	9
Refer to AAA	87.5%	12.5%	8
Services Easily Accessible	62.5%	37.5%	8
Clients able to Pay	37.5%	62.5%	8

Unmet Needs for Caregivers	37.5%	62.5%	8
Unmet Needs for Seniors	12.5%	87.5%	8
Unmet Needs for PWD	37.5%	62.5%	8
Fixed Reimbursement	85.7%	14.3%	7

There was no clear pattern of frequency of mentions for underserved geographic areas; these areas were noted by at least one respondent:

- Loris
- Myrtle Beach
- Conway
- Georgetown
- Williamsburg County
- Rural

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

- Transportation
- Caregiver Support
- Other needs mentioned were meals, home repair, healthcare, socialization, adult day care

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

- Transportation
- Healthcare
- Caregiver support
- Other needs noted were home care and adult day care

Quotes

The process takes too long to place a vulnerable adult into residential placement.

Transportation is always an issue

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 8. 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 8 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, less well educated and older than the general senior population in the region. These demographic characteristics are often connected.

Overall, respondents viewed Information, Referral, and Assistance to be the service most important to helping them stay where they are, followed by I-CARE (Insurance Counseling), caregiver services, senior center activities, services to help them maintain independence, and personal and home care. The most important service to caregivers is respite care, followed by monetary assistance in obtaining services. Within senior center activities, respondents viewed exercise and counseling (having someone to talk to) 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 more than a little important, with the most important being help with payments for medical care and prescriptions or prescription drug coverage. Personal and home care is viewed to be the least important, with the most important of these being transportation for errands and home repairs and modifications (for both upkeep and for safety).

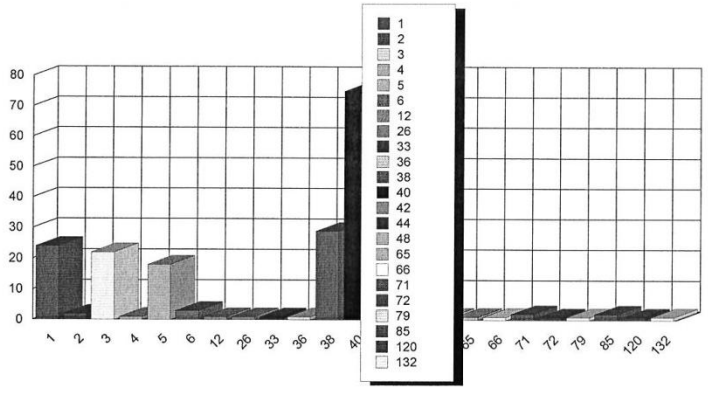
However, these are generalizations. There is a great deal of variation within categories. For example, service needs of caregivers vary depending upon whom they are caring for and whether they are also caring for children. Personal and home care, which is viewed as the least important to seniors who are already receiving services, is viewed as more important to caregivers and persons with disabilities. 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 8 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 8 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.

While partners believe they have a good relationship with the AAA, they believe they have little knowledge of the plan, do not understand how priorities are set for which clients receive services and are not clear on who is eligible to receive services. In short, the partners feel that they are a strong part of service provision and a small part of planning and prioritizing. This may or may not be an important issue, but should be explored.

C. Appendix C

Long Term Care Regional Ombudsman Report



05/15/201

	Cmplt#	Description
24	1	ABUSE, PHYSICAL (INCLUDING CORPORAL PUNISHM
2	2	ABUSE, SEXUAL
22	3	ABUSE,VERBAL/MENTAL (INCLUDING PUNISHMENT,
1	4	FINANCIAL EXPLOITATION (USE E FOR LESS SEVER F
18	5	GROSS NEGLECT (USE CATEGORIES UNDER CARE SE(
3	6	RESIDENT-TO-RESIDENT PHYSICAL OR SEXUAL ABUS
1	12	INFORMATION REGARDING MEDICAL CONDITION, T
1	26	DIGNITY, RESPECT - STAFF ATTITUDES
1	33	RESPONSE TO COMPLAINTS
1	36	BILLING/CHARGES - NOTICE, APPROVAL, QUESTION/
29	38	PERSONAL PROPERTY - LOST, STOLEN USED BY OTH
75	40	ACCIDENTAL OR INJURY OF UNKNOWN ORIGIN, FAL
1	42	CARE PLAN/RESIDENT ASSESSMENT - INADEQUATE, I
4	44	MEDICATIONS - ADMINISTRATION, ORGANIZATION
1	48	SYMPTOMS UNATTENDED, INCLUDING PAIN, PAIN NC
1	65	COMMUNITY INTERACTION, TRANSPORTATION
1	66	RESIDENT CONFLICT, INCLUDING ROOMATES

1

05/15/201

	Cmplt#	Description	
2	71	MENU - QUANTITY, QUALITY, VARIATION, CHOICE, C	
1	72	SNACKS, TIME SPAN BETWEEN MEALS, LATE/MISSED	
1	79	EQUIPMENT/BUILDINGS - DISREPAIR, HAZARD, POOR	
2	85	SUPPLIES AND LINENS	
1	120	FAMILY CONFLICT; INTERFERENCE	
1	132	SERVICES FROM OUTSIDE PROVIDER	
Grand Total:			172

2

ANE CASES Cases Opened Between 10/01/2011 and 09/30/2012 05/15/2013

Type	Number of Cases	Total Cases Medicaid	Law Enforcement	Attorney General (AG)	SLED
(NF) NURSING FACILITY					
ANE Cases	54	32	0	0	0
Other Cases*	103	61	0	0	0
Total	**152**	**93**	**0**	**0**	**0**
(RCF/BCF) RESIDENT CARE/BASIC CARE FACILITY					
ANE Cases	6	1	0	0	0
Other Cases*	14	1	0	0	0
Total	**20**	**2**	**0**	**0**	**0**
Grand Total:	**172**	**95**	**0**	**0**	**0**

***All other Complaints include Complaint Numbers 8-116, 118-120, and 122-133**

***Note* This report is NOT UNDUPLICATED on the case count, due to cases containing both ANE and Other complaints.**

1

ANE CASES Cases Closed Between 10/01/2011 and 09/30/2012 05/15/2013

Type	Number of Cases	Total Cases Medicaid	Law Enforcement	Attorney General (AG)	SLED
(NF) NURSING FACILITY					
ANE Cases	54	33	0	0	0
Other Cases*	102	60	0	0	0
Total	**151**	**93**	**0**	**0**	**0**
(RCF/BCF) RESIDENT CARE/BASIC CARE FACILITY					
ANE Cases	4	1	0	0	0
Other Cases*	14	1	0	0	0
Total	**18**	**2**	**0**	**0**	**0**
Grand Total:	**169**	**95**	**0**	**0**	**0**

*All other Complaints include Complaint Numbers 8-116, 118-120, and 122-133

Note This report is NOT UNDUPLICATED on the case count, due to cases containing both ANE and Other complaints.

1

CONSULTATIONS REPORT From 10/01/2011 To 09/30/2012

05/15/2013

Date	Ombud	Time	Referral Code	Other problem/question	Remarks
	Complaint				
FACILITY					
06/01/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FEEDING ISSUES	FEEDING ISSUES
	120 FAMILY CONFLICT; INTERFERENCE				
01/18/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
	120 FAMILY CONFLICT; INTERFERENCE				
08/17/2012	TASIA MCCULLOUGH S	3.00		RESIDENT ROOM CLEANED WITHOUT RESIDENT CONSENT	RESIDENT ROOM CLEANED WITHOUT RESIDENT CONSENT
	26 DIGNITY, RESPECT - STAFF ATTITUDES				
08/16/2012	TASIA MCCULLOUGH S	3.00	LAW ENFORCEMENT	MULTIPLE RESIDENT TRANFERS	MULTIPLE RESIDENT TRANSFERS
	19 DISCHARGE/EVICTION - PLANNING, NOTICE, PROCEDURE, IMPLEMENTATION				
08/09/2012	TASIA MCCULLOUGH S	3.00	LAW ENFORCEMENT	ABUSE OF RESIDENT BY FAMILY	ABUSE OF RESIDENT BY FAMILY
	3 ABUSE,VERBAL/MENTAL (INCLUDING PUNISHMENT, SECLUSION)				
08/07/2012	TASIA MCCULLOUGH S	2.00	LAW ENFORCEMENT	AD RESIDENT WITH BEHAVIOR PROBLEMS	AD RESIDENT WITH BEHAVIOR PROBLEMS
	26 DIGNITY, RESPECT - STAFF ATTITUDES				
08/07/2012	TASIA MCCULLOUGH S	5.00	LAW ENFORCEMENT	ABUSE OF RESIDENT BY FAMILY	ABUSE OF RESIDENT BY FAMILY
	1 ABUSE, PHYSICAL (INCLUDING CORPORAL PUNISHMENT)				
07/23/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FEEDING ISSUES	FEEDING ISSUES
	120 FAMILY CONFLICT; INTERFERENCE				
07/19/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES	RESIDENT HOARDS CONTRABAND	RESIDENT HOARDS CONTRABAND
	66 RESIDENT CONFLICT, INCLUDING ROOMATES				
08/27/2012	TASIA MCCULLOUGH S	4.00		ABUSE OF RESIDENT BY FAMILY	ABUSE OF RESIDENT BY FAMILY
	5 GROSS NEGLECT (USE CATEGORIES UNDER CARE SECTIONS F&G FOR NON-WILLFUL FORMS				
06/21/2012	TASIA MCCULLOUGH S	0.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
	120 FAMILY CONFLICT; INTERFERENCE				

CONSULTATIONS REPORT From 10/01/2011 To 09/30/2012

05/15/2013

Date	Ombud	Time	Referral Code	Other problem/question	Remarks
08/27/2012	TASIA MCCULLOUGH S	3.00	4 FINANCIAL EXPLOITATION (USE E FOR LESS SEVER FORMS OF FINANCIAL CMPLT)	FAMILY WITH MULTIPLE QUESTIONS	FAMILY WITH MULTIPLE QUESTIONS
05/15/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES 19 DISCHARGE/EVICTION - PLANNING, NOTICE, PROCEDURE, IMPLEMENTATION	RESIDENT BEING DISCHARGED FOR EXERCISING THE RIGHT TO REFUSE	RESIDENT BEING DISCHARGED FOR EXERCISING THE RIGHT TO REFUSE
05/09/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	ABUSE OF RESIDENT BY FAMILY	ABUSIVE HUSBAND
03/02/2012	TASIA MCCULLOUGH S	2.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	RESIDENT WANTS TO GO HOME/ WIFE CANNOT PROVIDE CARE IN THE HOME	RESIDENT WANTS TO GO HOME
02/17/2012	TASIA MCCULLOUGH S	0.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	FAMILY INTERFERRING CARE	FAMILY INTERFERRING CARE
02/29/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES 9 ACCESS BY OR TO OMBUDSMAN/VISITORS	FAMILY TAKING RESIDENT TO SPECIALIST WITHOUT CONFERRING WITH FACILITY PHYSICIAN	FAMILY TAKING RESIDENT TO SPECIALIST WITHOUT CONFERRING WITH FACILITY PHYSICIAN MULTIPLE ODERS BEING CHANGED .
02/17/2012	TASIA MCCULLOUGH S	6.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	SISTERS HAVING CONFLICT ABOUT VISITATION AND POA	SISTERS HAVING CONFLICT ABOUT VISITATION AND POA
02/08/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES 19 DISCHARGE/EVICTION - PLANNING, NOTICE, PROCEDURE, IMPLEMENTATION	RESIDENT LEVEL OF CARE HAS CHANGED FAMILY REFUSING TO SEEK APPROPRIATE PLACEMENT	RESIDENT LEVEL OF CARE HAS CHANGED FAMILY REFUSING TO SEEK APPROPRIATE PLACEMENT
01/25/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
07/18/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES 120 FAMILY CONFLICT; INTERFERENCE	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
03/22/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES 122 LEGAL - GUARDIANSHIP, CONSERVATORSHIP, POWER OF ATTORNEY, WILLS	WITNESS LIVING WILL	WITNESS LIVING WILL

CONSULTATIONS REPORT From 10/01/2011 To 09/30/2012

05/15/2013

Date	Ombud	Time	Referral Code	Other problem/question	Remarks
Complaint					
09/26/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FAMILY INTERFERRING CARE	FAMILY INTERFERRING CARE
120 FAMILY CONFLICT; INTERFERENCE					
09/19/2012	TASIA MCCULLOUGH S	3.00	SOCIAL SERVICES	RESIDENT ROOM CLEANED WITHOUT RESIDENT CONSENT	RESIDENT ROOM CLEANED WITHOUT RESIDENT CONSENT
26 DIGNITY, RESPECT - STAFF ATTITUDES					
09/05/2012	TASIA MCCULLOUGH S	3.00	SOCIAL SERVICES	DSS INTERVENTION	DAUGHTER MISMANAGING MOM CARE
4 FINANCIAL EXPLOITATION (USE E FOR LESS SEVER FORMS OF FINANCIAL CMPLT)					
09/04/2012	TASIA MCCULLOUGH S	3.00	SOCIAL SERVICES	RESIDENT REQUESTS TO GET UP AND DRESSED NOT ANSWERED PROMPTLY	RESIDENT REQUESTS TO GET UP AND DRESSED NOT ANSWERED PROMPTLY
26 DIGNITY, RESPECT - STAFF ATTITUDES					
09/04/2012	TASIA MCCULLOUGH S	3.00		RESIDENT HAS ISSUES WITH THE MEAL QUALITY	RESIDENT HAS ISSUES WITH THE MEAL QUALITY
71 MENU - QUANTITY, QUALITY, VARIATION, CHOICE, CONDIMENTS, UTENSILS, MENU					
04/25/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
120 FAMILY CONFLICT; INTERFERENCE					
04/13/2012	TASIA MCCULLOUGH S	0.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
120 FAMILY CONFLICT; INTERFERENCE					
04/13/2012	TASIA MCCULLOUGH S	4.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
120 FAMILY CONFLICT; INTERFERENCE					
08/17/2012	TASIA MCCULLOUGH S	3.00		FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
4 FINANCIAL EXPLOITATION (USE E FOR LESS SEVER FORMS OF FINANCIAL CMPLT)					
04/23/2012	TASIA MCCULLOUGH S	2.00	SOCIAL SERVICES	MEDICATION ISSUES	MEDICATION ISSUES
44 MEDICATIONS - ADMINISTRATION, ORGANIZATION					
09/26/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FAMILY INTERFERRING CARE	FAMILY INTERFERRING CARE
120 FAMILY CONFLICT; INTERFERENCE					
03/20/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	RESIDENT BEING DISCHARGED FOR EXERCISING THE RIGHT TO REFUSE	RESIDENT BEING DISCHARGED FOR EXERCISING THE RIGHT TO REFUSE CERTAIN CARE SERVICES
19 DISCHARGE/EVICTION - PLANNING, NOTICE, PROCEDURE, IMPLEMENTATION					

CONSULTATIONS REPORT From 10/01/2011 To 09/30/2012

05/15/2013

Date	Ombud	Time	Referral Code	Other problem/question	Remarks
Complaint					
03/05/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	MISSED DOSAGES	FAMILY FEELS AS IF MEDS ARE NOT BEING DISPERSED CORRECTLY
44 MEDICATIONS - ADMINISTRATION, ORGANIZATION					
01/13/2012	TASIA MCCULLOUGH S	0.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
120 FAMILY CONFLICT; INTERFERENCE					
01/13/2012	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
120 FAMILY CONFLICT; INTERFERENCE					
10/18/2011	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	SISTERS HAVING CONFLICT ABOUT VISITATION AND POA	SISTERS HAVING CONFLICT ABOUT VISITATION AND POA
120 FAMILY CONFLICT; INTERFERENCE					
10/18/2011	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FAMILY MEETING	FAMILY MEETING
37 PERSONAL FUNDS - MISMANAGED, ACCESS/INFORMATION DENIED, DEPOSITS AND OTHER MONEY NOT RETURNED					
10/13/2011	TASIA MCCULLOUGH S	5.00	SOCIAL SERVICES	FACILITY HAVING HARD TIME COLLECTING FUNDS	FACILITY HAVING HARD TIME COLLECTING FUNDS
37 PERSONAL FUNDS - MISMANAGED, ACCESS/INFORMATION DENIED, DEPOSITS AND OTHER MONEY NOT RETURNED					
10/11/2011	TASIA MCCULLOUGH S	6.00	SOCIAL SERVICES	ADM IN LEGAL DILEMMA	DEPOSITION FOR CASE WITH ATTORNEY
26 DIGNITY, RESPECT - STAFF ATTITUDES					
04/16/2012	TASIA MCCULLOUGH S	3.00	SOCIAL SERVICES	ABUSIVE HUSBAND	ABUSIVE HUSBAND
3 ABUSE,VERBAL/MENTAL (INCLUDING PUNISHMENT, SECLUSION)					

Total Consultations: 42 **Total Time:** 156.00

Total Time: 156.00

Total Consults: 42

TRAINING REPORT From 10/01/2010 To 09/30/2011

05/15/2013

Date	Type Facility	Topic Ombud	Time	Number Trained	Remarks
OMBUD STAFF					
10/08/2010	OMBUD STAFF MYRTLE BEACH ESTATI	ELDER ABUSE AND NEGLECT TASIA MCCULLOU	5.00	25	
12/08/2010	OMBUD STAFF GEORGETOWN HEALTH	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	3.00	52	
02/11/2011	OMBUD STAFF CONWAY MANOR	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	12.00	157	
03/04/2011	OMBUD STAFF DR. RONALD E MCNAIR	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	7.00	62	
04/21/2011	OMBUD STAFF LAKES AT LITCHFIELD /	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	10	
04/27/2011	OMBUD STAFF GOOD SAMARITAN RESI	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	4.50	8	
05/04/2011	OMBUD STAFF COVENANT TOWERS HE	ELDER ABUSE AND NEGLECT TASIA MCCULLOU	5.50	12	
05/19/2011	OMBUD STAFF AGAPE	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	26	
06/13/2011	OMBUD STAFF COVENANT TOWERS HE	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	5.00	12	
06/14/2011	OMBUD STAFF SUMMITT PLACE OF NOI	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	6.50	25	
06/23/2011	OMBUD STAFF ANDERSON OAKS	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	6.00	21	
08/02/2011	OMBUD STAFF NHC HEALTHCARE, GAR	ELDER ABUSE AND NEGLECT TASIA MCCULLOU	4.00	71	
08/08/2011	OMBUD STAFF KINGSTREE NURSING F/	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	63	
08/10/2011	OMBUD STAFF MYRTLE BEACH MANOF	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	30	
08/11/2011	OMBUD STAFF MYRTLE BEACH MANOF	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	25	
08/18/2011	OMBUD STAFF AGAPE CONWAY	ELDER ABUSE AND RESIDENTS RIGHTS TASIA MCCULLOU	4.00	24	
08/31/2011	OMBUD STAFF GEORGETOWN HEALTH	HIPAA AND RESIDENTS RIGHTS TASIA MCCULLOU	2.00	45	
09/23/2011	OMBUD STAFF CONWAY MANOR	ELDER ABUSE AND NEGLECT TASIA MCCULLOU	12.00	168	
	Number Sessions: 18	**Total Time:**	**96.50**	**836.00**	
Total Time:			**96.50**	**836.00**	

Total Sessions: 18

1

D. Appendix D

Information, Referral and Assistance Report

Waccamaw Region AAA/ADRC
July 1, 2012-April 30, 2013

TOTAL CONTACTS	TOTAL SHIP CONTACTS
2370	920

STAFF	# OF CONTACTS
Brenda Blackstock	623
Danita Vetter	25
Valerie Gonzalez	539
Amanda Stoveken	1039
Unknown	144

County	# of Contacts
Charleston	11
Clarendon	9
Dillon	1
Florence	15
Georgetown	681
Horry	1018
Marion	1
Out of State	60
Richland	1
Spartenburg	1
Williamsburg	358
York	1
Unknown	213

E. Appendix E

SHIP Midterm Report

Waccarnaw Regional Council of Governments
2012 Progress Report for September 1 - December 31, 2012

In accordance with the mission of the SHIP Basic Grant Program's to enable local SHIP offices to assist Medicare beneficiaries who need or prefer information, counseling, enrollment assistance beyond what they are able to receive on their own, through outreach and education, Waccamaw Regional Council of Governments' SHIP Program submits this progress report and proposal for the grant funding period of September 1, 2012 through December 31, 2012.

The SHIP Basic Grant Program requires that each grantee to adhere to the overall program goal—our progress/proposal report provides detailed responses to the following program areas:

- Outreach and counseling efforts
- Presentations and Health Fairs
- Direct Contacts
- Consumers under the age 65
- LIS beneficiaries
- Part-D enrollment
- Proposed Activities for 2013

Outreach and Counseling Efforts

Waccamaw regional Council of Governments ship program expanded outreach in counseling efforts through the Caring Connection Newsletter with the Family Caregiver Program that reached at least 200 caregivers throughout our region. Through a partnership with the Georgetown Hospital System's Chronic Condition Training Program, we have disseminated information about the SHIP Program as well. In addition, through a unique partnership with Care Improvement Plus, our program has reached out to several beneficiaries who had specific questions regarding billing issues, Extra Help and Medicaid questions. Finally, our program just started plans to recruit new volunteers to help with promoting the SHIP Program.

Presentations and Health Fairs

Our SHIP Program has disseminated information about Medicare's new open enrollment periods, Low Income Subsidy, Medicare Advantage Plans, Medicare

Supplement Insurance, Medicare's Prescription Drug Plans, New Pre-existing Condition Medical Insurance, Fraud and abuse, Medicare's Wellness Preventive Services and SMP Program. This information was presented at the following Places:

- City of Georgetown Trick-or-Treat Event—October 2012
- St. Michaels AME Church—September, October, November and December 2012
- Georgetown Outreach Ministries Inc.—September 2012
- Neighbor-to-Neighbor Transportation Services—September 2012
- Lighthouse of Jesus Christ—September 2012
- Georgetown Women-in-Ministries—September 2012

Direct Contacts

In an effort to help client significantly improve their understanding of SHIP Program, our office has pushed to increase the number of one-on-one counseling session this reporting period. We conducted **100** one-on one counseling sessions between September 1-December 31, 2012. A breakdown of clientele is listed is attached.

Consumers under 65

Waccamaw Regional Council of Government has experienced an increase in the number of clients who are under the age 65 and clients who applied for LIS and MSP. We have counseled **25** beneficiaries who are under the age 65; assisted **51** people with Medicaid applications, and **64** with LIS applications. A breakdown of work is listed is attached

Part D enrollment

This enrollment period meet with aging staff and devised a plan that included everyone in the department and just the Medicare Specialist. We also met with our administrative assistants to ensure that calls were routed correctly and messages were taken accurately to ensure timely responses to inquirer's request. In addition, our Medicare Specialist worked on Saturdays during the open enrollment period to ensure that our client's would have the opportunity to sign up for a plan. We also are working with volunteers for next open enrollment to increase the number of contacts as well.

Our Strategy for increasing these numbers will include—On-going presentations with Health fairs, Senior Centers and Community-Based Agencies, will market our program in the Local News-Papers and also continue to post request for volunteers on our website.

WALK-1N CLIENTS: OCTOBER-DECEMBER 2012

OCTOBER:	
10/03/2012	Lyles, Gale
	Ray, Robert
10/04/2012	Clairmont, Dawayne
10/05/2012	Boykin, Patricia
10/08/2012	Hammond, Diana
	Armstrong, Elaine
	Thomas, Michael
10/09/2012	Braves, Barbara
	Haywood, James
	Haywood, May
10/10/2012	Palmer, Larry
	Palmer, Barbara
10/11/2012	Altman, David
	Altman, Diana
10/15/2012	Ritter, William
	Fryer, James
10/16/2012	Ritter, William
	McCollough, Priscilla
	Guyton, Rudell
	Deloach, John
	Deloach, Faye
	Boykin, Patricia
10/22/2012	Armstrong, Elaine
	Ritter, William
	Howard, Homer
10/23/2012	Talarico, Karen
	Talarico, Michael
	Long, May
10/24/2012	Parks, Alma
10/26/2012	Hardy, Michelle
10/29/2012	Deloach, John
	Deloach, Faye
10/30/2012	Altman, David
	Altman, Diana
NOVEMBER:	
11/2/2012	Brave, Barbara
	Brave, Vandrenia
	Knowlin, Patricia
11/05/2012	Flanigin, Jackie
	Walker, Titus
11/06/2012	Walker, Lula
	Walker, Calvin
	Armstrong, Erlise

11/10/2012	Cytaki, Margaret
	Browning, John
	Browning, Ms.
11/12/2012	Avant, Marsha
	Avant, Winfred
	Pope, Billy
	Causey, Joann
	Armstrong, Ruth
11/13/2012	Pope, Billy
	Avant, Marsha
	Ritter, William
	Parks, Alma
	Sykes, Debris
11/14/2012	Briggs, Joan
	King, Betty
	Hannah, Sadie
	Sykes, Debris
	Avant, Marsha
	Avant, Winfred
	Causey, Joann
	Armstrong, Ruth
11/15/2012	Spring, Tammy
	Avant, Marsha
	Avant, Winfred
	Causey, Joann
11/17/2012	Lyle, Gyle
	Lyle, John
11/20/2012	McFadden, Lorretta
11/28/2012	Middleton, Carolyn
	Armstrong, Ruth
	Armstrong, Erlise
11/29/2012	Singleton, Annie
	Williams, Carolyn
	Wright, Olyn
	Armstrong, Ruth
	Armstrong, Erlise
DECEMB	
12/03/2012	Sykes, Debris
12/04/2012	Smalls, May
12/05/2012	Drayton, Ellen
12/06/2012	Richardson, Mary
12/07/2012	West,
	Braves, Barbara
12/11/2012	Booth, Billie

[redacted]	Armstrong, Ruth
11/07/2012	Grate, Marcus
[redacted]	Custin, Genenia
[redacted]	[redacted]

12/12/2012	Mention, Melissa
	Causey, Joann
	Smith, Carolyn
12/19/2012	Guyton, Rudell
12/21/2012	Ritter, William

Name	Date	Application
McClary, Issac	September 2012	QI
Pritchett, Mary	October 2012	QI
McIntosh, Josa	October 2012	QI
McKenzie, Auther	October 2012	QI
Sabb, Dennis	October 2012	01
Walker, Titus	October 2012	QI
Graham, Esther	October 2012	QI
Thomas, Bessie	October 2012	QI
Turner, John	October 2012	QI
Mishoe, Brice	October 2012	QI
Hawkins, Edward	October 2012	QI
Morris, Donald	October 2012	QI
Bullard, Vivian	October 2012	QI
Pope. Elwood	October 2012	QI
Masten, Vicki	October 2012	QI
Selock, Bonnie	October 2012	QI
Pope, Virginia	October 2012	QI
Bryant, Edna	November 2012	QI
Godfrey, Robert	November 2012	QI
Morrison, Melissa	November 2012	QI
Dewitt, Kenneth	November 2012	QI
Cox, John	November 2012	QI
Blanchard, Dena	November 2012	QI
Brink, Carolyn	November 2012	QI
Chavis, Debra	November 2012	QI
Reid, Doris	December 2012	QI
Rizzo, Barbara	December 2012	QI
Armstrong, Sennie	December 2012	01

Huffesetler, Betty	December 2012	QI
Valentin, Anna Maria	December 2012	QI
Brave, Barbara	December 2012	QI

Name	Date	Application
McClary, Issac	September 2012	Medicaid
Poston, Deana	September 2012	Medicaid
Walters, Cynthia	September 2012	Medicaid
Booth, Charles	October 2012	Medicaid
Hutto, Joyce	October 2012	Medicaid
Ritter, William	October 2012	Medicaid
Poston, Deana	October 2012	Medicaid
Davis, Maggie	October 2012	Medicaid
Mouzon, Daisy	October 2012	Medicaid
Fiumara, Concetta	October 2012	Medicaid
Brave, Vanunderia	November 2012	Medicaid
Alston, Geneva	November 2012	Medicaid
Grate, Marcus	November 2012	Medicaid
McFadden, Loretta	November 2012	Medicaid
Sanguine, John	November 2012	Medicaid
Goodman, Elizabeth	December 2012	Medicaid

Brown, Debris	December 2012	Medicaid
Smith, Carolyn	December 2012	Medicaid

Name	Date	Application
Boykin , Patricia	September 2012	LIF
Braves, Miranda	December 2012	LIF 1

Name	Date	Application
Mishoe,	September 2012	LIS
Giles, Helen	September 2012	LIS
Martin,	September 2012	LIS
Palmer, Larry	September 2012	LIS
Hawkins, Edward	September 2012	LIS
Poston, Deana	September 2012	LIS
Vanfleet, Mary	September 2012	LIS
Gray, Ronald	September 2012	LIS
Gray, Elaine	September 2012	LIS
Booth, Charles	October 2012	LIS
Blum, JP	October 2012	LIS
Ray, Robert	October 2012	LIS
Ray, Lauretta	October 2012	LIS
Armstrong, Eriles	October 2012	LIS
Armstrong, Ruth	October 2012	LIS
Cardwell, Phyllis	October 2012	LIS
Cardwell, Andrew	October 2012	LIS
Capps, Blanche	October 2012	LIS
Thomas, Bessie	October 2012	LIS
Graham, Esther	October 2012	LIS
Turner, John	October 2012	LIS
Morris, Donald	October 2012	LIS
Bullard, Vivian	October 2012	LIS
Masten, Vicki	October 2012	LIS
Pope, Elwood	October 2012	LIS
Valentin, Anna Marie	October 2012	LIS
Geathers, Maggie	October 2012	LIS
Selock, Bonnie	October 2012	LIS
Davis, Maggie	October 2012	LIS
Davis, Willie	October 2012	LIS
Fersch, Lynda	October 2012	LIS
Talarico, Michael	October 2012	LIS
Parks, Alma	October 2012	LIS
Flumara, Concetta	October 2012	LIS
Strait, Ronald	October 2012	LIS
Strait, Johnnie	October 2012	LIS
Pope, Virginia	October 2012	LIS
Martin, Barbara	October 2012	LIS

Williams, Beverly	October 2012	LIS
Godfrey, Robert	November 2012	LIS
Morrison, Melissa	November 2012	LIS
Guear, Henry	November 2012	LIS
Johnson, Johnny	November 2012	LIS
Cox, John	November 2012	LIS
Bridges, Johnnie	November 2012	LIS
Bray, Robert	November 2012	LIS

'Bray, Lauvenia	November 2012	LIS
Behnken, Catherine	November 2012	LIS
McFadden, Loretta	November 2012	LIS
Perkins, Judith	November 2012	LIS
Powers, Dixie	November 2012	LIS
Powers, James	November 2012	LIS
Bellamy, Katrina	November 2012	LIS
Brink, Carol	November 2012	LIS
Mills, Judy	November 2012	LIS
Chavis, Debra	November 2012	LIS
Parson, Mernerva	December 2012	LIS
Cox, John	December 2012	LIS
Rizzo, Barbara	December 2012	LIS
Armstrong, Sennie	December 2012	LIS
Cooper, Edith	December 2012	LIS
Cooper, Eddie	December 2012	LIS
Spiegel, Denise	December 2012	LIS
Spiegel, Steve	December 2012	LIS

F. Appendix F

SMP Report

REGION VIII SMP PROGRESS REPORT FOR GRANT No.90AM2706
REPORT PERIOD 07/01/-12/31/2012

What did you do to promote the National and Regional SMP Program?

Waccamaw Regional Council of Governments' (WRCOG) Staff promoted the National and Regional SMP Program during this period by distributing copies of the Waccamaw Regional Council of Governments' Aging Resource Directories. Page (2) discusses the AAAs Medicare Fraud Program and Page (4) describes ways to protect oneself against fraud. These directories are distributed to libraries, DSS offices, Medicaid offices, senior centers, Council on Aging offices, Rural Health Centers, medical offices, and to other sites throughout the Region.

Our Waccamaw Regional Council of Government's (WRCOG) SMP staff has expanded outreach and counseling efforts through the Caring Connection Newsletter with the Family Caregiver Program that reached at least 200 caregivers throughout our region. Through a partnership with the Georgetown Hospital System's Chronic Condition Training Program we have disseminated information about the SMP Program. In addition, through a unique partnership with Care Improvement Plus, our program has reached out to several beneficiaries who had specific questions regarding billing issues, Extra Help and Medicaid questions.

Our WRCOG SMP program has increased the number of one-on-one counseling sessions, this program period our program has conducted and educated 100 beneficiaries in 96 counseling sessions.

Our WRCOG SMP staff has partnered with local churches to do speaking engagements that informed their congregations about the SMP, Medicare and SHIP Programs. The sessions were specifically designed to help the beneficiaries recognize the scope of fraud and abuse and gave the beneficiaries the opportunity to ask specific questions relating to the SMP, Medicare and SHIP Programs.

Our WRCOG SMP staff disseminated information about the SMP, Medicare and SHIP Programs at the following:

- Lighthouse of Jesus Christ's Leadership Conference—500 attendance;
- City of Georgetown Trick-or-Treat Event;
- St. Michael's AME Church—30 attendance;
- Georgetown Outreach Ministries—32 attendance;

- Georgetown Transportation Services—25 attendance;
- Georgetown Women-In-Ministries—35 attendance.

Our WRCOG SMP staff met with Care Improvement Plus representatives to educate them on the LIS, Medicare's Savings Programs, SMP and SHIP Programs. This meeting was so enlightening to them that they agreed to disseminate information about the SMP Program on a regular basis. As a result, many clients who potentially eligible for the LIS program were identified and consumers are being educated and empowered to protect themselves against fraud. 15 people where reach because of this partnership.

Regional Marketing Activities

Regional marketing activity consisted of distribution and dissemination of brochures, Waccamaw Regional Council of Government's Resource Directories pamphlets, pens, jar openers and fact sheets to local social service agencies, libraries, churches, faith-based organizations, caregivers and consumers.

This program period we have downloaded several outreach and advertising materials, from the National SMP resource website and from the CMS website, to empower and educate beneficiaries on protecting themselves against fraud.

Finally, our SMP staff has downloaded "the SMP Newsletter template" and "the Stop Health Care Fraud Fact Sheet template" to promote the visibility of the National SMP Program as well as educate and empower seniors to prevent health care fraud--the theme our SMP Program.

What did you do to improve beneficiary education and inquiry resolution?

Our WRCOG SMP Program has implemented a plan to improve and increase beneficiary education by recruitment of volunteers. In addition, our plan includes specific strategies and procedures that address volunteer screening, training and management in order to reduce risk, provide more effective service, and improve the quality of beneficiary education. Our SMP staff has help developed a web page on our Waccamaw Regional Council of Government's website that specifically advertises for volunteers.

To improve inquiry resolution, our office has hired a data entry clerk to ensure intake on these claims is done in a timely manner and to reduce waiting times on resolutions. Typically, when a complex issue or concern comes into our office we do the intake process here in our office and submitted to the Lt. Governors' Office on Aging for follow-up and resolution.

Finally, our office has recruited a volunteer to help with inquiry resolution and data entry. Information on this endeavor will be reported in the next reporting period.

Statistics for this reporting period:

- 2 active volunteers that work to educate beneficiaries about how to prevent Medicare Fraud;
- Educated 100 beneficiaries 96 one-on-one counseling sessions;
- Resolved 70 simple inquiries for information or assistance from beneficiaries;
- Educated 830 beneficiaries through the dissemination of outreach information and materials.

How did you foster the National SMP Program Visibility?

We have fostered the National SMP Visibility during presentations and at information booths/exhibits. Our SMP Staff has created a Volunteer web page that will display the theme for our SMP Program-- "Empowering Seniors to Prevent Health Care Fraud" and provide a link to the National SMP Resource website fostering the National SMP Program's visibility. This endeavor is currently in progress.

In addition to web-media, our SMP staff has downloaded *"the SMP Newsletter template"* and *"the Stop Health Care Fraud Fact Sheet template"* to promote the visibility of the National SMP Program as well as educate and empower seniors to prevent health care fraud--the theme our Regional SMP Program.

How did you improve your efficiency?

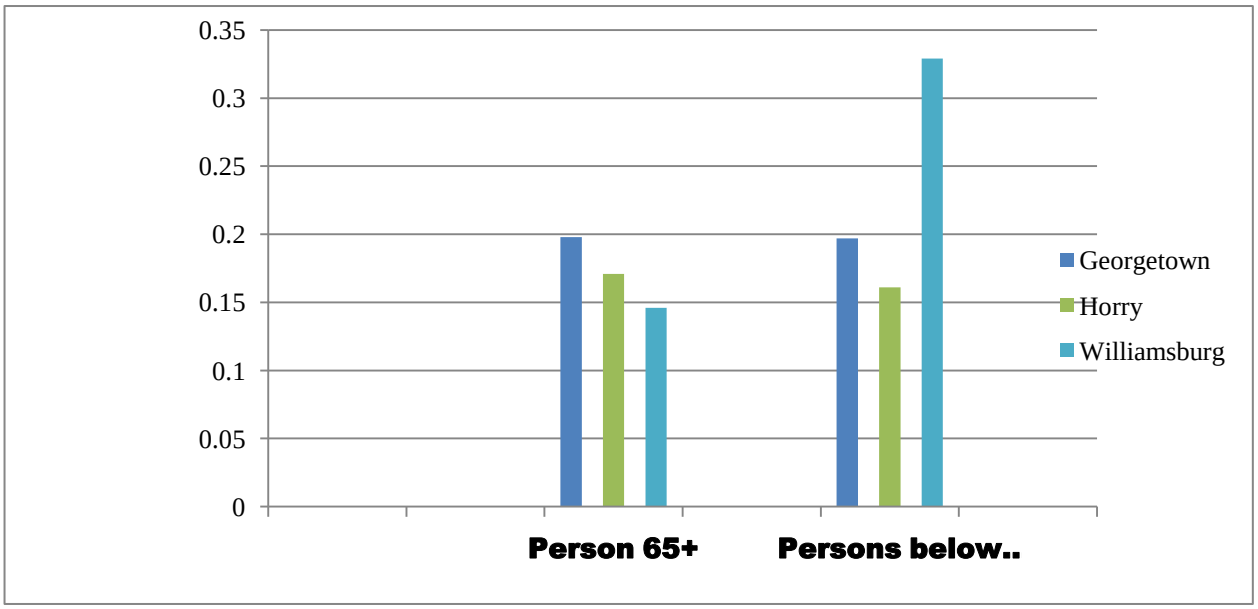
We increased our efficiency by requesting clients to fax materials or mail in requested information. In addition, we have hired an additional staff person to assist with the intake process and keying data into the system. We find that clients comply with our requests quite timely in alleged fraud cases.

Our SMP Staff utilizes the SMART FACTS System to collect, tract, asses and measure our program's performance. In addition, we use the data to asses our overall program's progress in reaching our objectives, goals and outcomes. This data will help us discover what areas of our program that need improvement and developing a plan of action to address these concerns.

Our SMP Staff has design a customer service satisfaction survey help us improve our program's efficiency as well. Outcomes of this endeavor will be reported in next period.—See attached

These outcomes enabled our SMP Program to develop a comprehensive work plan that focuses on the following areas of our SMP Program: 1. Volunteer Recruitment 2. Partnerships and other community relationships 3. Networking to utilize best practice models and proven approaches to outreach, education and recruitment of volunteers. Our SMP Staff is currently networking with other SMP Programs in the state to address these areas of concerns that will improve our outreach and contacts for the next reporting period and improve our overall SMP program's management.

How did you target populations for your training?



County	Total Population	People over 65	Poverty Level
Georgetown	60,158	11,920	19.7%
Horry	269,291	**46,070***	16.1%
Williamsburg	34,423	5,039	**32.9%***

Source: 2010 Census Data--

*The Census Data shows that Williamsburg County has the highest level of poverty out of Georgetown and Horry counties and that Horry County has the highest concentration of people that are over 65.

The demographical statistics from the 2010 Census shown above, will used as a rational for tailoring our outreach efforts and measures to target communities that have the greatest level of need.

New Partnerships

Our agency has just recently entered into a partnership with the Williamsburg County Inter-agency Counsel, Georgetown Assisted Rides Program and Williamsburg County Disaster preparedness Council to help reach this underserved population in Williamsburg County. Our agency will increase our number of home visit and make regular scheduled visits to the local senior centers in Williamsburg County in addition to presentations and health fairs to address outreach in the rural area. Through the Councils on Aging centers, churches, rural health centers, pharmacy referrals we will continue to use these resources as additional avenues to reach our target population in rule areas.

Up Coming Events

- Benefits Bank Training
- Television Interview
- Senior centers
- Presentation with Williamsburg Interagency Council
- Presentation at Mental Health—Williamsburg County
- SHIP and SMP Training

Confidentiality

Finally, our SMP Program will use confidentiality agreements to make sure proprietary information remains confidential. In cases when the volunteer will be sharing confidential information with another person or organization and because he or she will be given access to confidential demographical and personal information that belongs to another person or agency, this form will allow our agency to protect privileged information and to ensure that the signer cannot legally expose it. A copy of confidentiality form is attached.

Confidentiality Agreement

It is understood and agreed to that the below identified discloser of confidential information may provide certain information that is and must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under patent and/or trade secret laws, it is agreed that

1. The Confidential Information to be disclosed can be described as and includes:

Invention description(s), technical and business information relating to proprietary ideas and inventions, ideas, patentable ideas, trade secrets, drawings and/or illustrations, patent searches, existing and/or contemplated products and services, research and development, production, costs, profit and margin information, finances and financial projections, customers, clients, marketing, and current or future business plans and models, regardless of whether such information is designated as "Confidential Information" at the time of its disclosure. Demographical information of clients, consumers and beneficiaries including time and dates of services, provider information all information that is designated as "Confidential Information" at the time of its disclosure.

2. The Recipient agrees not to disclose the confidential information obtained from the discloser to anyone unless required to do so by law.

3. This Agreement states the entire agreement between the parties concerning the disclosure of Confidential Information. Any addition or modification to this Agreement must be made in writing and signed by the parties.

4. If any of the provisions of this Agreement are found to be unenforceable, the remainder shall be enforced as fully as possible and the unenforceable provision(s) shall be deemed modified to the limited extent required to permit enforcement of the Agreement as a whole.

WHEREFORE, the parties acknowledge that they have read and understand this Agreement and voluntarily accept the duties and obligations set forth herein.

Recipient of Confidential Information:

Name (Print or Type):

Signature:

Date:

Discloser of Confidential Information:

Name (Print or Type):

Signature:

Date:

G. Appendix G

Family Caregiver Support Program Report

WACCAMAW REGIONAL COUNCIL OF GOVERNMENTS FAMILY CAREGIVER PROGRAM

JULY 1, 2011-JUNE 30, 2012 YEAR-END REPORT

JUSTIFICATION TO DATA REPORT

This year brought changes to the Waccamaw Regional Family Caregiver Program with the addition of a new face in the Family Caregiver Advocate Position late in the fiscal year. Our new caregiver advocate comes from a background of thirteen years in the aging business, where she served in several different positions within the aging network including PDA Waiver Caremanager, Ombudsman (11 yrs), Protective Service Worker, Guardianship Caremanager, DOM Care Caremanager, and Option Services Caremanager. Her education includes a Bachelor of Science Degree in the Rehabilitative Science field with a concentration in Gerontology. In the interim, the Waccamaw Family Caregiver Support Program (FCGSP) with the help of the Aging staff was able to continue to serve the many caregivers in the region with much needed respite and supplemental services.

Our program not only provides respite and supplemental grants of up to $500 for caregivers and grandparents; but is also in the process of introducing a series of educational caregiver trainings, updating program material filing systems , developing partnerships to increase visibility of the program and meet the needs of caregivers in the community, improving contact/ intake processes with caregivers, developing a volunteer base, and finding methods of determining what caregivers need to make their job less stressful. It is the goal of the Waccamaw Regional Family Caregiver Support Program (FCGSP) to provide a quality and satisfying experience for the caregiver. With this in mind we will proactively strive to meet the needs of the caregivers in our region. The following material presents brief explanations of Waccamaw Region Family Caregiver Program activities, accomplishments, and goals for the future.

NEW CAREGIVER RESOURCES AND PARTNERSHIPS

One of our first accomplishments for this service year was in the development of a partnership between the Waccamaw Area Agency on Aging Family Caregiver Program and Georgetown Hospital Systems. This partnership focuses on providing training to caregivers who care for loved ones suffering from specific conditions that have been shown to be present in individuals who are constant readmits to the hospital system. The Family Caregiver Training (FCT) series invites professionals in the medical, legal, and community resources area, to present information to the caregiver and care receiver to aid in transition from the hospital setting to home. The goal is to increase the knowledge base of the caregiver and care receiver by: providing information about the care receiver's health condition and it's processes; empowering the caregiver by providing practical care giving tips; raising awareness of, and providing information about, legal affairs planning; supplying information about, and building a team of community resources.

The present Waccamaw FCGSP advocate has been meeting on a one-to one basis with various community group representatives, care agencies, support groups, referral sources, and educational institutions, to learn more about local community resources, and to disseminate more information about the Family Caregiver Support Program and what it has to offer. Touching base with various resources in the community has not only served to enlighten us about the services, operations, and procedures offered by various helping organizations and agencies; but also affords us the opportunity to provide a wider array of informational materials, and referral sources, to our caregivers.

Presently the Waccamaw family caregiver advocate is working on developing a partnership with the local university's nursing program in hopes that this will provide a volunteer base for our caregivers who are in need of help: with errands (grocery store, post office, dry cleaners), a short respite of an hour or two, assist with small chores around the home, and/or someone to stay with their loved ones to allow the caregiver to attend a support group meeting. This would serve to provide the caregivers with much needed relief, the care receivers would have a respite as well, and nursing students receive invaluable one-on-one training experience with those they may possibly be caring for upon graduation.

We are also concentrating our efforts on developing a volunteer base to assist with administrative aspects of the program, as well as, with organization and facilitation of caregiver activities and programs. Advertising in the local paper, speaking with local

civic organizations (Lions Club, Rotary Clubs), and acquiring help through other helping agencies will also be explored.

New Outreach Materials

Waccamaw Family Caregiver forms, brochures, educational material, filing and input systems, are being updated to improve the efficiency and effectiveness of the program. The goal is to increase understanding of the family caregiver program for all in need of accessing it, and to make navigation of the program process an easier and less stressful experience for the caregiver. An initial challenge involved getting those previously involved with the program use to a new way of doing things. We are also updating caregiver forms, procedures, and filing system, to provide better accountability for, and concrete explanation of, where and how program funds are used. Another area of concern targeted for improvement involves timely and comprehensive communication following a referral or initial contact with a potential caregiver or persons interested in the caregiver program. As a result of this effort there has been increased positive response and comment concerning the accessibility of the program and the family caregiver advocate efforts.

Our new newsletter, "The Caring Connection" will be completed and sent out in October 2012. This newsletter will provide useful and practical information to our caregivers, as well as, encourage active participation in what goes into it each quarter. Within the newsletter is a section called the "The Recipe Corner." This section of the newsletter requests caregivers submit favorite recipes. If enough recipes are received from our caregivers we will put them in a recipe book and use the book as a fund raiser at year's end. Recipes will also be randomly chosen to be featured in future newsletters. Hopefully our recipe section will open the way for more input and participation by our caregivers.

THREE CAREGIVER STORIES/VIGNETTES

Our first story begins with caregiver Mary who cares for her mother and uncle in her home. When Mary first contacted the caregiver program she reported she was having difficulty getting her relatives to their doctor appointments because of their health conditions. Mary, like most caregivers, was not concerned for her own needs, but was more worried about how she was going to manage to meet her relatives' needs. Both mom and uncle have a dementia, along with other health issues. The logistics of taking them together somewhere was proving to be overwhelming for their caregiver. Mary had tried other various resources to get help but had been unsuccessful. When we explained what the FCGSP could do for her she was ecstatic. The respite portion of our program

would fit the bill. Mary could now find someone to care for one relative while she took the other to their doctor appointment. When we discussed the possibility of Mary getting some much needed respite for herself she was overcome. Mary has had very little time to think of herself and we were offering her the resources to allow her to do just that. Since that time Mary has called to thank the caregiver advocate for providing help when no one else would. It is truly a rewarding experience to help caregivers like Mary.

Our second story concerns great grandmother C who is responsible for eleven grandchildren. That's right, eleven! This grandmother always has a positive attitude and is an inspiration to us all. We are amazed at her vitality, and the energy she exudes is contagious. She inspires all who come in contact with her; and we were glad she was able to use our supplemental services to ease the financial burden she is under as the result of taking on the responsibility for all of these children. C is a returning client to the caregiver program and we look forward to helping her in any way we can. Even with all the responsibility she undertakes C reports she looks forward to contributing to our newsletter recipe section. Our great grandmother is truly a treasure who, through being who she is, gives much more than she can ever receive.

The last story we have to share involves caregiver Linda. Linda cares for her mother Bea who resides with her. Bea has a dementia and has also suffered recent compression fractures to her back due to a fall. Other health problems Bea experiences include; limited range of motion and mobility, Diabetes, and severe hearing problems. Linda came to the caregiver advocate worried she would have to give up her job to care for her mother as she could not continue to afford to pay for the Adult Day Care program she had her mother in without some kind of financial assistance. Linda values her job and the thought of giving it up was agonizing, but one she would do if necessary to keep her mother living at home and not in a facility. Juggling the responsibilities many caregivers do is never easy. The caregiver advocate was able to ease Linda's burden by providing a respite award to help pay for Bea's day care. The caregiver advocate also referred Linda to the Alzheimer's Program which is able to provide Linda with respite funds as well. Linda could now continue to work at the job she loved and have her mother remain at home where they both want her to be. This served to be the optimum solution for Linda and Bea. The caregiver also discussed options for the future including the Community Long Term Care Program, and Palliative and Hospice care options. Since that time Linda has called often to thank us for the assistance we rendered. The caregiver advocate explained she is always available to help with any concerns Linda may have through her care giving journey.

All of the caregivers mentioned in our stories above will be invited to attend any support groups or trainings we offer. They will also be provided with any information that will help them have a successful care giving experience. We here at The Waccamaw Regional Caregiver Program will continue striving to do what we can to raise

awareness in our community and state about the importance of comprehensive programming that meets the needs of caregivers and care receivers across the nation. We feel that our caregivers' challenges are ours as well, and we will act accordingly to meet those challenges now and in the future.

H. Appendix H

Budget Documents

Please see separate PDF file for all budget documents

REGION: Waccamaw Worksheet for Staffing Budget and NAPIS Staffing Profile for SFY 2013-2014

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.

The light blue portion is to identify staff and the time each spends only on statutory functions of the 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	Hours Charged to Other Title III Services **(III-D) (LA)(CM)**	Hours Charged to Discretionary Grants or Local Funding
Planning and Administration		**3750**	**2876**	**874**	**1820**	**1710**	**1820**	**1820**	**0**	**1560**
Aging Unit Director	**Kimberly Harmon**	**1820**	1492	328			0	0		0
Program Manager	Danita Vetter	**1820**	1274	546						**0**
Program Developer		**0**	0	0			0		0	0
Aging Fiscal Accounting		**0**	0				0		0	0
Clerical Support Staff		**0**	**0**							0
Clerical Support Staff		**0**	**0**		0	0	0	0	0	0
FTEs by AAA ACTIVITIES		**2.06**	**1.58**	**0.48**	**1.00**	**0.94**	**1.00**	**1.00**	**0.00**	**0.86**
Ombudsman		**1820**			**1820**					**0**
Senior Ombudsman	**Tasia Stackhouse(M)**	1,820	0		1820	0				0
Other Ombudsman Staff		0			0					
Other Ombudsman Staff		0			0					
Other Ombudsman Staff		0			0					
Other Ombudsman Staff		0			0					
Other Ombudsman Staff		0			0					
FTEs		**1.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
I & A		**1710**				**1710**	**0**	**0**		0
Primary I&A and R	**Amanda Stoveken**	1,820	110			1710		0		0
Backup I&R		0					0	0		
FTEs		**0.94**		**0.00**	**0.00**	**0.94**	**0.00**	**0.00**	**0.00**	**0.00**
Insurance Counseling/SMP		**1820**				**0**	0	**1820**		**0**
Primary Counsellor	**Brenda Blackstock (M)**	1,820					0	1820		0
Backup Counsellor		0				0	0	0		
FTEs		**1.00**		**0.00**	**0.00**	**0.00**	**0.00**	**1.00**	**0.00**	**0.00**
Family Caregiver Program		**1820**				**0**	**1820**	**0**		**0**
Caregiver Advocate	**Valerie Gonzalez**	1,820	**0.00**				1820			0
Backup Advocate		0				0	0	0		
FTEs		**1.00**	**0.00**	**0.00**	**0.00**	**0.94**	**1.00**	**1.00**	**0.00**	**0.00**
Other AAA Direct Services		1,560							**0**	
Assisted Rides Coordinator	**Trina Cason**	1,560							0	1560
Medication Management		0							**0**	
FTEs		**0.86**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.86**
COMBINED SERVICE DELIVERY		**8730**								
Intern Hours		0	0			0	0	0	0	
Volunteer Hours		0			0			0	0	
TOTAL PAID HOURS		**12,480**								
TOTAL PAID FTEs		**6.86**								

Enter Staff Names	**Annual Payroll Hours All Sources**
AGENCY'S FTE	**1820**
Kimberly Harmon	1820
Danita Vetter	1820
Tasia Stackhouse	1820
Brenda Blackstock	1820
Valerie Gonzalez	1820
Amanda Stoveken	1820
Trina Cason	1560
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
Paid Hours	12480
Interns	0
Volunteers	0
Total Hours	**12,480**

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: Waccamaw	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	$222,520	$66,748	$21,876		$28,587	$19,604	$6,084	$1,690	$6,422	$10,258		$29,997	
4	Fringe Benefits	$127,620	$38,281	$12,547		$16,396	$11,243	$3,489	$969	$3,683	$5,883		$17,204	
5	Contractual	$101,951												$101,951
6	Travel	$11,750	$4,000	$1,209		$95	$1,118	$924	$505	$873	$1,002		$1,759	
7	Equipment	$2,525	$1,125				$1,400							
8	Supplies	$1,200					$1,200							
9	Indirect Costs	$129,855	$45,928	$15,053		$19,670					$7,058		$20,640	
10	Allocated Costs	$0												
11	Other Direct Costs	$26,954	$6,860				$11,125	$3,775	$684	$4,510				
12	TOTAL OPERATING BUDGET	$624,375	$162,942	$50,684	$0	$64,748	$45,690	$14,272	$3,848	$15,488	$24,202	$0	$69,600	$101,951
13	**LESS: In-kind Above Match**	**$0**												
14	**LESS: Local Cash Above Match**	**$0**												
15	TOTAL AREA PLAN BUDGET: LGOA	$624,375	$162,942	$50,684	$0	$64,748	$45,690	$14,272	$3,848	$15,488	$24,202	$0	$69,600	$101,951
16	**COMPUTATION OF GRANT**													
17	APPROVED AREA PLAN BUDGET	$624,375	$162,942	$50,684	$0	$64,748	$45,690	$14,272	$3,848	$15,488	$24,202	$0	$69,600	$101,951
18	LESS: State 5%Match	$8,056		$2,534	$0	$3,237	$2,284							
19	LESS: Required Grantee Match	$73,842	$40,736	$5,068	$0	$6,475	$4,569				$6,050	$0	$8,185	
20	Federal Share	$526,989	$122,207	$43,082	$0	$55,036	$38,836	$14,272	$3,848		$18,151	$0	$61,415	$101,951
21	BREAKOUT OF LOCAL MATCH (L19	$73,842	$40,736	$5,068	$0	$6,475	$4,569				$6,050	$0	$8,185	
22	Local Cash Match Resources		$40,736	$5,068		$6,475	$4,569				$6,690		$8,185	
23	Local In-kind Match Resources	$0												
24	State Funds Used as Local Match	$0												
25	Total Local Match (Must = Line 25)	$67,792	$40,736	$5,068	$0	$6,475	$4,569					$0	$8,185	$0
27	FRINGE RATE AS % OF SALARIES: 57.35%										INDIRECT COST AS % OF FUNDED PERSONNEL:		37.09%	
28	Yellow cells are calculated values-**DO NOT enter data in th** Blue indicates cells in which data **normally** should not be entered. Use of State funds for local match must be approved BEFORE budget is sub													

	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC
1	AAA COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2012 - 2013 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	$22,972				$4,844	$3,437.96	$88,624	$28,587	$0	$33,799	$0	$31,254	$182,265	Personnel Salaries	
4	$13,175				$2,778	$1,971.75	$50,828	$16,396	$0	$19,385	$40,255	$17,925	$144,788	Fringe Benefits	
5							$0	$0	$0	$0	$23,087	$0	$23,087	Contractual	
6	$52				$80	$133.00	$5,209	$95	$0	$3,420	$101,951	$265	$110,940	Travel	
7							$1,125	$0	$0	$1,400	$2,761	$0	$5,286	Equipment	
8							$0	$0	$0	$1,200	$0	$0	$1,200	Supplies	
9	$15,806				$3,333	$2,365.59	$60,980	$19,670	$0	$0	$0	$21,505	$102,156	Indirect Costs	
10							$0	$0	$0	$0	$27,698	$0	$27,698	Allocated Costs	
11							$6,860	$0	$0	$20,094	$0	$0	$26,954	Other Direct Costs	
12	$52,005	$0	$0	$0	$11,036	$7,908	$213,627	$64,748	$0	$79,298	$195,752	$70,950	$624,375	TOTAL OPERATING BUDGET	
13							**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**LESS: In-kind Above Match**	
14							**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**LESS: Local Cash Above Match**	
15	$52,005	$0	$0	$0	$11,036	$7,908	$213,627	$64,748	$0	$79,298	$195,752	$70,950	$624,375	TOTAL AREA PLAN BUDGET: LGOA	
16	**COMPUTATION OF GRANT**						**NOTE:** Legal Assistance, Med Management,Case Management, Minor Home Repair, and Consumer Directed HCBS								
17	$52,005	$0	$0	$0	$11,036	$7,908	**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					$2,759		**Services**	**III-B**	**III-D**	**5% Match**	**10% Match**	**Total Title III**	**State Funds**		
20	$52,005	$0	$0	$0	$8,277	$7,908	Legal Assistance	$3,687		$217	$434	**$4,338**			
21					$2,759		Medication Management		$0	$0	$0	**$0**			
22					$2,759		Case Management	$0		$0	$0	**$0**	$0		
23							Minor Home Repair	$0		$0	$0	**$0**	$0		
24							Consumer Directed HCBS	$0		$0	$0	**$0**	$0		
25					$2,759		85% Federal	**$3,687**	**$0**				**TOTAL STATE**		
27							5% Match	**$217**	**$0**						
28							10% Match	**$4**	**$0**				**$0**		

REGION: Waccamaw

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 _96_% In-Home Services _0 % Legal Assistance _4_%

Enter Total III B after Transfers for SFY 2012-2013		$403,569	**and SFY 2013-2014**	$244,841
ACCESS SERVICES	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
A. Transportation	$311,972	77.30%	$182,213	74.42%
B. Information & Assistance (**III-B** funding **Only**)	$51,000	12.64%	$55,036	22.48%
C. Case Management	$0	0.00%		0.00%
D. Outreach	$0	0.00%		0.00%
TOTAL ACCESS EXPENDITURES	$362,972	89.94%	$237,249	96.90%
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	$36,561	9%	$0	0%
B. Level II Homemaker with Limited Personal Care	$0	0%	$0	0%
C. Level III Personal Care with Limited Medical Assistance	$0	0%	$0	0%
TOTAL IN-HOME EXPENDITURES	$36,561	9%	$0	0%
LEGAL ASSISTANCE	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
LEGAL ASSISTANCE EXPENDITURES	$4,036	1.00%	$7,592	3.10%

	A	B	C	D	E	F	G	H	I	J	K	L	N	O
1		Waccamaw SUMMARY PROGRAM BUDGET-COMPUTATION OF GRANTS SFY14												Page 1
2		IN-HOME & COMMUNITY-BASED SERVICES											NUTRITION SERVICES	
3	**NOTE:** Match Ratio **if using III-E** is 88.24(F) to 11.76(L)	Transportation	Chore or House-keeping	Medical Transportation	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	Case Manage-ment	TOTAL Supportive Services	Congregate Meals	Home Delivered Meals
4	**CONTRACTED UNITS**	**224,165**	**1,928**	**0**	**0**	**0**	**0**	**35**	**3,804**	**0**	**0**	**N/A**	**42,399**	**135,346**
5	**Title III Federal B, C**	$182,213	$0	$0	$0	$0	$0	$7,592	$55,036	$0	$0	$244,841	$247,739	$462,489
6	**Title III Federal E**						$0		$0	$0		$0		
7	**State 5% Match B and C**	$10,718	$0	$0	$0	$0	$0	$447	$3,237	$0	$0	$14,402	$14,573	$27,205
8	**Local:Cash match**	$36,703	$0	$0	$0	$0	$0	$893	$6,475	$0	$0	$44,071	$29,146	$54,410
9	**Local:In-kind match**		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
10	**Total Local Match**	$21,437	$0	$0	$0	$0	$0	$893	$6,475	$0	$0	$28,805	$29,146	$54,410
11	**ACE-Bingo**		$40,290	$0	$0	$0	$0		$0	$0	$0	$40,290		$8,950
12	**State H&C-B Services (ACE-CS)**				$0	$0	$0		$0	$0	$0	$0	$0	
13	**Restricted State Revenue (if applicable)**				$0	$0	$0		$0	$0	$0	$0	$0	
14	**NSIP**											$0	$0	$170,355
15	**Cost Share/GRI -State Services**	$0	$0	$0	$0	$0	$0			$0	$0	$0	$0	$0
16	**GRI for Title III (Estimate)**	$4,186	$426	$0	$0	$0	$0			$0		$4,612	$4,024	$2,410
17	**Total Contracted Funds**	**$233,820**	**$40,716**	**$0**	**$0**	**$0**	**$0**	**$8,932**	**$64,748**	**$0**	**$0**	**$348,216**	**$295,482**	**$725,819**
18	**Contracted Rate**	**$1.0431**	**$21.1183**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**$255.19**	**$17.0211**	**#DIV/0!**	**#DIV/0!**	**N/A**	**$6.9691**	**$5.3627**
19	**NOTE: Contracted rate Includes Local Match**													
20	**COMPUTATION OF NET (AIM) UNIT COST AND UNITS PER FUNDING SOURCE**													
21	**Net Contracted (AIM) Rate**	$1.0431	$21.1183	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$255.19	$17.0211	#DIV/0!	#DIV/0!	NA	$6.9691	$5.3627
22	**AIM Units: ACE-BINGO**		1,908	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	#DIV/0!			1,669
23	**AIM Units:State H&CB Svs**	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	#DIV/0!			0
24	**AIM Units: Restricted State Revenue (if applicable)**		0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		0	#DIV/0!	#DIV/0!			0
25	**AIM Units: State Cost Share/GRI**	0	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!			0
26	**NSIP Share of Meal Unit Cost**												$0.0000	$1.2744
27	**AIM Title III Meal Rate**												$6.9691	$4.0883
28	**AIM Units: Title III GRI (Estimate)**	4,013	20	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!		577	589
29	**AIM Units:Title III (F+S+L)**	205,516	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	35	3,804	#DIV/0!	#DIV/0!		41,822	133,088
30	**TOTAL CONTRACT UNITS**	**209,529**	**1,928**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**35**	**3,804**	**#DIV/0!**	**#DIV/0!**	**N/A**	**42,399**	**135,346**
31	**NOTE: Contracted Units for All Services Include Units Projected for GRI and State Services Income**													
32	**Total of All Other Resources by Service**	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	NA	$0	$0
33	**Total of Units Served with those Other Resources**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	NA	**0**	**0**
34	**TOTAL SERVICE BUDGET**	$233,820	$40,716	$0	$0	$0	$0	$8,932	$64,748	$0	$0	N/A	$295,482	$725,819
35	**Total Unit Cost**	**$1.1159**	**$21.1183**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**$255.1837**	**$17.0212**	**#DIV/0!**	**#DIV/0!**	NA	**$6.9691**	**$5.3627**

	P	Q	R	S	T	U	V	W	X	Z	AA	AC
1	Waccamaw SUMMARY PROGRAM BUDGET-COMPUTATION OF GRANTS SFY14											Page 2
2		PREVENTION AND WELLNESS SERVICES								INSURANCE COUNSELING		TOTALS
3	CONTRACTED FUNDS	Health Screening	Nutrition Risk Follow-up	Health Promotion	Physical Fitness	Home Injury Prevention	Medication Management	Minor Home Repair (State Funds Only)	TOTAL Wellness	Medicare Fraud (SMP)	I-CARE SHIP and MIPPA	All Sources (Both Pages)
4	**CONTRACTED UNITS**	**0**	**0**	**14,899**	**0**	**0**	**3,857**	**0**	**N/A**	**500**	**2,796**	**N/A**
5	**Title III Federal D, SMP, I-CARE**	$0	$0	$21,507	$0	$0	$4,840	$0	$26,347	$8,277	$52,005	**$1,041,698**
6	**Title III Federal E**								$0			**$0**
7	**State 5% Match D**	$0	$0	$1,265	$0	$0	$285		$1,550			**$57,730**
8	**Local:Cash match**	$0	$0	$2,530	$0	$0	$569		$3,099	$2,759		**$133,485**
9	**Local:In-kind match**	$0	$0	$0	$0	$0	$0		$0	$0		**$0**
10	**Total Local Match**	$0	$0	$2,530	$0	$0	$569		$3,100	$2,759		**$118,220**
11	**ACE-Bingo**		$0			$0		$0	$0			**$49,240**
12	**State H&C-B Services (ACE-CS)**		$0			$0		$0	$0			**$0**
13	**Restricted State Revenue (if applicable)**		$0			$0		$0	$0			**$0**
14	**NSIP**								$0			**$170,355**
15	**Cost Share/GRI -State Services**	$0	$0	$0	$0	$0	$0	$0	$0			**$0**
16	**GRI for Title III (Estimate)**	$0	$0	$0	$0	$0	$0		$0			**$11,046**
17	**Total Contracted Funds**	**$0**	**$0**	**$25,302**	**$0**	**$0**	**$5,694**	**$0**	**$30,996**	**$11,036**	**$52,005**	**$1,463,554**
18	**Contracted Rate**	**#DIV/0!**	**#DIV/0!**	**$1.6982**	**#DIV/0!**	**#DIV/0!**	**$1.4762**	**#DIV/0!**	**N/A**	**$22.0720**	**$18.5998**	**N/A**
19	**NOTE: Contracted rate Includes Local Match**											
20	**COMPUTATION OF NET (AIM) UNIT COST AND UNITS PER FUNDING SOURCE**											
21	**Net Contracted (AIM) Rate**	#DIV/0!	#DIV/0!	$1.6982	#DIV/0!	#DIV/0!	$1.4762	#DIV/0!	NA	$22.0720	$18.5998	NA
22	**AIM Units: ACE-BINGO**		#DIV/0!			#DIV/0!		#DIV/0!				
23	**AIM Units:State H&CB Svs**		#DIV/0!			#DIV/0!		#DIV/0!				
24	**AIM Units: Restricted State Revenue (if applicable)**		#DIV/0!			#DIV/0!		#DIV/0!				
25	**AIM Units: State Cost Share/GRI**		#DIV/0!			#DIV/0!		#DIV/0!				
26	**NSIP Share of Meal Unit Cost**											
27	**AIM Title III Meal Rate**											
28	**AIM Units: Title III GRI (Estimate)**	#DIV/0!	#DIV/0!	0	#DIV/0!	#DIV/0!						
29	**AIM Units:Title III (F+S+L)**	#DIV/0!	#DIV/0!	14,899	#DIV/0!	#DIV/0!	3,857					
30	**TOTAL CONTRACT UNITS**	**#DIV/0!**	**#DIV/0!**	**14,899**	**#DIV/0!**	**#DIV/0!**	**3,857**	**#DIV/0!**	**N/A**	**500**	**2,796**	**N/A**
31		**NOTE: Contracted Units for All Services Include Units Projected for GRI and Fees**										
32	**Total of All Other Resources by Service**	$0	$0	$0	$0	$0	$0	$0	NA	$0	$0	NA
33	**Total of Units Served with those Other Resources**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	NA	**0**	**0**	NA
34	**TOTAL SERVICE BUDGET**	$0	$0	$25,302	$0	$0	$0	$30,996	NA	$11,036	$52,005	NA
35	**Total Unit Cost**	**#DIV/0!**	**#DIV/0!**	**$1.6982**	**#DIV/0!**	**#DIV/0!**	**$0.0000**	**#DIV/0!**	**NA**	**$22.0720**	**$18.5998**	**NA**

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	$233,820	224,165	$1.0431
Housekeeping or Chore	$40,716	1,928	$21.1183
Medical Transportation	$0	0	#DIV/0!
Personal Care with Limited Medical Assistance	$0	0	#DIV/0!
Home Living Support	$0	0	#DIV/0!
Legal Assistance	$8,932	35	$255.2000
Adult Day Care	$0	0	#DIV/0!
Respite Care	$0	0	#DIV/0!
Information, Referral & Assistance	$64,748	3,804	$17.0210
Care Management	$0	0	#DIV/0!
Group Dining	$295,482	42,399	$6.9691
Home Delivered Meals	$725,819	135,346	$5.3627
Health Screening	$0	0	#DIV/0!
Nutrition Risk Follow-Up	$0	0	#DIV/0!
Evidence Based Health Promotion Program	$25,302	14,899	$1.6982
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	$5,694	3,857	$1.4763
Outreach	$0	0	#DIV/0!
I-Care Calls/Contacts	$52,005	2,796	$18.5998
SMP Calls/Contacts	$11,036	500	$22.0720
Caregiver Services	$101,951	202	$504.7329

All entries must include both AAA delivered services and contracted services

NUMBER OF MINORITY PROVIDERS	0
NUMBER OF RURAL PROVIDERS	4
TOTAL NUMBER OF PROVIDERS	4

Client Demographics - Target Populations Served Shown as % of Total Persons Served

REGION: Waccamaw | **YTD Data From AIM** | **SFY2012-2013**

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 SFY13** (g)	Of Total Persons Served % Who Received Services **for the First Time** in SFY'12
Area Agency on Agin	83	42	50.60%	73	87.95%	25	30.12%	21	50.00%	4	9.76%	0	0.00%
Georgetown	620	430	69.35%	611	98.55%	422	68.06%	323	75.12%	99	52.11%	0	0.00%
Horry	1167	436	37.36%	1123	96.23%	787	67.44%	323	74.08%	464	63.47%	0	0.00%
Williamsburg	355	294	82.82%	276	77.75%	215	60.56%	172	58.50%	43	70.49%	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!
	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	2225	1202	54.02%	2083	93.62%	1449	65.12%	839	69.80%	610	59.63%	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 2012 poverty level established by the Bureau of the Census.

(e) Of those whose self reported income was below the 2012 poverty level cited above, this is the number who were minority

(f) Of those whose self reported income was below the 2012 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 2013 **or who had not received any contracted service since June 30, 2011**

SUPPLEMENTAL DETAIL - Breakout of the ethnicity of the Minority Population SERVED in SFY 2012-2013					
Service Delivery Contractors	**African-American**	**Hispanic**	**Native American or Alaskan Native**	**Asian/ Pacific Islander**	**Unknown Ethnicity**
Area Agency on Aging	39	0	2	1	0
Georgetown	430	0	0	0	0
Horry	430	0	4	2	0
Williamsburg	294	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Regionwide	1193	0	6	3	0

Waccamaw DESIGNATED AND UNDESIGNATED FOCAL POINTS IN THE PSA IN 2013-2014 **At a 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
Georgetown	Georgetown County Bureau of Aging Services	2104 Lincoln Street, Georgetown, SC 29440	Yes	Local Service Provider Office	Georgetown Housing Authority
Georgetown	Andrews Senior Center	102 E. Main Street, Andrews, SC 29510	Yes	Senior Center	Georgetown County
Georgetown	North Santee Senior Center	1484 Mt. Zion Church Road, Georgetown, SC 29440	Yes	Senior Center	Georgetown County
Georgetown	Plantersville Senior Center	1458 Exodus Drive, Georgetown, SC 29440	Yes	Senior Center	Tri Community Services Board
Georgetown	St. Luke Senior Center	245 Ritch Road, Georgetown, SC 29440	Yes	Senior Center	Georgetown County
Georgetown	Parkersville Community Center	83 Duncan Road, Pawleys Island, SC 29585	Yes	Community Center	Georgetown County
Horry	Horry County Council on Aging	2213 North Main Street, Conway, SC 29526	Yes	Local Service Provider Office	HCCOA
Horry	Aynor Senior Center	845 North Main Street, Aynor, SC 29511	Yes	Senior Center	HCCOA/Town of Aynor
Horry	Bucksport Senior Center	8879 Henrietta Bluffs Road, Bucksport, SC 29527	Yes	Senior Center	HCCOA
Horry	Burgess Senior Center	10299 Highway 707, Myrtle Beach, SC 29577	Yes	Senior Center	HCCOA leases building
Horry	Conway Senior Center	1519 Millpond Road, Conway, SC 29526	Yes	Senior Center	HCCOA/City of Conway
Horry	Grand Strand Senior Center	1268 21st Avenue, Myrtle Beach, SC 29577	Yes	Senior Center	HCCOA
Horry	Green Sea/Floyds Senior Center	5269 Highway 9, Nichols, SC 29581	Yes	Senior Center	HCCOA leases building
Horry	Loris Senior Center	4214 Railroad Avenue, Loris, SC 29569	Yes	Senior Center	HCCOA leases building
Horry	Mount Vernon Senior Center	3200 Highway 366, Loris, SC 29569	Yes	Senior Center	HCCOA leases building
Horry	North Strand Senior Center	2309 Watertower Road, Longs, SC 29668	Yes	Senior Center	HCCOA leases building
Horry	South Strand Senior Center	1032 10th Avenue North, Surfside Beach, SC 29575	Yes	Senior Center	HCCOA leases building
Williamsburg	Vital Aging of Williamsburg County, Inc.	912 Fourth Avenue, Kingstree, SC 29556	Yes	Local Service Provider Office/Senior	Vital Aging
Williamsburg	Hemingway Wellness Center	500 W. Broad Street, Kingstree, SC 29556	Yes	Senior Center	Williamsburg County Govn't
Williamsburg	Greeleyville Wellness Center	241 Gourdin Street, Greeleyville, SC 29056	Yes	Senior Center	Town of Greeleyville

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 undesignated focal points.