Central Midlands Area Agency on Aging/
Aging and Disability Resource Center

2014–2017 AREA PLAN

For the Central Midlands Region of South Carolina
Fairfield, Lexington, Newberry
& Richland Counties

This is draft until Public Hearing and Board approves June 27, 2013.

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I. Introduction

Purpose

The area plan is a multi-year plan which identifies and assigns priority to the needs of older persons. It also specifies how the needs will be met and services to be provided with Older Americans Act (OAA) and state funds. The plan establishes the manner in which the Area Agency on Aging /Aging and Disability Resource Center will develop a coordinated and comprehensive service delivery system. This plan is submitted to the state unit on aging which in South Carolina is the Lieutenant Governor's Office on Aging.

The original 1965 Older Americans Act had a vision of full restorative services in a comprehensive and coordinated system for older Americans. Older Americans are to be able to pursue meaningful dignity and the targeted cohorts are designated to be Hispanic, Native Americans, other minorities, people with Alzheimer's, rural residents and those without sufficient resources.

According to the Thomas (Library of Congress) Senate 105-036 Part 1 Developments in Aging 1996, "in 1973, the area agencies on aging were authorized. These agencies, along with the State Units on Aging (SUAs), provide the administrative structure for programs under the OAA. In addition to funding specific services, these entities act as advocates on behalf of older persons and help to develop a service system that will best meet older Americans' needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the OAA, and services supported by other Federal, State, and local programs." Congress has never authorized sufficient funds to meet all the requirements of the Older Americans Act. Older Americans Act monies are seed monies supplemented by state, local and private donations and private pay sources.

FUNCTIONS OF AN AREA AGENCY ON AGING (AAA)

THE OLDER AMERICANS ACT OF 1965 as AMENDED establishes area agencies on aging and describes the responsibilities and functions of area agencies on aging. Additionally, the South Carolina State Unit on Aging in its MANUAL OF POLICIES AND PROCEDURES establishes minimum functions of an area agency on aging:

PLANNING

- Assess kinds of and levels of services in the Planning and Service Area (PSA)
- Assess effectiveness of services in the PSA- Prioritize unmet needs
- Set measurable, attainable goals, objectives, and standards of performance for meeting priority needs in the initiation, expansion, improvement and coordination of services for older persons:
- Develop strategies to be used in accomplishing objectives
- Identify and analyze barriers which impede accomplishment of objectives
- Conduct on-going analyses to obtain feedback useful for revision and refinement of objectives
- Assign staff and financial resources to carry out planning responsibilities
- Establish procedures to receive information through public hearing, from
- Advisory Council Members, local officials, older persons, and public and private agencies

- Establish procedures for involvement of seniors participating in aging programs
- Plan and implement activities which advocate for older persons
- Develop method for distributing resources in the PSA

PROGRAM DEVELOPMENT

- Organize and implement activities to maintain and enhance existing programs
- Develop new programs as needed
- Establish methods to reduce, eliminate, or expand services

COORDINATION AND SERVICE DELIVERY

- Structure working relationship between agencies to achieve a full continuum of services
- Identify a full continuum of care for community, in-home and institutional services
- Develop an accessible service system
- Persons can go to one agency to seek assistance
- Services are geographically distributed
- Barriers are minimized
- Maximize independence
- Provide care and services in the least-restrictive setting
- Allow elderly consumer to participate in decisions
- Provide incentives for elderly to remain in communities

II. Executive Summary

The Central Midlands Aging & Disability Resource Center (ADRC) and Area Agency on Aging (AAA) serves four counties in the Midlands of South Carolina. The four counties served are: Fairfield, Lexington, Newberry and Richland counties.

At the 2010 decennial Census, the Central Midlands region had a population of 708,359; an increase of 112,106 persons in the decade since the 2000 Census. Of this total, 117,327 or 16.6%, were aged 60 or older.

The four counties within the Central Midlands AAA region can be divided into two separate and distinct areas. Richland and Lexington counties are predominantly urban in nature, containing, notably, the state capital, Columbia and the main campus of the University of South Carolina, as well as being two of the six most populous counties in the State. These two counties do, however, have very distinct rural areas such as Eastover, Pelion and Swansea. There are also suburban areas such as Irmo and Lexington.

Newberry and Fairfield counties display distinctly more rural characteristics, with much lower population totals, which tend to be concentrated in and around each county seat (Newberry and Winnsboro, respectively), with large portions of each county containing significant swathes of both farmland and National Forest.

The population of Lexington County increased by 21.5% between 2000 and 2010, from 216,014 to 262,391, making it the 6th fastest-growing county in the state. Much of the population growth in Lexington County is suburban in nature and is centered in and around the town of Lexington, which has seen significant residential and commercial construction activity over the past few years.

Richland County's population has increased by 19.9% in the period between the last two censuses, increasing from 320,677 to 384,504. Richland County has the second-largest population in the State of South Carolina and is home to many state government offices, higher educational establishments, large businesses and Fort Jackson, the largest US Army basic training facility on the eastern seaboard.

Newberry County's population has increased by 3.9% over the past decade from 36,108 in 2000 to 37,508 in 2010. Much of the growth in Newberry County has occurred in the southern portion of the county due, in part, to the attraction and affordability of lakefront properties on the north shore of Lake Murray.

Fairfield County had the smallest population growth of the four counties in the Central Midlands region over the past decade, increasing by just 502 persons from 23,454 in 2000 to 23,956 in 2010. Fairfield County is the most economically-distressed county in the region and is the only county in the region to have a current population that is lower than was reported a century ago (29,442 in 1910). Fairfield County has traditionally had the highest unemployment rate of any county in the region. In July 2012, Fairfield County had an unemployment rate of 12.2% (3.1 percentage points higher than in Richland County). In 2008, unemployment reached a reported 14.0% in Fairfield County.

The CMCOG AAA/ADRC does not expect to make improvements in monitoring fiscal responsibility and service delivery. It expects to maintain levels of these activities only due to sequestration cuts. The AAA/ADRC will attempt to monitor monthly as the state

policies and procedures indicate. Service delivery at the contractor level may remain stable if requested state funds are include in the state budget. Service delivery at the AAA/ADRC level is expected to decline or at best remain stable. Outcome measures are outlined in the plan in the service delivery section. The AAA/ADRC completes Annual Assessments each fall and Quality Assurance reviews in the spring. Site inspections of all sites are performed annually. Unannounced visits are scheduled as needed.

Fairfield County Council on Aging, serving Fairfield County since 1977, currently has one senior center that was built with Permanent Improvement Project (PIP) funds which were requested in 2000. The services provided by the agency include: care management, group dining meals, food coop, home-delivered meals, home care I and II, medical equipment loan program, arthritis exercise program and transportation. The agency expects to open a senior center in the Jenkinsville community in the near future.

Newberry County Council on Aging, serving Newberry County since 1977 has one senior center built with PIP funds in Newberry in 1994. The Derrick Senior Center in Little Mountain was built with PIP funds, opening in 2011. Whitmire Senior Center is located in a store front in Whitmire. The services offered are: adult day care, care management, group dining meals, home delivered meals, home care I and II, medical equipment loan, arthritis exercise program, and transportation.

Lexington County Recreation and Aging/Irmo-Chapin Recreation Commission, serving Lexington County since 1977 has four senior centers which were built with PIP funds-Bauer Center Batesburg-Leesville, Gilbert (gym), Pine Ridge and Swansea. Pelion has received expansion PIP funds as has Lexington and Seven Oaks Park in Irmo. Irmo-Chapin expects to complete its expansion of the Seven Oaks Park Center in this four year period. Chapin is located in Crooked Creek Park. Tri- City is located in Tri- City Leisure Center. The services provided are care management, group dining meals, home delivered meals, home care I, medical equipment loan, arthritis exercise program and transportation. Generators have been purchased for several senior centers with emergency PIP funds.

Senior Resources, Inc., serving Richland County since 1977 has five senior centers located in parks and recreation facilities including , Blythewood in Killian Park, Pacific Park, Bishop Ave, Eastover and Hopkins. Trenholm Road Methodist Church and Westminister Presbyterian are home delivered meals sites. The services offered are: care management, group dining meals, home delivered meals, home care I and II, medical equipment loan, arthritis exercise program and transportation.

The Area Agency on Aging /ADRC also contracts with Corporate Care, LLC for home care II in Lexington County, Traditions Elder Care, LLC for adult day care in Richland County and SC Legal for legal services in the region.

The AAA/ADRC is partnering during the four year period with Sexual Trauma Services of the Midlands, the 11th Solicitor's Office and the West Columbia Police Department to provide training on Elder Abuse to law enforcement and victims' services providers. The grant is made possible by the Office on Violence Against Women in the Department of Justice. In addition to the training the grant offers funds to set up a Collaborative Community Response Team and some victims' services.

During the four year period, the Area Agency on Aging/Aging and Disability Resource Center (AAA/ADRC) expects to collaborate with the Transportation Department of Central Midlands Council of Governments (CMCOG) to begin an Assisted Rides program in the region. The Lieutenant Governor's Office on Aging (LGOA) is seeking to implement a statewide Assisted Rides Volunteer Transportation Program and/or Voucher program. The goal is to improve transportation information and options to eligible seniors and people with disabilities in a section of the region who choose to remain in a community setting and need transportation to do so. Objectives include: development of a "choice" program whereby seniors and people with disabilities would be able to choose between the volunteer program or voucher options for transportation; identification of best practices utilized by nonprofit organizations, faith based organizations and ancillary entities that currently assist their consumer base with transportation needs and promotion of information sharing in the region.

The AAA/ADRC expects to initiate Medicaid Managed Care coordination through one or more Medicaid Managed Care Organizations during the four year period. Medicaid Managed Care is a delivery system model that improves access to care and care coordination by assuring that enrollees have access to a primary care provider and a network of providers.

The AAA/ADRC will begin to issue respite vouchers that have previously been distributed through the Alzheimer's Association. The vouchers will be distributed in a manner similar to the respite funds currently distributed through the Family Caregiver Support Program (FCSP). The South Carolina Association of Area Agencies on Aging (SC4A) has applied for a grant for Targeted Technical Assistance regarding implementing Medicaid Managed Care coordination.

The AAA/ADRC has offered assistance with Care Transitions, but has not yet been successful in reaching an agreement with the collaboration of Palmetto Health and Fairfield Hospital.

The AAA/ADRC through Annual Assessment visits in the fall and Quality Assurance reviews in the spring. The Annual Assessment briefly looks at several services if contractors are providing more than one service. The Quality Assurance reviews explore two or three services in more depth. Annual site inspections also occur. The AAA/ADRC plans to continue these activities in the four year period. Unannounced visits to contractors take place when complaints are received. ZMUSRs are submitted monthly to the AAA/ADRC and are monitored through desktop monitoring by the Grants and Contracts Manager. Required reports are submitted and reviewed by the same staff. The AAA/ADRC staff will attempt to deliver home delivered meals and visit senior centers as outlined in the State Policies and Procedures. The regional contractors have been allowed to submit reports electronically by providing a screenshot of the AIM information. This will reduce paper costs and allow for electronic storage of necessary information.

A procurement process for the three year period will occur in the summer of 2013 and contractors will be selected for the services chosen by the Regional Aging and Advisory Committee (RADAC). RADAC has chosen to allow the services to remain the same in the region; however, the LGOA has determined that the service of Home Care III will not be provided with Older Americans Act and state funds. The contracted services will include the core services of home delivered meals, group dining, home care, and

transportation as well as adult day care and legal assistance. With price increases and sequester cuts, the region anticipates serving fewer clients in this four year period. There will be a strong emphasis on serving the priority clients which includes older clients who are low income, minority or non-English speaking as well as those with Alzheimer's Disease and other dementias. The Family Caregiver Support program will continue to allow consumer choice as much as possible.

The AAA has strived to sustain the ADRC with no funding in the past fiscal year. The Information, Referral and Assistance Specialist handles calls from people with disabilities, most often referring them to Able SC (formerly Disability Action Center).

III. Overview of the AAA/ADRC

Mission Statement

The **Mission Statement** of the AAA/ADRC is to promote a positive experience of aging for older individuals, the disabled community and their families. The Central Midlands Council of Governments (CMCOG) is the regional lead agency for advocating, planning, coordinating and developing resources to help localities provide a comprehensive range of social and health related services within a statewide aging and disability network.

Vision Statement

The **Vision Statement** is to continue to function as a vital part of the continuum of care for seniors and people with disabilities in the region evolving as home and community based services increase and institutionalization decreases.

Organizational Structure

The Central Midlands AAA/ADRC is a part of the Central Midlands Council of Governments. The Central Midlands Regional Planning Council was created by state legislation in 1969. Area agencies on aging were required by the Older Americans Act. The South Carolina Commission on Aging designated the Council as the region's Area Agency on Aging in 1977. As an arm of the Council, the Central Midlands Development Corporation (CMDC) was established as a South Carolina corporation on May 17, 1982. CMDC, a non-profit, is organized for charitable purposes as delineated in community development, environmental conservation, elderly services, and transportation improvement. The name of the Central Midlands Regional Planning Council was changed to Central Midlands Council of Governments in 1996.

CMCOG provides a wide range of services. The major activities are the Area Agency on Aging, Transportation Planning, Workforce Development, and Community Planning, Research and Demographics. As shown in the CMCOG's organization chart (page 9a), the AAA is managed by a Director of the Area Agency on Aging, who reports to the Executive Director. The Regional Ombudsman directs the Ombudsman program. The AAA Director and the Regional Ombudsman Director are both members of the CMCOG's management team, and advise the Executive Director, the RADAC and the CMCOG Board of Directors on aging–related issues.

The AAA receives administrative, human resources, procurement and fiscal management services from the CMCOG. Because the AAA is part of a regional agency providing diverse services to four counties and many municipalities, the AAA's capabilities are

enhanced and extended. Other CMCOG departments are available to assist the AAA with planning and service issues. The Planning and Research Department is a source of help with demographics, graphic design and mapping. The Transportation Department provides federal funding to a number of area agencies providing services to seniors.

Staff Experience and Qualifications

The *Director of the Central Midlands Area Agency on Aging* has a Master of Public Administration degree with a concentration in Community Health from East Carolina University in Greenville, NC and a BA in Psychology from the University of North Carolina-Chapel Hill. She completed post graduate study in the Master of Teaching program at the University of South Carolina. She has approximately twenty five years of experience with twenty three years in the field of aging in North Carolina, South Carolina and Arizona which includes work in two area agencies on aging, Medicaid medical review of long term care facilities, a Robert Wood Johnson grant funded project to coordinate services for the elderly and Medicaid level of care and quality assurance. She is a Certified Information and Referral Specialist in Aging (CIRS-A) and completed the Boston University Geriatric Social Work Certificate in Aging in June of 2009. She has completed Dementia Dialogues training. She attended the National Center for Long Term Care Business and Strategy Planning Workshop at Scripps Gerontology Center at Miami of Ohio University. She is responsible for the operations of the area agency on aging. She has been a member of the Board of Directors of the Southeastern Association of Area Agencies on Aging (SE4A) and served on the Web site and Legislative Committees for that organization. She was Sponsorship and Exhibitor Chair of the past SE4A Conference Planning Committee. She was Conference Chair for the 2000 conference. She has served as President, Vice-President and Secretary of the South Carolina Association of Area Agencies on Aging (SC4A). The Family Caregiver Advocate and the Information, Referral/Assistance Specialist rotate as back-up for the Director of the Area Agency on Aging. She serves as back-up for the Information, Referral/Assistance (I,R/A) Specialist.

The *Aging Program Coordinator/Administrative Assistant II* has a diploma in Child Development from Orangeburg-Calhoun Technical College in Orangeburg and has seven years administrative experience at the CMCOG. She has past experience at Blue Cross/Blue Shield, Palmetto GBA and Babcock Center. She is I-CARE certified, CIRS-A certified and serves as back-up for the I, R/A Specialist. She serves as staff for the RADAC and Silver Haired Legislators. She will be entering data for the aging program in AIM, SHIPTALK and SC ACCESS (OLSA). She plans to complete the Boston University Geriatric Social Work Certificate in Aging in the summer of 2013.

The *Grants and Contracts Manager* has an Associate of Science in Accounting degree from NY City Community College, Certificate in Microcomputer Application and Software and Bachelor of Science degree in Business Administration from the University of South Carolina. She has been employed for eighteen years at CMCOG- three years as Accountant and fifteen as Manager of Contracts and Grants serving as Aging Fiscal Officer. Prior experience includes years with Haskins & Sells and Sterling Drugs, Inc., in New York, Cost Accounting-Southern Plastics and Contracts & Grants Specialist-University of South Carolina.

Regional Aging Advisory Council

The by-laws state:

- The membership shall consist of those individuals appointed by the Council for two-year terms. The term may be extended by mutual agreement upon completion of the term.
- At least fifty percent (50%) of membership shall be of age 60 years or older. The membership shall be representative of the disability community.

Formula for Membership:

- Representatives shall consist of one (1) member for each three thousand (3,000) persons age 60+within each county as identified by current census data.
- Minority elderly representation will equal the percentage of 60+ minority elderly in the
- CMCOG planning and service areas as indicated by the current census data.
- Vacancies on the Committee shall be filled by the Council upon recommendations by the Committee. All prospective members will be required to submit an application.

The duties are:

- Promote and encourage local communities to recognize the needs and promote the establishment of programs for older persons and disabled persons.
- Establish priorities, based upon the needs of the local communities and the region.
- Develop and revise, on a yearly basis, regional comprehensive Aging and Disability Program plans based upon the needs and established priorities.
- Make recommendations to the Council for approval or disapproval of applications from units of local governments, the Council, and/or local service provider agencies.
- RADAC members assist with quality assurance reviews and set priorities for the area plan. They assist in advocacy and volunteer work at the AAA/ADRC.
- Some RADAC members are eligible to be participants and express their views regarding matters of general policy development and administration of the area plan.

Current Funding Resources

There are no other resources other than Administration on Aging (AOA) or Centers for Medicare and Medicaid (CMS) funds or state funds which allow administrative funding for the AAA/ADRC. There is a small amount of reimbursement for training time allowed in the Department of Justice grant discussed in this plan. The contracts require as a condition that each funding source have a distinct client population. The internal controls for the CMCOG/AAA/ADRC are very strong with different individuals in control of check signing, verification, bank reconciliation and deposits. Managers/Directors approve all expenses.

Written Procedures

The AAA/ ADRC has a policy and procedure manual separate from the state policies and procedures which is distributed to all contractors and is a supplement to the state policies and procedures. The CMCOG Personnel Manual also outlines written procedures. The

contractors have policies and procedures submission of which is required in the focal point application. If contractors are not focal points, policies and procedures are reviewed during the annual assessments and quality assurance reviews.

Sign-in sheets

Sign-in sheets have been reviewed as a part of the annual assessments and quality assurance reviews. These will be sent to the AAA/ADRC in electronic form during the four year period. The contracts will note these requirements.

Activity Calendars

The senior center activity calendars are mailed to the AAA I-CARE Coordinator monthly. They are reviewed for quality and content. The calendars are reviewed during monitoring.

Service Units Earned

The Grants and Contracts Manager reviews the ZMUSRs and reports submitted to her to assure that they are earned units of service.

Reimbursement for Services

Unit costs are broken down into the following categories in the proposals: salaries, fringes, travel, printing, advertising, supplies, space, utilities volunteer recognition, professional fees, allocated costs, in-kind expenses, depreciation and costs less additional revenues and in-kind used are divided by estimated number of contracted units which produces a unit cost. Unit Cost includes the match where required. Unit costs are reviewed by the evaluation committee during procurement as a part of the contractor selection process. The units served are reviewed monthly when ZMUSRs and reports are submitted.

Client Data Collection

The data entry has been done by a receptionist/administrative specialist at the CMCOG. Due to budgetary constraints, these functions will be transferred to the Aging Program Coordinator/Administrative Specialist II who is CIRS-A certified. The Ombudsmen will continue to utilize an Administrative Specialist to input data. SHIPTALK data has been entered by the receptionist and/administrative specialist. Due to budgetary constraints, the Aging Program Coordinator/Administrative Specialist will enter into SHIPTALK.

Client Assessments

The assessment process will continue to be a part of the contracted unit of service. The AAA will begin to provide client selection, if funding for a contractual position is available. The contractor will submit each assessment to the AAA/ADRC's Client Selection Specialist who will determine the clients based on the AIM priority score. The Client Selection Specialist, who will be an MSW or RN, will be engaged on a contractual basis. Contractors assess the clients at least annually and reassess prior to the due date. This is monitored monthly through desktop monitoring and during annual assessments and quality assurance reviews. The AIM assessment priority score will define the clients most in need. All contractors have termination protocols in place. The termination protocols are reviewed during annual assessments and quality assurance reviews.

General Fiscal Issues

The Central Midlands Council of Governments AAA/ADRC will comply with the General Fiscal Issues of components as set forth by the South Carolina Aging Network's Policies and Procedures Manual:

- CMCOG AAA/ADRC will expend any prior year funds first before expending any new year funds.
- Planning and administration funds for Title IIIB, Title IIIC1, and Title IIIE of the Older Americans Act will be expended before any program development or OAA Title IIIE service funds are expended for AAA/ADRC activities.
- The Federal share of a grant award is earned only when the cost is incurred and the non-Federal share of the cost has been contributed.
- All invoices and all financial and program reports will be submitted in the format provided by the LGOA and on the schedules set by the LGOA. Invoices and financial reports will be submitted to the Accounting and Finance Division while program reports will be submitted to the appropriate program manager as specified by the LGOA.
- CMCOG AAA/ADRC will conduct competitive procurement in order to comply with Federal and State guidelines. Once the vendor selections have been made, CMCOG AAA/ADRC will submit to the LGOA a breakdown of the contractors' unit costs per service. This will be submitted annually. Contractors will be paid according to the agreed upon unit cost.
- With each invoice, the CMCOG AAA/ADRC will verify the units served and earned.
- Payment requests for both internal and flow-through expenditures will be submitted monthly in accordance with the policies set forth by the LGOA. The CMCOG AAA/ADRC will keep invoices current in the event of mid-year budget cuts or reductions.

General Provisions for the AAA/ADRC

The AAA/ADRC policies and procedures are updated to include any revisions in the state policies and procedures as well as the program instructions of the state unit on aging. The Geographic Information System staff of the COG provide mapping of clients in the region to show that the clients are targeted groups. See attached map in appendices.

The CMCOG has a staff member who is Spanish speaking and can provide the interpretation services for the CMCOG.

The Requests for Proposals indicate that the proposals must show how contractors will comply with the state policies and procedures. The contractor's contracts include verbiage to assure that contractors follow the state policies and procedures. The AAA/ADRC and contractors prioritize services to the targeted populations of low income, minority individuals and those living in rural areas. The AAA/ADRC and contractors adhere to federal, state laws, regulations and guidelines. The AAA/ADRC accepts the standards and programmatic requirements for all services authorized by the LGOA.

The AAA/ADRC provides a full-time Director of the Area Agency on Aging. The AAA/ADRC maintains a RADAC committee who meets every other month to advise the AAA on development of the plan as well as administration and operations of the plan. RADAC members are recommended by other members of the committee or staff. Final approval is issued by the CMCOG Board of Directors Chair.

The PSA and AAA/ADRC directors are strong advocates for aging issues. The CMCOG Board will have one board meeting annually that discusses aging issues; however, other issues may need to be discussed at the meeting due to timetables of other departments of the CMCOG. The LGOA and other appropriate representatives of the LGOA are always welcome to attend the meetings of the CMCOG Board of Directors as the meetings are open to the public. The PSA Director attends quarterly PSA Directors' meetings. The AAA/ADRC Director attends monthly meetings at the LGOA. The PSA Director will attempt to provide six hours of community service annually. The PSA Director will provide the LGOA with a list of board members as this is public information. The list is updated annually.

The AAA/ADRC will offer technical assistance and training as described in the Older Americans Act. Some training cannot be designed for current contractors that would allow them to have an unfair advantage in the procurement process. The regional training and education plan is included in the appendices. This is updated annually during the CMCOG's budget process.

The AAA/ADRC does not means test in client selection. Services are targeted to low income individuals. The AAA complies with the Civil Rights Act of 1964 and requires its contractors to do so. The AAA/ADRC does not impose residency as a requirement to receive services.

The RADAC determines the level of need for supportive services based on the needs assessment. The AAA takes into consideration the needs of the residents of rural areas by attending interdisciplinary meetings in those areas and the I, R/A Specialist and I-CARE Coordinator will be visiting the areas regularly.

In the regular quarterly meetings with contractors, the AAA/ADRC will use current client data from AIM to review and geocode client information, so it can be mapped and analyzed in the Geographic Information System. It would be possible to make adjustments if key service areas are missing.

There are not identifiable numbers of Native Americans in the service area. The AAA/ADRC coordinates with Able SC to assess needs of people with disabilities.

The AAA reviews assessments in annual assessments and during quality assurance review. Assessments will now be reviewed monthly during desktop monitoring to see that they are up to date.

The AAA directly provides for the services of ombudsman, information and referral, family caregiver support services and insurance counseling. The agency will not expend less than the 2000 fiscal year expenditures on the Ombudsman program.

The AAA/ADRC is requesting a waiver for the number of daily participants for the Winnsboro Senior Center and the Derrick Senior Center in Little Mountain as well as Whitmire Senior Center. The Blythewood Senior Center requests a waiver for number of

days served, so it can continue to serve clients four days a week. The Eastover and Hopkins Senior Centers need a waiver for number of participants. The AAA will be performing Client Selection, so will be assuring that the clients are those in the greatest social and economic need.

The AAA develops emergency preparedness plans and updates annually. The contractors have disaster plans as well. The AAA will meet with emergency management directors in the region.

The AAA/ADRC and all contractors will only maintain lists of clients for evaluation and provision of services purposes. Health Insurance Portability and Accountability Act information will be protected as applicable. The AAA will submit substantial changes in the Area Plan to the LGOA.

The AAA/ADRC will appoint a Training Liaison. The Liaison will have a strong understanding of programs and finances in the aging network. The Training Liaison will train new contractors. The AAA/ADRC e-mails contractors regularly and provides orientation annually.

The AAA/ADRC and contractors review sign-in sheets and route sheets as a part of the annual assessment and quality review process. The AAA/ADRC enters data into OLSA to record contacts. The SHIPTALK system is utilized to enter insurance counseling contacts. Funding for I, R/A is not used outside of the I, R/A program.

Fiscal controls are maintained at the AAA/ADRC. Funds used do not supplant other funds. Each funding has a distinct funding source, although changes occur because of attrition. The unit cost breakdowns are included elsewhere in this plan. The unit costs are outlined as a part of a response to a Request for Proposals. Once a cost is negotiated, the unit costs are set. Increases of an amount below the CPI are entertained in January for the following fiscal year. All invoices are submitted in the format requested. The AAA submits a budget each year to the LGOA. All of the prior fiscal year's funds are expended first before any of the new year's funds are expended. Planning and administration funds are expended before any funds for program development are expended for staff.

The AAA/ADRC maintains proper records with necessary supporting documents. The CMCOG has an audit each year which it submits to the LGOA in the first nine months of the year following the audited year.

Revenue received from voluntary contributions is used to expand the service from which it came. The voluntary contribution system is explained in writing and verbally to all clients.

The amounts expended in FY 2000 in rural areas have been maintained in the years following that date. The AAA/ADRC assures that the matching requirement is met by all contractors. The AAA/ADRC assures that amounts provided by the state for cost of living are only used for that purpose. The NSIP funds are only used for the purchase of meals. The AAA/ADRC does not use contract funds to carry out activities which are not associated with the funding.

The AAA/ADRC Director assures that contractors are earning the units through annual assessments, quality assurance reviews and desktop monitoring completed by the Grants

and Contracts Manager. The AAA/ADRC will assure that no one compensated by an AAA/ADRC will receive services counted as a unit.

Waivers are requested for Winnsboro Senior Center, Whitmire and Derrick Senior Centers in Little Mountain in the area of attendance at group dining. Little Mountain has recently opened and Winnsboro traditionally has had fewer group dining clients, but large numbers of home delivered meals recipients. In Richland County waivers are requested for Hopkins and Eastover. Blythewood will need a waiver to continue to serve seniors four days per week.

The senior center activity calendars will be forwarded to the I-CARE Coordinator who will review them and forward to the LGOA. The AAA/ADRC Director will attempt to deliver three home delivered meals from different routes monthly. The AAA/ADRC Director will attempt to visit three senior centers monthly.

Procurement will incorporate the state policies and procedures as well as state and federal procurement law. Grievance procedures are included in the Requests for Proposals (RFPs). Contractors will be encouraged to resolve all issues pertaining to procurement at the regional level. Legal ads will be purchased to advertise procurement. Targeting requirements will be included in the RFP. Consent requirements will be outlined in the RFPs. Legal representation will be sought for the RFP review committee. A pre-proposal conference will be held. The RFP will require the necessary technology. Due process is provided those seeking contracts with the agency. Electronic copies of contracts and amendments are forwarded to the LGOA. Debarment and suspension is checked prior to issuing contracts.

Senior centers are maintained for ten years following the utilization of Permanent Improvement funds. The I-CARE Coordinator will perform inspections of the senior centers annually to assure all applicable fire, safety, health and sanitation standards or licensing requirements are met. Multi-generational activities are encouraged. Coordination occurs with mental health agencies. The AAA/ADRC assures the integrity and public purpose of the services provided. The AAA/ADRC strives to assure that a loss or diminution of services does not occur. This will be difficult with the sequestration cuts.

Technical assistance is offered to minority contractors. Two new primarily minority senior centers have opened in the region. On-going contract management is one of the major functions of an AAA/ADRC. The AAA/ADRC collaborates with contractors to see that there is an emergency delivery plan for home delivered meals. A public hearing is offered for the public review of the area plan. The contractors adhere to the regional holiday schedule.

Outreach efforts will continue, but will not increase due to the loss of staff and funding. The Information, Referral and Assistance Specialist has committed to traveling to rural areas for outreach more often than in the past. This is contingent upon the availability of a state vehicle and time. The AAA/ADRC serves clients who walk-in to the office. The CMCOG is a short distance from a COMET bus stop. Contractors target outreach for the OAA and state programs to those populations listed as targeted. Non-English speaking clients can be served using the Spanish speaking employee of CMCOG or a language line for other languages. The current contractors attend the RADAC meetings where the area plan is discussed and often comment at the public hearing.

The AAA/ADRC coordinates with federal agencies. For instance the AAA/ADRC recently coordinated with the US Department of Health and Human Services Centers for Disease Control and Prevention during the National Health and Nutrition Examination Survey (NHANES).

The CMCOG has a visible point of contact at 236 Stoneridge Drive in Columbia, SC. The contractors use outreach methods to identify the targeted populations. The AAA/ADRC and contractors provide language assistance as described elsewhere in this plan. The AAA/ADRC identifies public and private resources. Services are increased through grants such as the recent one from Harbison Foundation. A fulltime I,R/A Specialist is employed.

The AAA/ADRC assures that it will adhere to the Older Americans Act requirements of proportion served and targeted populations. The AAA/ADRC shall maintain integrity and public purpose of services provided. Diminution of services will not occur due to commercial contracts or non-governmental relationships. No parts of the costs including administration costs used for commercial or nongovernmental relationships will be paid with funds under the titles.

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

One contractor may be in danger of becoming high risk and this is monitored by the AAA/ ADRC. All monitoring is not equal as those who may become high risk are monitored for risk signs. For example, a contractor who is at high risk may be required to show additional documentation to prove financial stability in the proposal.

IV. Overview of the Planning and Service Areas

Service Delivery Areas

The service delivery areas are Fairfield, Lexington, Newberry and Richland counties. See maps in appendices. See Executive Summary for description.

Objectives and Methods for Services in OAA Targeted Populations

According to the March-April 2011 issue of Aging Today '…Hispanic, Asian and black populations will all experience major growth by mid-century. Projections indicate Hispanic growth at 188%, Asian growth by 213% and black population growth by 71%. Around the same time non-Hispanic whites will cease to be the majority population in America.' Planning in the region will need to change as the minority groups change. In the next four years, the significant minority populations are expected to be Hispanic and black. Outreach through Hispanic Leadership Council and Alianza Latina as well as historically black places of worship will continue.

The populations of those 50 and above in the region will increase from 30.8% to 32.4% or to a total of 252,487 people in 2017.That includes 41.8% of the population in Fairfield County, 34.8% of the population in Lexington County, 29.5% in Richland County and 39.8% in Newberry County. Although the majority of services are designed for the over 60 population, long term care planning workshops will need to be geared for the 50 and over populations. The numbers in poverty in each county in 2011 included 21.9 % in Fairfield County, 14.8% in Lexington County, 18.5% in Richland County and 17.1% in Newberry County. Outreach to rural, poverty stricken areas of the region will continue. The Alzheimer's and other dementia respite vouchers flowing through the FCSP will increase contact with caregivers of those care recipients.

Ten-Year Forecast of the Planning and Service Area Region

According to "Demography is Not Destiny: The Challenges and Opportunities of Global Population Aging" in the Spring 2013 Generations ' Population projections suggest that by 2060 the proportion of people older than age 65 will almost equal the proportion younger than age 15 (18 percent versus 20 percent). And in the more developed regions of the world in 2060, there will be 156 people older than 65 for every 100 children younger than age 15'.

The four areas which are expected to have the most impact on the region during the next four years are: transportation, long term care systems, affordable housing and medical facilities. Transportation will continue to be an unmet need with the growing older population. The new Assisted Rides program will provide a small segment of the region with a volunteer transportation program and/or vouchers for transportation. There will be a need for more medical escort transportation as the boomers age. There is one of the current contractors who is able to offer this transportation with local funds.

Long term systems must change from an emphasis on institutionalization to home and community based services. Approximately 500 Medicaid beds have been discontinued in South Carolina and those who would have received care at this level must be served at another level of care. Additional home and community based state funded services would help in this area.

Medical homes for clients will be essential as Medicaid Managed Care is implemented in the region. Any assistance the AAA/ADRC can offer for care coordination will help older Medicaid clients live independently and with dignity. According to "International Approaches to Long-term Services and Supports" in Spring 2013 Generations, 'the U.S. Census Bureau estimated that worldwide, the number of people older than age 80-those most likely to need long-term services-will increase by 233 percent between 2008 and 2040 (Kinsella and He, 2009).' Medical homes accompanied by good care coordination can postpone the need for long-term care services and supports in an institution.

Affordable housing is still a problem in the region with the waiting time for subsidized housing predicted to be 3-5 years. Many more calls to the AAA/ADRC come from seniors in danger of eviction than seen in the past. The AAA/ADRC will continue to write letters of support to the developers seeking to build subsidized housing.

Emergency Preparedness

The CMCOG AAA/ADRC's purpose in an emergency or disaster situation is to ensure that the needs of the elderly in the region are adequately met. This AAA/ADRC plans to do this by resuming operations within the CMCOG as quickly as possible following a disaster and facilitating the activities among the local contractors, the local emergency management network and the aging network.

To the degree possible during the time of a disaster, it is the responsibility of the CMCOG AAA/ADRC and the contractors in Fairfield, Lexington, Newberry and Richland counties to provide for the protection of life and property, to maintain routine services and to try to restore to normality the lives of older adults. During and immediately after an emergency, staff will find the demands made upon their time by clients, other professionals, community agencies, and volunteers overwhelming. Emergencies and critical needs will be commonplace; yet the resources needed to solve problems will be disrupted, inoperable, or destroyed. Staff will find themselves expected to resolve situations and care for clients' needs. At the same time, the number and availability of staff for the agency may be reduced and the energy level of remaining staff greatly diminished by demands of family and household. For these reasons, planning for agency response is critical in disaster preparedness.

This plan is intended to improve the readiness and response capability of the CMCOG AAA/ADRC in emergency and disaster situations. The role of an area agency is (1) to ensure the capability of the agency to continue or to resume operations as quickly as possible following a disaster, and (2) to facilitate the coordination of activities between the local aging contractors, the local emergency management network, and the aging network.

During a disaster, CMCOG AAA/ADRC and local contract agencies will work together to coordinate and to assist in service delivery. Depending on the scope of the disaster, the CMCOG AAA/ADRC may be required to become a direct contractor as it assists service contractors to locate at-risk clients, and help to arrange or deliver services. The CMCOG AAA/ADRC will work closely with existing, authorized and experienced local service contractors and county authorities within the regional aging network. If due to the disaster a local contractor becomes disabled, the CMCOG AAA/ADRC will assist with service provision until operations can be stabilized. These Standard Operating Procedures

for Emergencies and Disasters apply to the paid and volunteer personnel of the CMCOG AAA/ADRC.

The AAA/ADRC plans to hold training with the senior center site managers and any other interested personnel of the contractors to discuss disaster preparedness during hurricane season. Staff will have members of the Emergency Preparedness offices in the region come to discuss preparedness plans with the group. Staff will also participate in the annual Great Southeast Shakeout along with instructing site managers to participate in this worldwide drill. Staff will assist the LGOA with any assistance that may be needed in planning for a disaster response. Staff plan on delivering the Family Emergency Preparedness Handbook and other preparedness guides such as tornadoes, thunderstorms and lightning safety checklists to contractors and other senior groups in the region.

Staff continue to maintain copies of emergency procedures from current contractors that cover such topics as winter storms, fires, tornados and hurricanes. As new contractors are awarded contracts, staff will request copies of their emergency procedures when contracts are dispersed.

The Catawba AAA/ADRC and CMCOG/ADRC have an agreement to help each other in an emergency. Staff will be in contact with agencies such as the Emergency Preparedness Offices in each of the counties, Red Cross Chapters in each of the counties for assistance with shelters and other disaster services, the Salvation Army for disaster services, regional hospitals that handle special needs people in times of disaster, Department of Social Services in each county, and the SC Hispanic Outreach to assist in interpretation for Hispanic seniors, if needed. Staff, also, have contacts with other agencies such as Clemson University Cooperative Extension Offices in each county, SC Animal Care and Control to help with animal care. Staff will be dispersing a fact sheet on pet care emergency preparedness. The fact sheet includes such information as emergency supplies, developing a buddy system, talking to the vet about emergency planning and notifying others if a pet is in the evacuated home or not. In plans staff have information on contacting other sources for information and assistance such as the National Guard, Department of Transportation-traffic information-road closures, SC Insurance News Service, AIRS, and weather information-NOAA.

Staff have some information for people with disabilities and special needs. This information includes creating a personal support network, creating a plan to shelter in place due to certain types of emergencies, creating a plan to get away, creating a plan for service pets, creating two emergency kits –one for sheltering in place and one if evacuating, and creating a family emergency plan.

For other airborne illnesses, such as the pandemic flu this agency will work with DHEC, local health departments, and the LGOA to help cover any needs that staff or contractors can meet to help in resolving problems that will arise from a pandemic flu. Staff are working with senior groups to get information out on the need to prepare for the pandemic flu by getting emergency kits together. Staff have information sheets and posters that staff will disperse on what to include in these two week kits. Staff have included in these information sheets, information about local radio stations that broadcast EAS messages, a recipe for a rehydration electrolyte drink for adults and teens, and a list of precautions to avoid getting the flu and spreading the flu.

The Long Term Care Ombudsman staff will ask facilities about their Emergency Preparedness plans during on-site visits and consultations. Facilities will be encouraged to coordinate their plans with other facilities, making sure they do not over burden one facility in case of emergency. Staff will be reminded to consider the special needs of all residents specifically oxygen and ambulatory status in facility with stairs.

In addition to the Emergency Preparedness plan noted by this AAA/ADRC, the CMCOG Ombudsman staff will review facility Emergency Preparedness plans during Routine Visits and/or call facilities monthly for a copy of their plan for review and review annually. These plans will be reviewed, making sure the continuity of care is addressed, transportation, food, medications, emergency services, coordination with the disaster relief service for their respective region/county was conducted, documentation related to resident care related concerns are maintained for emergencies and updated contact numbers are noted. Ombudsman staff will request a copy of the facility's plans and discuss areas that may need to be addressed with the facility and DHEC. Ombudsman staff will maintain communication with the facilities experiencing a disaster and with the LGOA via cell phone, maintain updates through the internet from the office and will assist in making contact with services needed as deemed necessary. Facilities will be encouraged to maintain the listings for emergency numbers for food banks, American Red Cross, Salvation Army, United Way, local shelters, transportation and the facility they partner with in case of a disaster.

V. AAA/ADRC Operational Functions and Needs

Assessment of Regional Needs

The needs assessment was conducted by System Wide Solutions and completed in October of 2012. A copy of the CMCOG portion of the needs assessment is included in the appendices. The major findings included: I,R/A is viewed as the service most important to helping seniors and people with disabilities stay where they are, followed by senior center activities, I-CARE services to help maintain independence, caregiver services and personal and home care services. The most important services to caregivers are respite services, followed by monetary assistance in obtaining services. Within senior center activities, the seniors saw exercise, counseling and having a senior center nearby as most valuable. Services to maintain independence came in fifth, with the most important service being the Ombudsman. Monetary assistance for dentures, eyeglasses, although less important, was listed.

A total of 584 surveys were completed in the CMCOG region. 72.4% of the respondents were already receiving a service. The survey respondents were older than the population in general and the most respondents came from Richland and Lexington counties. The largest group of respondents were white females. More than half of the respondents completed less than high school.36.4% of the respondents were below the poverty line. See Appendix B for a copy of the needs assessment.

Program Development

The CMCOG receives few dedicated funds for program development. The program development funds received during the fiscal year 2013-2014 will be used to develop the Client Selection program.

The CMCOG region will attempt to maintain as much choice as possible in its Family Caregiver Support Program. Due to the additional staff responsibility of respite vouchers for Alzheimer's and other dementia clients, the program may not be able to utilize as much consumer choice as has been possible in the past. The Information, Referral and Assistance program attempts to empower the client to make his/her own decision with the information provided. The I-CARE program also gives the top three choices for prescription drug programs for clients and allows the consumer to choose. There are several contractors in the region who offer private pay programs. For instance, Senior Resources, Inc., Newberry Council on Aging and Lexington County Recreation and Aging offer private pay programs.

Program Coordination

CMCOG AAA/ADRC will continue to provide contract orientation for the contractors within 30 days of a new contract period. The AAA/ADRC will attempt to have quarterly meetings with contractors as outlined in the new state policies and procedures. The meetings will be held before the RADAC meetings to facilitate attendance at those meetings. The AAA/ADRC will continue to coordinate with Sexual Trauma of the Midlands to present training on Elder Abuse for law enforcement and Victim services' providers.

AAA/ADRC and Long Term Care

The AAA/ADRC is attempting to maintain Information and Referral services to those with disabilities in an effort to maintain the ADRC without funding. The staff of the AAA/ADRC benefited from the additional training allowed by the ADRC funding. Marketing was initiated and technology was purchased. The services will be maintained through Information and Referral unless additional funding is obtained.

Advocacy

The AAA/ADRC has adopted the priorities of the National Association of Area Agencies on Aging (N4A) for the next year. The priorities are: Reauthorization of the Older Americans Act (OAA), stopping sequestration of vital human needs programs, hold harmless OAA programs in FY 2014 with at least 5.26 percent increase above FY 2012 in order to keep pace with projected population growth and price increases, move State Health Insurance programs (SHIP) from Centers for Medicare and Medicaid (CMS) to Administration for Community Living (ACL) and provide $ 52 million in FY 2014, to fund Chronic disease self-management and falls prevention programs through the Prevention and Public Health Fund. N4A says 'Deficit reduction must not be used as an excuse to undermine the very programs that keep our nation's older adults from falling into poverty, suffering ill health or otherwise struggling to live independently and with dignity." The AAA/ ADRC will continue to advocate through and with N4A at the national level and will advocate with the RADAC and Silver Haired legislators at the state level. The SC4A has met to do Strategic Planning in this fiscal year and intends to continue to meet annually for this purpose.

Priority Services

The RADAC met in November of 2012 to determine the services the region would procure. After much discussion the committee decided to keep the same services as previously procured (Home delivered meals, Group dining, Home Care I, I and II, Transportation, Adult Day Care, Legal Services and Disease Prevention and Health Promotion); however, the LGOA has determined that the region will not procure Home Care III in the next procurement cycle.

Priority Service Contractors

All contractors including legal services contractors are required to submit in their proposals: 1) a certificate on non-collusion; organizational capability and experience information; 3) service delivery plans; 4) explanation of how unit costs are calculated; 5) cost proposals; 6) agency charter; 7) certificate of incorporation; 8) non-profit letter if applicable; 9) letter from Secretary of State; 10) constitution; 11) By-laws; 12) list of Board of Directors/Commissioners; 13) mission statement; 14) board member agreement; 15) list of collaborative partners; 16) organizational charts; and 17) job descriptions and resumes. Information such as volunteer handbooks, cost sharing information, client/agency agreements and client grievance procedures are also included. Proof of liability insurance and an audit or recent financial statements are submitted.

Transportation

Transportation is a critical access need in the region. The funding available currently in the region can only meet the basic needs of those who are transported to group dining

sites for a meal with Older Americans Act and state funding. The need for additional transportation to medical appointments and for essentials such as grocery shopping is of top priority. Transportation questions were included in the 2012 Needs Assessment and transportation continues to be the most requested service, according to information and referral calls received. Transportation units are monitored during desktop monitoring when ZMUSRs are received each month. A sample of units is observed by the Grants and Contracts Manager. Transportation units are monitored in annual assessment and quality assurance reviews and original documentation is observed at these times.

Nutrition Services

Nutrition services are reviewed during annual assessment and quality assurance reviews. In the past four year period, the requirement for having twenty five participants daily allowed for the total amount to include both group dining and home delivered meals. In the new four year period, this requirement will change according to the new state policies and procedures. The staff will check numbers of clients during desktop monitoring, visits to the senior centers (some of which are unannounced) and during annual assessments and quality assurance reviews. The AAA/ADRC receives activity calendars from the senior centers and the I-CARE Coordinator reviews them monthly. They are also reviewed during monitoring and reviews. Each contractor's service delivery plan refers to the targeted populations.

Each client is prioritized and placed on the waiting list based on the priority score. With client selection at the AAA/ADRC level (should funding allow), the AAA/ADRC will be able to choose the targeted populations for services. Clients will be prioritized according to the AIM prioritization score.

Requests for Proposals require that contractors provide cost sharing programs except when other federal programs prohibit it. Contractors are required to ask recipients of state services to cost share.

The cost sharing policy in the AAA Policies and Procedures states "the level for participation by the consumer is based upon the individual's willingness and ability to share in the cost and the agency's total cost of the service. A contribution occurs when the recipient of a service is provided the opportunity to make a donation toward the cost of the service on a voluntary basis. A fee is when the recipient of a service is expected to pay all or part of the cost of the service as a condition for receiving the service. Contributions are the required method for Title III services. Fees are the required method for services provided using state funding."

The menus are posted at each senior center and these are reviewed during annual assessments, quality assurance reviews and site inspections. The contractors contact the AAA/ADRC to make menu change requests.

Since the contractors in the region have negotiated their own contracts with caterers, there has been little opportunity to arrange services with schools or hospitals. A pilot program with a restaurant in Blythewood was tried, but was not successful due to a lack of transportation for the interested participants.

Training and Technical Assistance

The AAA/ADRC requires that each staff person have twenty-four hours of training annually to be an employee of the AAA/ADRC. To maintain a Certification in Information, Referral Systems in Aging (CIRS –A) ten hours of training related to information, referral and assistance must be attended every two years. Licensed social workers attend training to maintain their licenses. Other accreditation groups require training and staff maintain these hours.

Orientation is held for all contractors during the first 30 days of a new contract. There has been no one area of training needed in quality assurance reviews. Most recently contractor staff have been encouraged to seek training regarding the Omnibus Adult Protection Act and harassment issues. Technical Assistance is provided through on-site visits and in written communication. The AAA/ADRC will provide technical assistance to other agencies offering services to seniors as time allows. Orientation is offered to new Regional Aging and Disability Advisory Committee members each year.

The most recent needs assessment still shows the need for long term care planning training in the region. Staff have met with members of the congregation of Washington Street United Methodist Church to discuss ways the faith based organization may be able to do some training in this area.

The training plan is included in the appendices. The training plan will be contingent upon funding.

Monitoring

The contract is reviewed at the time of annual assessment to assure that contractors are following the contract which is based on the proposals. The contracts state that the contractors must allow for representatives of the LGOA, US Department of Health and Human Services, Government Accountability Office, etc. to audit the agencies at any time. The AAA/ADRC has signed conditions from the LGOA which states it will allow the same representatives to observe its records at any time.

Contract Management

If contractors are performing satisfactorily with few discrepancies at the time of annual assessment and quality assurance reviews, contractors are notified in writing of the intent to extend the contract on or prior to 90 days before the end of the contract. A maximum of three contract extensions will be allowed in this area plan period. Copies of contracts and amendments are always provided to the LGOA within 30 days of issuance. In this area plan period, contracts will be provided electronically. Annual assessments and quality assurance reviews are the methods for assuring that services are delivered as required. At the time monthly ZMUSRs are submitted, reports are reviewed to assure that requirements are met. The CMCOG follows the CMCOG board approved procurement plan when obtaining services. The activity calendars are reviewed monthly by the I-CARE Coordinator and during site inspections, annual assessment, quality assurance reviews and unannounced visits.

Grievance Procedures

Any older individual who feels he/she has been discriminated against for any of the reasons listed below in the "Grievable Concerns" section has a grievable concern. A

written complaint should be filed with the director of the contractor agency at the appropriate address within thirty (30) days of the alleged discrimination. Contractors for Fairfield, Lexington, Newberry and Richland counties are as follows, respectively:

Corporate Care, LLC
Attention: Carolyn Cooley
5111 North Main Street
Columbia, SC 29203

Fairfield County Council on Aging
Attention: Angela Connor
210 East Washington Street
Winnsboro, SC 29180

Lexington County Recreation and Aging Commission
Attention: Lynda Christison
125 Parker Street
Lexington, SC 29072

Newberry County Council on Aging
Attention: Lynn Stockman
1300 Hunt Street
Newberry, SC 29108

Senior Resources, Inc.
Attention: Pamela Dukes
2817 Millwood Avenue
Columbia, SC 29205

South Carolina Legal Services
Attention: Andrea Loney
2109 Bull Street
Columbia, SC 29201

Traditions Elder Day Care, LLC
Attention: Frank Wiley
1500 Woodrow St
Columbia, SC 29205

The individual who receives the complaint will see that a prompt and complete investigation is conducted. If the investigation indicates a failure to comply with these assurances, the complainant will be notified and the matter will be resolved by the appropriate means. If the investigation indicates that the complaint is unjustified, the complainant will be notified immediately.

All grievable concerns (written or verbal) filed by an individual to a contractor shall be documented and maintained in a central (confidential) file for no less than three (3) years.

Documentation shall include all identifying information on the complainant and the older person who is the subject of the complaint; dates of the incident (s), complaint, and subsequent contacts; and, a narrative summary of the complaint and its resolution.

Complainants who voice or otherwise indicate any dissatisfaction with the disposition of their complaints shall be referred immediately to the Central Midlands Aging and Disability Resource Center.

Upon receipt of a grievable concern, the Central Midlands Aging and Disability Resource Center will schedule the review of the complaint with the Advisory Committee Grievance Sub-Committee. The Aging and Disability Resource Center will assure that the Committee is duly notified of the receipt of a complaint, and the date, time and place of the review. The Aging and Disability Resource Center will assure that the complaint review is accomplished within forty-five (45) days of receipt of the complaint.

Grievable Concerns

Reasons for a grievable concern include:

- Residency or citizenship imposed as a condition for the provision of service.
- By reason of handicap, be excluded from participation in, be denied benefits of, or be discriminated under any program or activity.
- On the basis of race, color, or national origin be excluded from participation in, be denied benefits of, or be discriminated under any program or activity.
- A means test shall not be used to deny or limit an older person's receipt of service.
- Payment of fees for service (beyond a free and voluntary opportunity to contribute to the cost of the service) shall not be used as a condition to deny or limit an older person's receipt of service.

Aging and Disability Resource Center Responsibilities

- The following lists specific tasks of the Aging and Disability Resource Center:
- Acceptance of the complaint as a grievable concern as interpreted by the Advisory Committee Grievance Sub-Committee) will be acknowledged in writing within three (3) working days of receipt of the complaint (see "Comp. 1" form in Appendices).
- Immediate contact will be made with the contractor named in the complaint requesting a written summary of the agency's involvement with the older individual who is subject of the complaint. This summary is to be provided to the Aging and Disability Resource Center within three (3) working days of the request.
- The Aging and Disability Resource Center may make the follow-up or investigative contacts with the complainant or subject of the complaint, provider staff persons, and additional persons as deemed appropriate.
- The Aging and Disability Resource Center will schedule the complaint review, advising complainant(s), subject(s), and contractors. Reviews will be scheduled within forty-five (45) days of receipt of the complaint.
- The Aging and Disability Resource Center will advise its liaison in the state unit of aging of the complaint. When the complaint is resolved to the satisfaction of the complainant or subject, the Aging and Disability Resource Center will advise the state. If the complainant and/or the subject of the complaint are/is not satisfied with the resolution, a referral to the liaison will be made in the state unit on aging

and the contractor will cooperate fully with the state unit on aging and follow through with recommendations made.

Advisory Committee Role

All complaints received by the Central Midlands Aging and Disability Resource Center will be reviewed by the Regional Aging and Disability Advisory Committee (RADAC). Investigations at the Aging and Disability Resource Center level that do not favor the complainant may be further heard and investigated by the RADAC. Notification to the complainant of the result of investigations at the Aging and Disability Resource Center level will be given within 45 days of receipt of the complaint. Any decision may be appealed to the next level, and ultimately to the state unit on aging. All other individuals or their representatives will be told of and given a written copy of the grievance procedure at the time of application for service.

Description of the Complaint Review

The Advisory Committee Grievance Sub-Committee shall meet. Prior to any disbursement of written or verbal identifying information regarding the complaint, the Aging and Disability Resource Center shall stress the requirement that all such information must be protected with confidentiality. Further, the committee members will be cautioned to identify any possible conflicts of interest they may have in regards to the complainant or the subject of the complaint. In the presence of any such conflict of interest, the committee member shall disqualify her/himself and not participate in that particular complaint review.

The Central Midlands Aging and Disability Resource Center will present the complaint to the Grievance Sub-Committee in ten (10) minutes or less.

The complainant and/or the subject will (each) be allowed up to the ten (10) minutes to present information to the committee.

The contractor will be allowed up to ten (10) minutes with which to present information to the committee. The committee may ask questions of anyone (beyond the ten minute time limit).

Performance Outcome Measures

All contractors set performance outcome measures at the beginning of each contract period and update as needed each year. The reports of outcome measures are due in January and July of each fiscal year. Each internal service in the AAA/ADRC sets its outcome measures in the area plan and then reports in the area plan update.

Resource Development

AAA/ADRC staff ask about Grant Related income during annual assessment and contractors report on the income and numbers of units served. All internal direct services staff set their performance outcome measures in the area plan and modify in area plan updates. Grants are applied for and occasionally obtained such as the Harbison Foundation funds recently received by the FCSP.

Cost-sharing and Voluntary Contributions

Each Central Midlands regional contractual agency is required to meet the contribution requirements.

Definition – A voluntary contribution is a gift or a donation, freely given, without persuasion, coercion, or legal obligation.

Each Contract agency must:

- Provide each older person with an opportunity to voluntarily contribute to the cost of the service;
- Protect the privacy of each older person with respect to his or her contribution;
- Establish appropriate procedures to safeguard and account for all contributions;
- Develop a suggested contribution schedule for services provided under the Older Americans Act program. In developing a contribution schedule, the contract agency must consider the income ranges of older persons in the community and other sources of income. The contract agency's Board of Directors must approve such schedules and changes.
- Central Midlands' regional contractual agencies shall not deny any older person a service funded under the Older American Act because the older person will not or cannot contribute to the cost of the service.
- Contract agencies shall not bill, request, demand or solicit fees for Title III services from a client, family member, relative or organization.
- Contributions made by older persons who are recipients of services are considered program income and must be reported to the Central Midlands Council of Governments AAA/ADRC. Contributions must be spent during the budget year in which they are generated. Contributions must be spent in the Title III Service area in which they are generated.

FEES FOR NON-TITLE III SUPPORTED SERVICES

Definition – Fees or payments for service are legal obligations and are required in order to receive the service.

When non-Title III funds are used to support a service in whole or in part, the Central Midlands' region contractual agencies may require a fee in order to provide a service. Such fees should be established by the contract agency, approved by the contract agency's Governing Board, provided in writing and explained in advance or receipt of service to the client. The fees for such private pay clients may be paid by the client or subsidized in whole or in part by local sources; e.g., civic or religious organizations, United Way.

Fees should be identified and tracked by client.

Private pay fees must be based upon the full cost of the service as determined by the provider, as no part of the cost may be supported by Title III.

Each Central Midlands regional contractual agency who offers private pay services shall have established a written methodology for determining priority for services under Title III as opposed to unsubsidized service. This methodology may not include a means test.

Confidentiality and Privacy

Contract agencies funded by the Central Midlands Council of Governments AAA/ADRC must have procedures to ensure that no information about an older person, or obtained from an older person is disclosed in any form that identifies the person without the informed written consent of the person or his/her legal representative, unless the disclosure is required by court order, 45 CFR 92.42 or for other program monitoring by authorized federal, state, area agency on aging, or local monitoring agency.
The Central Midlands Council of Governments AAA/ADRC requires contract agencies to ensure that lists of older persons compiled under information and referral services are used solely for the purpose of providing services, and only with the informed consent of each individual on the list.

The Aging and Disability Resource Center will obtain written assurances from the contract agencies that they will comply with the confidentiality requirements of this section.

VI. AAA/ADRC Direct Service Functions

Staff Experience and Qualifications

The *Family Caregiver Advocate* (FCA) holds a Bachelor of Social Sciences degree with a major in Public Policy with concentration in Health Care Management from Penn State and a Master of Social Work degree and a Master of Public Health degree from USC, as well as a certificate in Gerontology from USC. He has approximately 27 years of experience with 18 years working with seniors and other vulnerable populations. He worked for the SC Department of Health and Environmental Control (DHEC) conducting inspections and investigations in health care facilities (e.g. hospitals, nursing homes, renal dialysis, residential care and others) in the state of South Carolina. Since 2001, the FCA has been working in an area agency assisting caregivers and seniors raising children by locating services, providing counseling, training, and facilitating support groups, and administering reimbursement to eligible recipients. He has also provided addictions treatment to all populations for about seven to eight years. He is a Certified Addictions Counselor II (CAC II). The FCA has served on the South Carolina Gerontological Society Board for five years to include positions as Vice President and President. He has taught social work courses, (e.g. Gerontology, Community Analysis, Social Policy and an introductory course) at Limestone College from 2004-2007. He teaches Policy in the USC School of Social Work. He also completed the Dementia Dialogues training.

The *I-CARE Coordinator* holds an Associate of Applied Science degree in Human Services and an Associate of Arts degree in Paralegal Services from Midlands Technical College and has twelve years of administrative experience and four years of professional experience at CMCOG. She is a Certified I-CARE Worker, CIRS-A and was DTV Coordinator for the National Telecommunications and Information Administration grant. She received training in Advance Directives and is Advanced Directives Coordinator. She has been provided with the essentials for training potential volunteers to become Ombudsmen Witnesses. Although her major responsibility is I-CARE, she is also the Emergency Preparedness Coordinator and is responsible for the site inspections, nutrition and activities at the senior centers. She plans to complete the Boston University Geriatric Social Work Certificate in Aging in the summer of 2013.

The *Information, Referral & Assistance Specialist* has a Bachelor of Science degree in Psychology from Georgia Southern College and SC State College & University. She has worked for over 20 years with assisting people dealing with mental illness and/or substance abuse, victims of domestic violence and with the aging population. She has held the positions of RSVP Director, Senior Center Manager, SCSEP Manager and Intake/Gateway Specialist (CIRS-A) while working for The Legacy Link Area Agency on Aging/ADRC in Gainesville, GA. Carol returned to SC and began working as Information, Referral/Assistance Specialist with CMCOG AAA/ADRC in August 2012.

The Regional Long-Term Care Ombudsman Director has long-term care experience, to include working in nursing homes. She has been the Regional Long-Term Care Ombudsman since 1994. She is also a Licensed Baccalaureate Social Worker and earned her BA in Sociology from the University of South Carolina. She and her staff have written educational guides and handbooks on long-term care which have been used in community trainings, physician's offices and hospice agencies. The handbooks are titled, *Choosing Long-Term Care Placement* and *Empowering Residents and Families in Long-*

Term Care Facilities (which is also a Resident and Family Council Guide). She assists in developing materials for the Friendly Visitor Program. She trains volunteers and the community on long-term care issues, abuse, neglect and exploitation. She manages the ombudsman staff, advocates for residents, investigates complaints and writes findings.

The Senior Long-Term Care Ombudsman Investigator has been an Ombudsman since 1998. She is also a Licensed Baccalaureate Social Worker and earned her BA in Social Work from Benedict College. She is also a CIRS-A and has also completed the Dementia Dialogues training. She conducts community and facility trainings.

She also conducts trainings on Advance Directives and participated in a social work symposium training for social workers on long-term care issues. She assists with training volunteers and also developed Resident Rights training materials. She advocates for residents, investigates complaints and writes findings.

The Long-Term Care Ombudsman Investigator has been an Ombudsman since 2003 and was certified in 2004. She earned her BS Degree in Business Administration from Paine College. She also coordinates the Friendly Visitor Program. She recruits, trains and assist in the certification process of volunteers. She has developed materials in effort to promote the Friendly Visitor Program. She advocates for residents, investigates complaints and writes findings.

The Long-Term Care Ombudsman Program Coordinator has been the program coordinator since 2005. She has over 7 years with Central Midlands Council of Governments in providing administrative duties. She enters all cases in the Ombud 4.2 program and in the computerized in-house log. She handles referrals, hospital requests, consents, case follow-ups, filing and taking intakes. She assists in project mail-outs. She is seeking a Human Services degree from Midlands Technical College.

Reductions in staff are expected in this four year period and will occur according to the specifications of the COG Reduction in Force policy approved by the CMCOG Board of Directors.

Long-Term Care Ombudsman Services

The Long-Term Care Ombudsman Program is governed by the Older Americans Act and the Omnibus Adult Protection Act (SC State Law). The CMCOG region is the second largest region in the state, with over 6,700 beds; therefore the staff maintains a high case load. Facilities are required to report abuse, neglect and exploitation to the Ombudsman Program as mandated by law. The Long Term Care Ombudsman Program protects the health, safety and welfare of vulnerable adults, age 18 and over in long-term care facilities. The CMCOG Long Term Care Ombudsman Program investigates, mediates and advocates on behalf of residents in facilities. Investigation of abuse, neglect and exploitation complaints takes priority. The Ombudsman staff also provide community education and in-service education in facilities. Ombudsman staff encourage Resident/Family Councils, conduct consultations and assist callers with referrals as necessary. Ombudsmen also make weekly Routine Visits to facilities to make observations and monitor resident care/services and advocate as necessary. CMCOG Ombudsman Program has a confidential 800 number for caller convenience, confidential voicemail for reporting and a confidential fax line so that facilities are able to fax in their

mandated reports. This program maintains confidentiality of the residents and resident related information.

CMCOG Ombudsman Services goals include responding to the priority of abuse and neglect complaints within a 24 to 48 hour response time. Residents request for services will also take precedence depending on the nature of the request. Another goal for this program is to educate law enforcement personnel on the laws governing abuse/neglect/exploitation and the authority of the Ombudsman Program. Since many of abuse/neglect/exploitation cases often require the assistance of law enforcement, it benefits residents if all entities are equipped to address the critical issues that residents are facing on a daily basis. CMCOG Ombudsman staff have noticed that law enforcement is often unsure of the steps to take when called to the facility related to an allegation. Proper training would equip them to the growing number of reports they will be getting related to elder abuse, neglect and the growing number of vulnerable adults being financially exploited. The last goal is to educate facility staff of the harm done when residents report respect and dignity issues. Training and consultations will be held in effort to teach staff and equip them with skills needed to provide quality service and make residents feel comfortable in their environment. Respect and dignity has been identified in this region as an on-going concern in some facilities. The CMCOG Ombudsman Program is responsible for 115 facilities, totaling 6,751 beds. (See Chart with 2 year Case Load History and Facility/Beds Statistics)

The State Ombudsman Program has been a source of technical support, serves in an advisory capacity and has supported with hands-on assistance during facility closures. The State Ombudsman Program provides guidance and community resources during monthly meetings. This regional program has joined training efforts with the State Ombudsman Program in community education events. The State Ombudsman has also been a support in legal matters and discharge hearings. They provided technical support and assisted with contacting legal assistance in difficult cases in which the resident needed such representation. They played an intricate role in resolving those difficult legal cases. In effort to improve services in the next 4 years, the CMCOG Ombudsman Program plans to encourage Resident Council activities in long-term care facilities by providing educational materials and attending when invited. The Central Midlands Ombudsman Program also plans to address the on-going identified concern of the lack of respect and dignity by facility staff. Training will be provided to staff and consultations will be held with administration to address areas identified during weekly visits. Improvement in these two areas will benefit the quality of life of residents. They will feel empowered with an improved sense of safety. This program will also work on developing large print materials, Spanish written materials and Braille information. A major strength of this program is the ability of the Ombudsmen to resolve most of the complaints reported while onsite. Due to the knowledge of the Ombudsmen staff and the skills developed, the staff is able to resolve many complaints through advocacy, care plan meetings, family meetings and/or by making the resident's preference known, with consent. One of the weaknesses identified is not being able to maintain volunteers in the Friendly Visitor's Program. Volunteers normally remain active for approximately one year. The Ombudsman Program Director has over 25 years of long-term care experience. She meets with staff daily related to their assignments, reviews case files and makes changes in assignments as reports needing immediate attention requires investigative

efforts and/or intervention. The State Ombudsman is apprised of issues that may be deemed as a concern for the program and she is consulted for questionable cases. Another weakness is the ability of the staff to complete case documentation in a timely manner due to the high volume of cases.

Advocate for residents in long term care facilities- Ombudsman staff will continue to advocate daily and as consent is given by the resident. Ombudsman staff will equip residents with Resident Rights materials and community resources as needed to resolve their concerns during weekly visits. Weekly Routine Visits will be made and residents' reported concerns will be handled immediately with resident consent. The advocacy goal also includes addressing an on-going concern in this region related to respect and dignity. The objective is to make sure our residents feel safe and respected in their facilities. Ombudsman staff will continue education and consultation efforts weekly during facility visits. Ombudsman staff will also be an ongoing voice for residents affected by the Optional State Supplement (OSS) changes.

Complaint intake, investigation and resolution-Ombudsman staff have trained the Ombudsman Coordinator to make complaint processing the highest priority and to forward each reported complaint to an investigator within two hours after getting the report. Egregious abuse and neglect complaints are given to an investigator immediately for staffing, investigation or appropriate referral. The Ombudsman's objective is to make sure the residents are in a safe environment and are not fearful. Abuse and neglect complaints will be given immediate priority and will be given a 24 to 48 hour response time.

Information and assistance- Ombudsman staff will provide information and assistance while onsite to facilities, during training events and via telephone. Information and assistance will be provided immediately and resources mailed within 24 to 48 hours after a request is made. The objective is to make sure residents and families are provided with the resources needed to make informed decisions and to advocate for themselves as needed. Ombudsman staff also provide facility staff with information as needed with the objective of improving resident care and quality of life. Ombudsman staff will also make referrals as needed for legal assistance as deemed necessary. SC Legal Services has provided timely services and the residents served thus far have reported positive results. SC Bar Association will be consulted for services as well.

Community education-Ombudsman staff will continue to provide community education at least three times monthly. Community education will be provided in the areas of Resident Rights, Advance Directives and the laws governing the Long-Term Care Ombudsman Program. The objective is to bring awareness to the challenges our residents face and to empower the community and educate them on identifying and reporting concerns to the appropriate entity as identified. As noted above, the effort to educate law enforcement on the laws governing abuse/neglect/exploitation is a long-term goal. Consultations will also be used as a community education method, which is done on a weekly basis.

In-service education- Ombudsman staff will continue to provide in-service education at facilities at least once monthly and will also provide in-service to facility staff during one-on-one consultations at least three times monthly. The objective of in-service trainings is to provide the staff with knowledge which would allow them to improve

effort in addressing their resident's needs. In-service education will have a focus on dignity and respect and measuring the effectiveness of the information given, Ombudsman staff will monitor the type of complaints made at those facilities identified as having a concern in this area. Resident Rights materials will be distributed to staff and residents and during weekly visits. New partner development and volunteer program development- It would be advantageous for the Central Midlands Ombudsman Program to develop a partnership with the State and County Department of Social Services (DSS) as both programs operate under the same state law as related to vulnerable adults. The objective would be to coordinate efforts during long term care facility closures. Although there is a Relocation Committee, responsibilities of both programs could be outlined in this effort, so relocation of residents would result in a coordinated transition of resident belongings, medications and coordinated effort of transportation. This effort would be an ongoing effort, but suggestions would be submitted to the State Ombudsman Program quarterly for consideration. The Friendly Visitor Program (volunteer program) continues to require recruitment efforts in this region. The goal for this region is to maintain six (6) Friendly Visitors in our long-term care facilities and for those volunteers to commit to at least two (2) years. Recruitment efforts include mail-outs, public announcements and community education efforts related to the value of the volunteer program and the benefits of being a volunteer. These efforts will be performed monthly by staff. Visits to residents in facilities- Ombudsmen will make weekly Routine Visits to facilities to make observations, monitor care/services and advocate as necessary. Immediate advocacy will be provided with the permission of the resident. Visits to facilities for abuse/neglect will take priority with a 24 to 48 hour response time by Ombudsman staff.

Assistance with the development of resident and family councils- Ombudsman staff will encourage Resident/Family Council Meetings and will also offer to attend and provide resources as identified by the council or the Ombudsman. Ombudsman staff will make the effort to talk with the Resident Council President during weekly visits and offer materials and assistance (ex: making signs, finding materials pertinent to the topic of the meeting, advocating for a private space) for a productive outcome and encourage participation. If there are areas in the minutes of the meeting that need to be addressed by facility staff, the Ombudsman will offer to advocate for the council. The goal is to encourage and establish four Resident/Family Councils per year.

Information and Referral/Assistance (I&R/A) Services

Long term goals for I, R/A services include assisting and advocating for aging and disabled individuals and their families, in all geographic areas in counties served, who need special support. This will be accomplished by promoting self-confidence and self-determination through education, planning and problem solving in order to bring them and needed resources together. The success of the program will be determined by ensuring reasonably convenient access to the I & R/A services; and, assuring senior and individuals with disabilities' needs are being served. Services will continue to expand to serve the disability community as funding allows.

Information and Referral/Assistance- Measures and Strategic Goals for further development of the regional I, R/A services include identifying resource needs and reducing gaps and duplication of services with increased awareness focused in the rural areas in the counties served. This includes making the I,R/A Specialist more accessible in

these communities where reluctance/distrust in calling a stranger for assistance still exists and lack of transportation prohibits personal contact. This increased access to person-to-person assistance will, in turn, increase knowledge and linkage to local resources while promoting the services offered by I, R/A. In addition, I, R/A services will continue to assist individuals/families in becoming aware of long term care options available to them. Options Counseling enhances their ability to remain in the community longer by promoting self-determination through problem solving and identifying personal and family resources.

The I, R/A Specialist will be going to the rural areas monthly per county to make services more accessible to individuals who lack transportation and prefer person-to-person contact. The focus will be to schedule in advance different locations in the rural areas of the counties to maximize access to services.

Challenges to be addressed in the delivery of I, R/A services are the increasing duties assigned to the Specialist position in regards to prioritizing outreach in rural, low-income communities and additional data entry requirements -(6,661) contacts recorded this last fiscal year vs. 2,325 stated in previous Area Plan for 2007-2008). Many of these individuals are aged and/or have a disability and live outside of populated towns and cities in their county. The I, R/A service recognizes the need to expand its availability and exposure into the rural areas in the service area. However, training/education is an on-going requirement along with the expense and networking costs to market and expand/increase services. These additional requirements in conjunction with the continuing decline in budget allocations (Sequestration) and reduction in support staff are detrimental to advancing/increasing services. I,R /A services are provided through Title III B funds and these are expected to be cut by 12.50 % in South Carolina. Traveling to rural areas will be contingent upon funding as there will be travel expenses.

Furthermore, life expectancy today in our service area ranges from 74.0 to 77.8 years increasing the need for home and community based services With the aging in place of the baby-boomer generation and the increasing number of individuals diagnosed with Alzheimer's Disease (or some type of Dementia); families recognize the need for information, options counseling and assistance in caring for loved ones. The Aging Needs Assessment/SWS Inc. October 15, 2012 found that "of the 584 respondents, 549 reported on how important information, referral and assistance services are to keeping them where they are now. All of the targeted groups view I,R/A to be very important (*mean=3.31-3.58, median=4.0*)". Residential care facilities, assisted living homes and nursing facilities are only beginning to adjust to the demands of residents needing their services for years and years. And, these costs are prohibitive for many reinforcing the need for awareness and availability of supportive services in the home.

The weakness in the I, R/A program is insufficient time to address detailed/multi-resource requests that often require research, community contacts and follow-up. And, additional trained personnel are needed in order to meet the outreach and marketing goals to increase awareness in our rural areas along with maintaining and expanding the current services.

Marketing strategies of I, R/A include continuing to successfully promote the toll-free telephone number and provide awareness of services through brochures, business cards,

flyers, websites, community outreach, speaking engagements, etc. in all counties served. Special efforts will be made to reach all populations, including those of the greatest social needs (physical and mental disabilities); language barriers; and/or cultural or geographical isolation. Marketing updates will be available in the annual Area Plan update.

Partnerships: Ongoing efforts are made to maintain and increase partnerships with non-profit, for-profit, faith-based and other community groups/organizations in order to be aware of resources in the service area. The I, R/A Specialist attends Interagency meetings in Richland, Lexington and Fairfield counties. These Interagency meetings are attended by non-profit, for-profit partners and faith-based organizations. The Alianza Latina meetings in Richland County are attended; staff is a member of the Collaborative Community Response Team in Lexington County (Abuse in Later Life Program/Sexual Trauma Services of the Midlands); Silver-Haired Legislature meetings are attended; have SHIP/I-CARE and FCSP partnerships; attend Family Connections of the Midlands Conference; met in 5/13 with Washington Street UMC representatives regarding health fair/workshop in the fall about senior issues. Steps will be taken to increase services in the rural areas of the counties served, anticipating additional partnering will occur with local agencies/organizations.

Interpreter Service: The latest Census shows that 5.4% of the total population in Fairfield, Lexington, Newberry and Richland Counties are of Latino/Hispanic Origin with 7.8% in Newberry Co. A timely and accurate interpreter service action plan has been established with an employee at CMCOG's S.C. Works to interpret for the I, R/A Specialist when needed by phone or email with a non-English inquirer.

Data Collection: The Information and Referral/Assistance Specialist and back-up staff documented six thousand six hundred and sixty one (6,661) contacts from April 1, 2012 thru March 31, 2013. Of these, three thousand five hundred and seventy five (3,575) are Options Counseling. The I & R/A services will continue to maintain and improve data collection with regard to demographics, client's needs, income, disabilities and available services/resources – identifying reported "unmet needs." Input of client service data will be entered into OLSA (SC ACCESS) by AIRS Certified Specialists when possible and in a timely and accurate manner by the tenth (10^{th}) day of the following month of service.

Information and Referral/Assistance staff utilizes SC ACCESS (OLSA) daily with checking previous client contacts in order to minimize duplication of data and in order for the inquirer to not have to repeat information during each call. The I, R/A Specialist makes inquirers aware of SC ACCESS on the internet and how to access the website. Also, information is emailed to inquirers using SC ACCESS when the requested information is available. A Central Midlands AAA/ADRC Senior & Disability Services Directory is used also and updated twice yearly.

Supervisory Responsibility/Review: The AAA/ADRC Director keeps staff informed of where she is when out of the office or designates a staff person to be in charge during the absence. The AAA/ADRC Director and I-CARE Coordinator serve as back-up for the Information and Referral/Assistance Specialist. The AAA/ADRC is a member of the Alliance of Information and Referral Systems (AIRS).

Currently, follow-up on client inquiries/referrals is made by the I & R/A Specialist as needed and when safety concerns are presented. This follow-up procedure will be increased by making five (5) out of every five hundred (500) calls monthly to inquirers to see if services were received. Also, the I, R/A Specialist will meet with the AAA/ADRC Director monthly to keep her abreast of call volume and range of call topics.

Crisis Calls: Procedures are in place regarding crisis calls with the I,R/A Specialist and the AAA/ADRC Director. The I,R/A Specialist has resources at her desk of Emergency Contact information for S. C. Suicide & Crisis Hotlines and local law enforcement. With the I, R/A Specialist's background in mental health and domestic violence, she has experience on how to handle a crisis call. A Geriatric Depression Scale (GDS) Scoring Instructions Questionnaire is also part of her crisis call resource book.

Outcome Measure: Increased physical presence in the rural areas of the counties served will enhance service awareness and delivery in these areas and increase I, R/A contacts by 5%.

Outcome Indicator: The I, R/A Specialist will visit, on a scheduled basis, rural areas in counties served one (1) time each month to make services available in person to underserved populations in the service area.

Data Source: Data will be collected separately in relation to these contacts in the rural areas by the I, R/A Specialist and reported to the AAA/ADRC Director during the monthly Supervisory meeting.

Outcome Measure: Increased physical presence in the rural areas of the counties served will enhance service awareness and delivery in these areas and increase I, R/A contacts by 5%.

Outcome Indicator: The I, R/A Specialist will visit, on a scheduled basis, rural areas in counties served one (1) time each month to make services available in person to underserved populations in the service area.

Data Source: Data will be collected separately in relation to these contacts in the rural areas by the I, R/A Specialist and reported to the AAA/ADRC Director during the monthly Supervisory meeting.

Outcome Measure: Public awareness and distribution of written information will increase by twenty five percent (25%) regarding I, R/A services and will educate more people about resource options available.

Outcome Indicator: Increased physical presence in all areas of the counties served will enable distribution of written information during each scheduled visit.

Data Source: The I, R/A Specialist will take written material to distribute to different locations during personal visits and document these activities.

Outcome Measure: Data collection in OLSA documenting gaps and unmet needs in services will improve by 50%.

Outcome Indicator: Increased follow-up services of 5 contacts per 500 monthly will increase awareness of unmet needs.

Data Source: I, R/A Specialist will make 5 contacts per 500 monthly (in addition to safety follow-up) to see if resources per referrals were accessed/available. This data will be presented to the AAA/ADRC Director during monthly Supervisory meeting.

I-CARE and Senior Medicare Patrol

The Central Midlands Council of Governments Area Agency on Aging/ADRC's I-CARE program provides accurate information on all Medicare issues, reaching beneficiaries who need help in understanding all facets of Medicare, and reaching beneficiaries who need all the "Extra Help" programs offered by the state and the federal government. The AAA/ADRC will strengthen the partnership with the Lieutenant Governor's Office on Aging I-CARE Program to assist with training and developing community contacts. The I-CARE program will explore contacts made through involvement with the Interagency Network in Richland and Fairfield counties. The I-CARE program will continue to strengthen the relationships with the faith based community, SC Hispanic Leadership Council and other civic organizations through the development of partnerships. The I-CARE program will also continue contacts with the local libraries in the communities; one partnership with a local library has already been established. With these resources, staff should be able to reach some of the underserved populations.

The I-CARE/SMP program will work with other departments such as I,R/A, Family Caregiver, and Ombudsman to increase one on one contact. The 2012 Medicare & You newsletter was distributed at health fairs, presentations, one on one contact via face to face at counseling locations as well as through the US mail. This newsletter was developed for Open Enrollment to inform Medicare beneficiaries and family members regarding changes to Medicare for 2013 and also included information regarding Flu Prevention, along with fraud information. Approximately 1500 newsletters were distributed. Staff utilized the prevention benefits though the "Your Guide to Medicare's Preventive Services" booklet -this information is discussed during presentations and then given to each participant. This publication is also distributed at the I-CARE booth at all health fairs. This publication continues to be mailed to individuals during Open Enrollment and other SEP enrollments. The new prevention guidelines for 2013 will also be included in all activities. Fraud information is a part of presentations and at exhibits. Information about fraud is included with the packet people receive during enrollments. This agency includes prevention and fraud prevention in all aspects of service delivery. All mailings have a fraud brochure included. The prevention booklet is especially given to people who are new to Medicare. Information about pre-existing condition plans has not been included as yet in presentations or booths. Information is given out to one on one contacts as requested. This region is looking for information and requesting more training on this topic. Some materials on this topic have been ordered.

As demand for training has increased, the I-CARE program continues to offer the free I-CARE Basic Training classes to individuals. The classes have been opened to social workers who work for home health agencies in hopes that they will be able to reach Medicare beneficiaries who may need the "Extra Help" programs or may need help in getting their drug plans or a Medigap policy. Staff do have three (3) volunteers and one (1) intern from Midlands Technical College who assist with these programs. Our goals for increasing the effectiveness of the volunteers are to provide recognition events, send

them report forms, and email them important messages from Medicare, so they can keep up with Medicare changes and other relevant Medicare information.

Staff continue to serve as the viable agency to assist individuals and family members of the services at Central Midlands AAA/ADRC by distributing written information in newsletters, newspapers, health fairs and during speaking engagements. Staff continue to inform the community that counselors are available to discuss Low Income Subsidy (LIS) and other pertinent Medicare issues. Staff screen callers for "Extra help" programs and mail out for the Plan Finder program. Staff mail out the results of the Plan Finder program and invite the client to come in to have the results explained to them, if needed. Through presentations, health fairs, and telephone contact, staff inform individuals about the assistance available to enroll in Part D plans. Staff also use the Medicare newsletter to encourage and inform individuals to enroll during Open Enrollment season.

There are many challenges that loom ahead for the next four years for these programs. There is an increased need for the Basic Training classes. Staff will continue to reach out to the Hispanic and Korean communities to educate them about I-CARE and fraud. Staff will increase our attempts to reach the targeted populations by getting more information to the places they visit such as clinics, food banks, Medicare providers' offices and places of worship in the region. Staff will continue to develop partnerships with agencies in the communities. Staff will continue to encourage individuals who take the Basic Trainings classes to do reports, so that staff can have better figures on the amount of work done on behalf of the beneficiaries. Staff also desire to expand our work force in these programs to have more trained and paid counselors to assist Medicare beneficiaries.

In the future staff would like to conduct a phone bank during open enrollment and offer education on Long Term Care issues. Long Term Care Insurance questions are becoming a real concern to clients.

The Senior Medicare Patrol program goals include: education of the beneficiaries on types of fraud and minimizing resistance to complaining about a problem. The Senior Medicare Patrol program will become more visible to the public as staff inform and educate about the importance of understanding fraud issues. This agency will try to recruit two active volunteers per county to provide educational events. Staff are working with the COA's and RSVP and Senior Companion programs for a list of volunteers who may be interested in taking the SMP training. Once volunteers are trained they can conduct outreach and exhibit at health fairs, etc.

Staff will continue to work with the COA's to spread fraud awareness through the senior centers. Staff will seek partnerships with the Department of Consumer Affairs and SLED to explore new fraud trends in the community as well as work closely with the LGOA. Staff are in the process of sending out posters and brochures about the SMP program to churches, nonprofits, clinics, senior housing and senior centers to inform them of our services and ability to come to their sites to conduct programs such as the Savvy Seniors informational guide. Staff are also examining the idea of having the COA's input articles into their newsletters about fraud and scams. Staff will also hold a Medicare Fraud workshop to educate volunteers on different fraud trends.

Additionally, staff purchased promotional items which are used at all events. Staff use the personal journals that are distributed at presentations and health fairs along with the SMP

brochure and the Medicare folder with the fraud message for Medicare Plan Finder information which is mailed out with each client contact and any other information as related to Medicare. Finally, staff utilize the SMP Stop Health Care Fraud tip sheet from Smart Facts.

Outcome Measure: Increase in presence in rural areas to help serve older persons with the greatest economic needs, greatest social need, low-income and low-income minority older persons by getting more information to the places that they frequent such as clinics, libraries, food banks and places of worship. Continue to work with Contractors, home health and hospice agencies and to develop new partnerships to reach homebound and underserved seniors in rural areas.

Outcome Indicator: The I-CARE Coordinator along with the I&R/A Specialist will visit on a scheduled basis rural areas in counties served on a monthly basis to provide and educate on services available to individuals in underserved populations in the region.

Family Caregiver Support Program

The Family Caregiver Support Program (FCSP) at Central Midlands Council of Governments (CMCOG) was implemented in the fall of 2001 with the current Family Caregiver Advocate (FCA). By January of 2002 there were connections in place with social workers, nurses, Councils on Aging (COA's), for-profit agencies, non-profit agencies and health care facilities who made referrals. The program had roughly $136k that staff assisted caregivers with through reimbursement and staff disbursed all of the funds by the end of the fiscal year in June. Staff have subsequently received increasing amounts of funds each year to include the FY 2012-2013 year with roughly $152k.

Staff recently began the first waiting list for the CMCOG FCSP. Staff have had to postpone any new applicants from enrolling until the fall. The FCA utilized a Master level Social Work candidate from USC's School of Social Work, in the first year of operation, and the FCA has used two to four candidates in each subsequent year. In 2004, the CMCOG hired one of the students full time and she assisted with the development of the program as the Aging Program Coordinator (APC) and later assisted with the development of the ADRC. From 2004 to 2010, these two staff, plus the students from mid-August until the end of April, served caregivers in the five areas under the NFCSP by:

- Providing information to callers;
- Providing assistance through explaining the aging network and how the FCSP could assist clients;
- Providing counseling with caregivers who were depressed, confused, lost, quite often crying on the phone due to feeling they had nowhere to turn (and staff developed contacts to make referrals for counseling and paid for some of these services), plus staff conducted training sessions, staff contracted with trainers to provide caregiver trainings as well—which were attended well in 2003-2004, plus, staff facilitated caregiver support groups from January of 2003 until in 2011, plus staff facilitated SRC support groups from 2003 to the present;
- Providing reimbursement for respite care services,(e.g. in-home, adult day care based, or 24 hour facility based); providing reimbursement for supplemental

services such as home modifications, nutritional supplies, incontinence supplies, ramps, wheelchair batteries, etc.

In addition, staff assisted Seniors Raising Children (SRC) with the five areas listed in the National FCSP, as well, by:

- Providing information about camps, FCSP services, and other services such as tutoring, and how the AAA in this region could assist them;
- Providing them with assistance like dealing with schools, agencies, etc.;
- Providing counseling for them with in-depth issues, developing and maintaining a support group beginning in 2003 through the present, training was delivered through securing experts, e.g. police, attorneys, social workers, and others, to present to the SRC;
- Providing reimbursement for respite for sitter services and camps, etc.;
- Providing reimbursement for expenses for the children's clothing, shoes, school supplies, etc. The FCA and the APC both assisted SRC with their purchases. Once the APC position was vacated, the FCA could no longer provide this service due to time constraints.

The FCSP at CMCOG will implement vouchers in FY 2013-2014. Staff will utilize the short, approval periods for the vouchers, (e.g. quarterly).

With ample staff, the FCSP had a monthly newsletter that staff produced and mailed to all current caregivers. This was developed each month from a purchased, national newsletter organization and staff added local news as well. Staff used it to inform caregivers and providers of services and events in the region, and to provide updates to the FCSP in the region. This was discontinued when the no one was hired to take the place of the APC in July 2011. The staff also purchased a quarterly newsletter for the SRC from the same organization and produced enough for the other nine regions. The SRC newsletter was also discontinued due to the lack of staff to produce it and mail it.

For almost a decade, the FCA was able to receive a call from an SRC and assist SRC make purchases. Since February of 2013, this group has been placed on the waiting list as well.

Initial goals were to adopt and practice the five goals set forth by the NFCSP and serve as many caregivers as possible with minimal amounts of funds, i.e. usually up to $500 for caregivers and up to $300 - $500 for SRC depending on the number of children being cared for that year. Another goal was to be responsive to caregivers and SRC as they presented their needs. Up until the current FY 2012-13, staff have succeeded in these goals. Due to data entry requirements and the increased number of items that need to be entered in all of the databases, staff are reducing our number of caregivers and SRC served this year, significantly. This year staff are planning to approve about 50-60 caregivers and 20-30 SRC in the first quarter. The reason for this change is quarterly reporting requirements, mandated data entry of the assessment prior to funds being distributed and increased requirements in other databases, e.g. OLSA/Tapestry/SCACCESS.

Documentation has been secured in the spring of 2013 for the upcoming FY for both caregivers and SRC. For caregivers, this includes a form that a professional (social worker, doctor, nurse, care manager) has completed with documentation of ADLs and

cognitive impairment. This information, combined with the information that staff receive in a phone conversation with the caregiver, will suffice for the LGOA's required information mandated in the annual assessment. While staff gather the initial information to determine if a voucher is awarded, staff target other clients, if the additional information is not adequate. Once all of the data is entered for the LGOA, staff will award funds. Staff anticipate many phone calls by SRC and caregivers who were accustomed to a different process.

Goal: is to have data entered each month for the LGOA. Even though staff anticipate not using all of the funds during this FY, staff will still strive to meet these data entry requirements. Unused funds may be carried over into the next fiscal year.

Goal: is to approve a small number of people for vouchers, per quarter, so that staff can effectively enter the information into the databases each quarter—roughly 50-60 caregivers and 20-30 SRC, initially, followed by fewer each quarter. Staff have denied many caregivers and SRC who meet the minimum criteria for the NFCSP, but did not score high enough to be awarded funds. If we find that we can approve more than this amount in the future, staff will certainly do so.

Goal: is to make a waiting list for new inquiries, and begin processing these new applications in the fall, each year, after beginning a list from January through September. Staff will have an "Open Enrollment" period from September until December 31st, so that new applicants may get services in one of the future quarters in the same fiscal year.

Goal: is to assist caregivers and SRC who have already been entered into the databases with funds, as in the past, but also with additional funds as situations change. Therefore, staff may serve one approved caregiver or SRC, with multiple voucher reimbursements in different quarters over the duration of the FY. Staff plan to serve these SRC and caregivers since they have already been approved and would be entered into the databases Those caregivers and SRC who need more supportive services will be provided such services. Staff will utilize their phone conversations and score sheets to determine if additional funds are warranted.

Long Term Goal: is to identify more relatives 55 years of age or older caring for people with a disability and increase the number of these clients served.

Long Term Goal: is to identify the most needy caregivers and SRC. Staff will then try to serve them as expeditiously as possible, if approved for funds, in spite of the long waiting list periods and the higher scoring requirements.

Long Term Goal: is to identify more organizations who serve people with disabilities and let them know that the FCSP serves people 55 and older who are caring for someone between the ages of 19 and 59 who is a loved one, but not a spouse or child of the person.

The CMFCSP procedures -When someone is sent an application and then returned, it is reviewed for accuracy and completion. If it is not complete or accurate, it is returned. If it is complete and accurate, it is then subject to the appropriate CMFCSP score sheet. If the score is not sufficiently high, then the person is sent a letter explaining that while they do meet the minimum criteria for the National FCSP, they will not be approved for funds since there are more needy people at this time. If they do qualify, then they are sent a voucher that states they may be reimbursed for receipts that they submit to the CMFCSP. At this particular juncture, these procedures seem to be working adequately and staff does

not see any need for changes. Staff have implemented the mailing of a post card or letter stating that staff have the information they submitted and that they will be hearing from the FCSP.

Challenges:

- Having more phone calls and inquiries than staff can accommodate which will be addressed by not marketing the program as much and continuing to keep the score threshold high; staff will also use the waiting list to keep track of all the people who inquire, but due to staff limitations cannot be sent applications, reviewed, scored, etc. Staff will also screen for caregivers not living with the care recipient and immediately place them on the waiting list;
- Not being able to serve all of the caregivers who staff would normally approve for the FY which will be addressed by keeping the scoring threshold high;
- Not being able to provide adequate data entry for the caregivers and SRC who have been approved and received vouchers and funds which will be addressed by significantly reducing the number of caregivers and SRC enrolled in order to keep up with the data entry requirements;
- Not being able to send applications to caregivers and SRC who contact us for assistance which will be addressed by continuing to utilize a waiting list; since the list grew from zero to 65 from February to mid-May, staff may need to implement an additional screening tool;
- Not being able to conduct minimal outreach; this has been addressed by staying involved with the Caregiver Coalition of the Midlands (CCOM), which serves caregivers in the region, when the FCA has time to attend this monthly meeting and yearly event in October;
- Having more dollars at the end of the FY for caregivers and SRC which will be addressed during the 2013-2014 FY, since this would be first time that staff have encountered this scenario.

The CMFCSP has had budgets for service dollars from $136k in 2001 to $152k in 2012-2013 FY. If the ACL's most recent numbers stay fixed, the state of South Carolina will realize a cut in the FCSP of 3.23%. According to the draft NGA received the week of May 13th, the service dollars for Central Midlands have been decreased from roughly $152k to $142,035. Staff will start the FY with these figures utilizing up to 10% for SRC ($14,203) and up to 20% for supplemental services ($28,406). Since staff use a first come first served philosophy to address the most needy clients, staff do not specify allocations per county. Unless staff can adjust these figures through the LGOA permitting higher allocations in these areas, staff will limit service dollars to these figures:

BUDGET

Total Dollars	Caregivers	SRC
142,035	127,832	14,203

There is one additional component to the disbursement of funds: even though the SRC funds should not exceed 10% of the total dollars, the supplemental funds for both caregivers and SRC are counted together and should not exceed 20% of the total dollars. The FCA will monitor this per the NFCSP requirement.

The timeline for the funding distribution for the FY will be issuing vouchers to caregivers and SRC in all four quarters. The first quarter will be for those existing caregivers and SRC who have high scores, and who have submitted the annual renewal packets:

Caregivers - Release of information form and physical exam form that includes an assessment of ADLs and cognitive impairment for the care recipient

SRC – List of children form and release of information form, respectively

Outcomes / Measures: The FCSP at Central Midlands will expect to see more funds going to people who are in the targeted groups. By keeping quarterly voucher time frames, staff think this will help manage the system more efficiently. Staff began last year including people's Social Security numbers in internal paper work, because staff send caregivers and SRC a 1099 form whenever $599 is exceeded in any given calendar year to be in compliance with IRS guidelines. Staff uses an internal system to track checks issued to caregivers and SRC which allows us to audit our data entry in AIM with our internal check writing system.

Staff plan to return phone calls quickly and be responsive to caregivers and SRC needs within the confines of the new time constraints on FCSP staff. FCSP staff will continue to track these three items listed below:

Outcome	Outcome Indicator	Measures
People who call the Family Caregiver Support Program (FCSP) will be supplied with information requested within three to five days of the phone call.	95% of the FCSP callers will receive the requested information or a referral to the appropriate service	The FCA will monitor this for compliance, as available
People who meet the NFCSP eligibility criteria through the application process will receive a score based on his/her caregiving experience; the FCSP score will determine if a caregiver is awarded a voucher for a quarter of this fiscal year, waits to the next quarter, or is put on a waiting list for the next FY.	The CMFCSP will continue to seek guidance through RADAC, the AAA Director, and other sources to ensure equity in the scoring criteria and to continuously review and update this process.	The FCA will monitor this for compliance, as available
Support groups for caregivers and SRC will be encouraged in the region	FCSP staff plans to facilitate a SRC group each month; CMFCSP staff will refer people seeking support groups to appropriate groups in the region	FCSP staff will track attendance through sign in sheets at the groups that CMCOG staff facilitate

Consumer choice: The FCSP at Central Midlands has utilized a consumer choice concept from the outset of the program. Caregivers and SRC may use a neighbor, faith-based community member or a friend to provide sitter services and or care for the loved one. In

most cases, caregivers appreciate this option since sometimes loved ones are not as comfortable with strangers in their homes. They may also use the available funds for respite care, home modifications, incontinence supplies, nutritional supplies or other approved items. Many times they choose to mix these items and get $300 in respite care reimbursement and $200 for incontinence supplies, for instance. They have expressed appreciation for this type of flexibility in the FCSP. Staff plans to continue this practice.

Consultations with other agencies: Staff have worked well with other agencies to determine which agency could help a particular person in a given part of the year. For instance, staff have encouraged people to use the Alzheimer's Association respite funds when FCSP respite funds were depleted. Staff have asked staff at Community Long Term Care (CLTC) to send us referrals especially referrals for clients who are waiting for services.

In regard to assisting SRC, staff holds a SRC gathering each month (support group). The topics include adoptions, securing financial assistance from parents, other resources, anti-bullying, camps, finding respite care through the year, but especially in the summer months when children are home more, providing ideas for activities, and giving them a place to meet to share with others what has worked and what has not worked from personal experiences. The budget has included SRC from the outset and the FCSP has always run out of the 10% of funds allocated for SRC.

Caregiver policies and procedures began with only the approval of individuals who met the minimum criteria for the NFCSP, (i.e. 60 years of age and above with documented health problems in the form of limitations of at least two activities of daily living (ADL) in the category three (3) and above, or a cognitive impairment). These forms were completed by nurses, social workers, doctors and care managers familiar with people's health problems. Staff screened the ADL forms submitted to exclude those completed by CNAs.

After staff implemented the practice of using a score sheet, staff did not deny many caregivers or SRC in the first two years. These files were also held throughout the year and if funds were available later in the year staff would consider approving them for funds. Since 2010, Staff have prioritized to the targeted caregivers and SRC. In preparation for the 2013-2014 FY, staff have raised the score thresholds to 60 for caregivers and 45 for SRC, respectively. The scoring procedures have been thoroughly scrutinized for properly assigned values and components that staff believes will accurately capture the caregiving circumstances.

The staff at CMCOG have tried to enter phone calls into OLSA/Tapestry/ SC ACCESS when these were received. However, due to time constraints, staff have not entered each call as staff receives it into OLSA/Tapestry/SC ACCESS and then into AIM as a "Care Coordination" entry. In the 2011-2012 FY staff were mostly entering in AIM and the OLSA/Tapestry/SC ACCESS calls were low. The next year staff entered more in OLSA/Tapestry/SC ACCESS, and the AIM "care coordination" calls were low.

Detailed specifications: Staff provide information to people who call our office and staff mail them information pertinent to their situations. For instance, staff have booklets for understanding people with dementia and staff mail these out to people when requested. Staff provide other information as well.

In regard to assistance, staff help people with their situations by taking the time to listen carefully and then staff help clarify some of the issues. At times, a person will want to keep working or need to keep working while keeping their loved one at home, but leaving their loved one alone is not an option during the day. Staff then discusses the ways that adult day care works, which types might apply—in the Columbia area we have social models as well as medical model adult day care—and send them a list of the ones available.

In regard to counseling / training / support groups, staff provide extensive discussions regarding their situations, letting someone else come into the home to give them a break and give their loved one a break from them as well. Staff may refer them to support groups or counseling centers. Staff have initiated training activities in the past in all four counties. The FCSP has paid trainers to set up the trainings, coordinate these, and staff would pay for the respite care while they attended, still there was a low attendance.

The FCA began facilitating the support groups in 2003. The FCA has facilitated a SRC support group since 2003. This group has between 4-13 people attending over the years. Staff have led various topics. Staff have allowed the attendees to request speakers on particular topics and then staff located these individuals and scheduled them. Staff have had a holiday gathering the first Tuesday of December for the last eight years.

The respite care portion of the FCSP has been by far the most utilized in regard to funds and services. Staff have allowed caregivers to choose who will provide the respite care, friends, neighbors, faith-based community members, which staff refer to as "informal caregivers", or paid workers who work for an in-home care agency. Staff allows the caregivers to choose the person or agency that will provide the care. In some cases staff have arranged for an agency to provide an invoice for the services. Staff also provides a list of in-home care agencies. Caregivers have been allowed to reserve funds for late in the fiscal year for a trip and or for the loved one to stay in a 24 hour facility, (e.g. nursing home or assisted living facility). SRC have requested respite assistance to pay for camps, and staff have approved these services as funds permit. SRC have expressed the need for babysitter services to give them a break, and the FCSP has helped with this.

The supplemental portion of the program has been the most creative area since staff have helped caregivers with getting their doors widened when a loved one came home from the hospital and needed a wheelchair, but could not get through some of the doorways. The FCSP helped pay for the installation of ramps, repair floors, and other home modifications. There have been efforts to stretch the dollars by checking to see if the caregiver had a friend or loved one who could provide the repairs and the FCSP only paid for materials.

The FCSP paid for nutritional supplies and incontinence supplies; and, at times, staff allowed vendors of the SRC and caregivers' the choice to invoice us for these services and then the items were sent to their homes. Caregivers do appreciate this effort since having to go out shopping is not always appealing, according to caregivers interviewed.

Service gaps: The service gaps seem to be caregivers across the region caring for someone with minimal health problems, but these caregivers would still appreciate breaks (respite). There are some people in areas who do not know about our program. There are

plenty of professionals, social workers and nurses who are aware of our program in the region and readily refer people to staff.

Staff expect any service gaps, identified or unidentified to increase over the next four years for the following reasons: there are more people moving into the caregiving roles since many people have not prepared for the expenses of 24-hour care facilities, and people usually want to stay at home—they want to age in place. As of 2011 there are 10,000 people turning 65 every day in this country versus 6,000 turning 65 daily in the previous four or five decades. As these people experience deterioration in their health, they will need caregivers. Staff will continue to strive to identify and help caregivers with no assistance and no other involvement in programs that provide regular care, (e.g. CLTC, hospice).

Partnerships: Staff will continue to forge partnerships with providers over the next four years. Staff have some systems in place that allow staff to ensure services and payment, (i.e. reserving funds for a later date, requesting that the in-home care agency check with the FCSP prior to providing services and then billing). The FCA will continue to rely on existing partnerships over the next four years. Staff will continue to partner with agencies to try to create seamless services; for instance, when a person has been approved for CLTC but these services had not started yet, staff would allow them to receive respite care until the services start, thus helping the caregiver with respite care. The FCA has participated in community meetings to promote caregiver issues such as the Caregiver Coalition of the Midlands (CCOM), a couple of breakfast groups that assist seniors, the Gerontological Society, and others since 2001. The FCA's time constraints have continued to limit the time devoted to such interactions and there has been a gradual decrease in such activities on the part of the FCA.

New ways to Access information: The AAA/ADRC plans to utilize e-mail and the CMCOG website more to give caregivers quicker access to information and FCA contact information. Staff will continue to assist people with information by locating services and then describing how these individuals may access such services.

Reimbursement model -The AAA/ADRC reimbursement model permits caregivers and SRC to choose their source of provider for services and when they want to receive such services. However, with the new model for 2013-2014, and possibly for the next four years, staff will be reducing the periods when they may use services/receive reimbursement for services. Instead, the FCSP wants caregivers to have the flexibility to utilize vouchers where they deem it appropriate and to what extent they deem appropriate for their needs and the needs of the care recipient.

Priority groups identified by OAA: In the past staff purchased handbooks that helped people keep track of medications, appointments, diagnoses. Staff purchased some of these in Spanish, some were general and some were targeted toward people with Diabetes. These were distributed at health fairs while we had an ADRC coordinator who was bi-lingual. Staff will attempt to locate professionals who may serve these identified populations and try to serve more of them as time permits.

Expansion of SRC services: When SRC face greater hardships due to being on fixed incomes, caring for children with disabilities, little support from the parents of the children and other family members, etc. staff have provided additional assessments and

where warranted have provided additional financial support. In the future, staff plan to continue assisting SRC and when staff have someone with extenuating circumstances who warrants attention or financial support beyond our normal amounts, staff plan to assist them further than the usual amounts.

Expansion of SRC component of the FCSP- There are no plans to increase the number of people served in the SRC category since staff do not have sufficient funds to help all of those currently identified. Instead, staff plan to utilize the increased threshold in the score used for SRC to determine who are the most needy and award them funds. In preparation for the 2013-2014 FY, we have excluded about 20% of the identified SRC.

In the last part of the 2012-2013 FY, staff developed a relationship with the Edgewood Foundation (formerly the Columbia Bethlehem Community Center) which the FCSP partnered with in the past. Staff plan to identify a few SRC who may be sponsored by the Foundation in June. Staff plan to assist a few SRC with the after school program there in the summer of 2013, and hopefully nurture this relationship. SRC will still have a choice in the services they choose to use with the FCSP dollars.

FCSP Services Made Available: The FCSP serves all four counties by accepting phone calls and inquiries regardless of location in the region. Staff provide information and assistance in all parts of the region. Staff have tried to conduct caregiver trainings in all parts of the region and staff have supported new caregiver support groups when these were started. Since staff utilize a consumer choice concept, and the caregivers and SRC may select the organization or individual that they choose, this permits equal access to FCSP dollars and services throughout the region. Staff rely on social workers in schools to inform SRC who need our assistance and other health care professionals to refer caregivers to us as needed. In addition, staff rely on the contractors in each county to inform the local citizens of the services available at the county level and at the regional level.

Cost Sharing: From the outset of the program staff utilized a cost sharing approach with both caregivers and SRC. This was a cumbersome process to determine if clients were in a 60%, 80%, or 100% reimbursement category. Staff discontinued the cost share component of the program around 2009-2010 due to time constraints and confusion for the people served. Staff have had over 400 active files in any given year Staff have now increased the score threshold, thus the score that staff derive from the application determines if funds are awarded. This process also excluded many caregivers and SRC from the program at the beginning of the 20013-2014 FY. Staff have been successfully targeting people based on this scoring mechanism which has been developed over a four to five year period. Staff have utilized the Family Caregiver Advisory Committee from 2002 until 2012 to help determine the best course of action with the program, and the development of the score sheets was one of those items. Subsequent to disbanding this committee, staff have been utilizing the Regional Aging and Disability Advisory Committee (RADAC) for such guidance.

Disease Prevention/Health Promotion

The region plans to continue to fund Arthritis Evidenced programs as much as funding allows. With a sequester cut of 5.37% to Title III D, the small amount of funding may not be sufficient to maintain these programs. Currently Senior Resources, Inc. and Newberry

County Council on Aging provide the Arthritis programs for Fairfield, Newberry and Richland counties. Lexington County Recreation and Aging Commission provide the services for Lexington County with local funds.

VII. Changing Demographics Impact on AAA/ADRC's Efforts

Intervention vs. Prevention

The funding is not adequate to provide more than minimal prevention programs in the region. Three counties plan arthritis programs with Title III D funding. The arthritis classes do not prevent arthritis, but are effective in reducing pain and preventing immobility. Such a small amount of funding is available that no one in Lexington County proposed to offer an evidenced based program. Nutrition education is required as a part of home delivered meals. Cognitive Intervention programs are one preventive program that have been encouraged in the region. Cognitive intervention generally improves reasoning, memory and speed of processing. Site managers in Richland and Lexington counties were trained to implement the program in senior centers where most of the participants have not been diagnosed with dementia or Alzheimer's. Speed of processing ability has been related to mobility and driving skills (2008 *Mind Alert Monograph*, American Society on Aging). This training could be offered in Fairfield and Newberry counties, if funding allows.

Senior Center Development and Increased Use

The AAA reviews Senior Center Operations once every three years in the Permanent Improvement Program (PIP) facilities to assure that the guidelines and quality assurance standards are met. Staff of the AAA have assisted interested contractors with grant writing to obtain PIP funding in the past. The South Carolina Association of Area Agencies on Aging has in the past planned and implemented state-wide training for site managers of senior centers. This is an option in the next four years if funding is available. The AAA refers to senior centers when the Information and Referral Specialist receives calls requesting such information. Site managers will be encouraged to attend training offered by the SC Council on Aging Directors (SCACAD). Participation at senior centers will be increased through special projects that are outlined in other places in this plan. Newberry County Council on Aging is a member of the National Council on Aging. With the new state policies and procedures, other councils on aging will be joining the National Council on Aging.

Alzheimer's Disease

Alzheimer's Disease and other dementias have always been targeted populations in Older Americans Act funding. Contractors are required to offer services to the targeted populations before other populations are served. Home and Community based services as well as the caregiver services allow for the caregivers for Alzheimer's and other dementia clients to care for these individuals in their homes for a longer period of time than might be possible without the services.

Legal Assistance Services

The AAA receives daily calls that require legal assistance; therefore, the agency continues to allocate more than the minimum required by the state unit on aging to legal services in the region. The attorneys for legal services are willing to see homebound clients in their homes if necessary and consult with clients in long term care facilities. Each legal services contractor develops procedures that assure that the maximum number of participants is served with limited resources. The AAA assures that the services are not

requiring prolonged litigation while completing annual assessments and quality assurance reviews. The legal services contractors provide lists of work completed under the contract which is not associated with the names of the clients in order to preserve client/attorney confidentiality. The most recent legal services contractor is a Legal Services Corporation Act provider and has the capacity to perform the functions under the Older Americans Act. The region will be referring clients to the bar association for wills and powers of attorney in the new plan period. The description of targeting objectives is included in the contractor's Outcome Measures plan.

VIII. Region Specific Initiatives

Elder Abuse

According to the U.S. Administration on Aging (AoA), each year an estimated 2.1 million older Americans are victims of elder abuse, neglect or exploitation. Experts believe that for every case of elder abuse or neglect reported, as many as five cases go unreported. Elder abuse takes many forms, including financial exploitation, physical abuse, neglect and emotional abuse.

The Administration on Aging suggests ten things anyone can do to help prevent elder abuse:

- Learn the signs of elder abuse and neglect.
- Call or visit elderly relatives, friends, and neighbors and ask how they are doing.
- Provide a respite for a caregiver by filling in for a few hours or more.
- Ask an older acquaintance to share his or her talents by teaching you or your children a new skill.
- Ask your faith leaders to discuss with their congregations elder abuse prevention and the importance of respecting older adults.
- Ask your bank manager to train tellers on how to detect financial exploitation of elders.
- Suggest that your doctor talk to his or her older patients individually about possible abuse.
- Contact your local adult protective services or long-term care ombudsman to learn how to support their work helping at-risk elders.
- Volunteer to be a friendly visitor to a nursing home resident or homebound elder in your community.
- Send a letter to your local paper, radio, or TV station suggesting it cover World Elder Abuse Awareness Day (June 15, 2013).

Some of the above will be suggested to advocacy groups and other adults involved with the AAA/ADRC. In an effort to impact elder abuse, CMCOG AAA/ADRC has partnered with Sexual Trauma Services of the Midlands, the Eleventh District Solicitor's Office and the West Columbia, SC Police Department to offer training on elder abuse to law enforcement and victims' services providers through an Office on Violence Against Women/ Department of Justice grant. This will continue through the 2013-2014 fiscal year. The CMCOG will participate in 21 trainings for law enforcement and 6 for victims' services providers during the grant period.

Assisted Rides

The region has applied for a grant from the LGOA to provide an Assisted Rides program through the Transportation Department of the CMCOG. The AAA/ADRC will collaborate with the Transportation Department to provide assisted rides through volunteers and a voucher program in a small rural area of the region.

Medicaid Managed Care

The AAA/ADRC expects to contract with one or more managed care organizations to provide care coordination for enrollees. This is a population that the AAA has served

minimally in the past in South Carolina and this initiative will allow the AAA/ADRC to expand the population served.

IX. Appendices

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Appendix C: Long-Term Care Ombudsman Service Report
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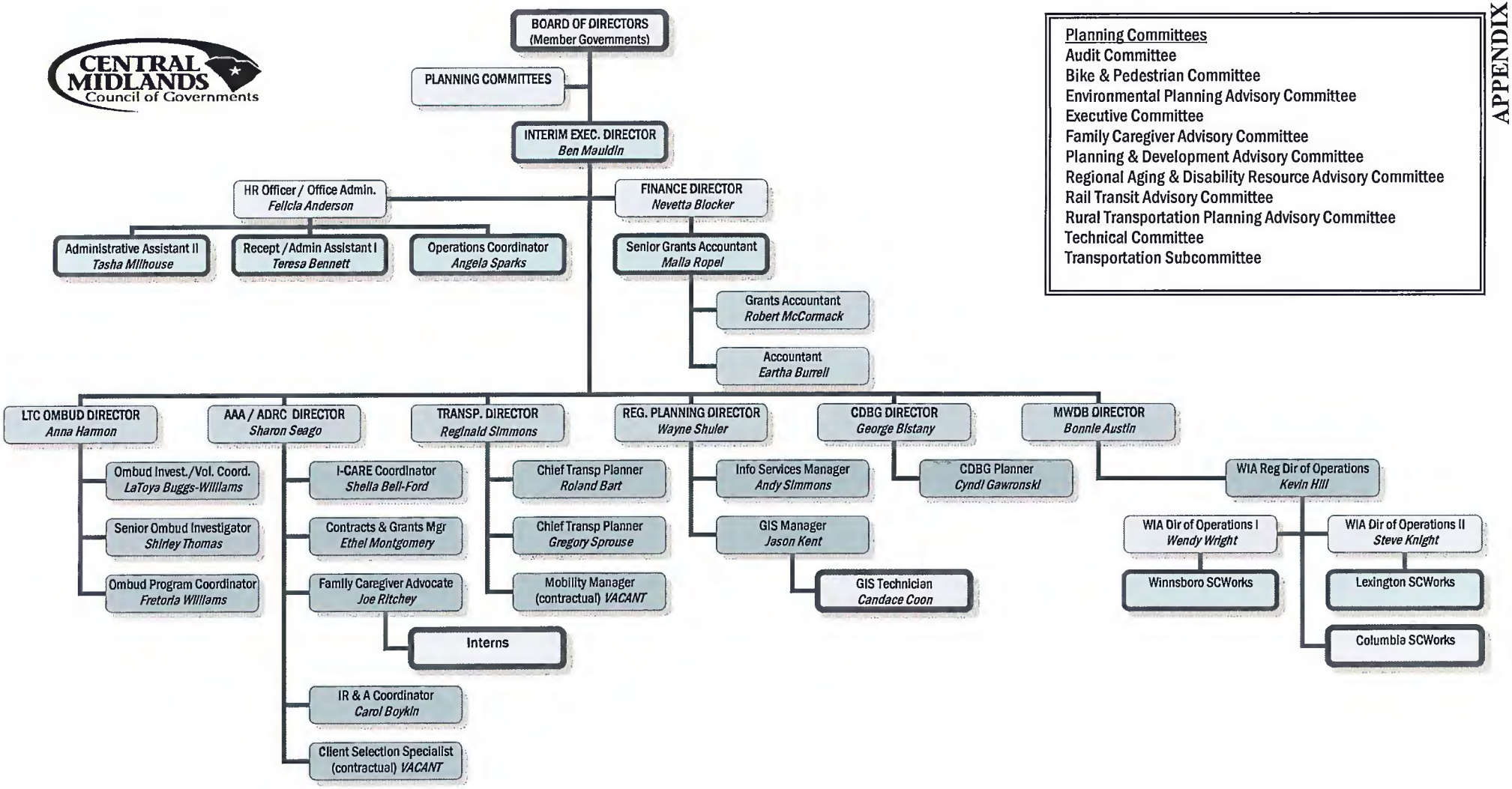
ORGANIZATIONAL CHART

APPENDIX A



Planning Committees
Audit Committee
Bike & Pedestrian Committee
Environmental Planning Advisory Committee
Executive Committee
Family Caregiver Advisory Committee
Planning & Development Advisory Committee
Regional Aging & Disability Resource Advisory Committee
Rail Transit Advisory Committee
Rural Transportation Planning Advisory Committee
Technical Committee
Transportation Subcommittee

Updated 6/3/2013

FINDINGS: REGION 4 – CENTRAL MIDLANDS

Representation of the Population

A total of 584 surveys were completed in Region 4. Respondents were asked a series of questions from which it was determined if the individual is a senior receiving services, a senior not receiving services, a caregiver, or an individual with a disability (ADRC target population). The categories are not mutually exclusive and an individual could be more than one of these categories or none at all. Of the 584 surveys completed, 423 (72.4%) were categorized as a senior receiving services, 86 (14.7%) were categorized as a senior not receiving services, 152 (26%) were categorized as being a caregiver, and 331 (56.7%) were categorized as having a disability. (However, this latter category was not used in the representation analysis, since Region 4 does not distinguish ADRC clients from other clients served by the AAA.)

For Region 4, the confidence interval for the sample of seniors receiving services is 4.6 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 good probability that the findings represent the responses that can be expected from seniors receiving services (plus or minus 4.6 percentage points). The confidence interval for seniors not receiving services is higher (10.5 points at a 95% confidence level assuming 50% agreement), which indicates less representation of the population of seniors not receiving services but is acceptable. The representation of caregivers is also acceptable (5.26 points at a 95% confidence level assuming 50% agreement). (See Table 4-1.)

TABLE 4-1: SAMPLE REPRESENTATION OF POPULATION

	Population Size	Sample Size	Representation
Seniors Receiving Services	6,295	423	4.60
Seniors Not Receiving Services	72,881	86	10.50
Caregivers	270	152	5.26
Individuals with a Disability		331	

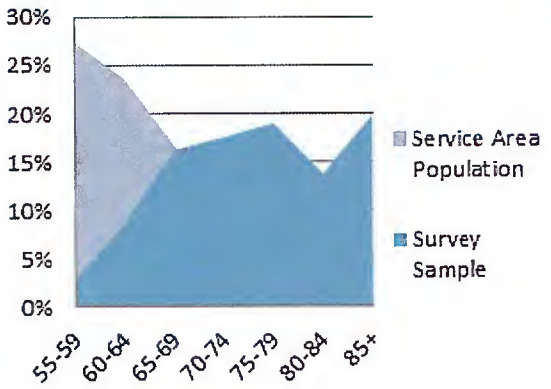
Demographic Characteristics of Seniors

Compared to the service area population, the survey respondents are older. A small percentage of survey respondents are under 55 (n=10, 2.1%), 55 to 59 years old (n=14, 2.9%), or 60 to 64 years old (n=42, 8.8%), whereas 27.4% and 23.6% 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 are almost equal at 65 to 69 years (n=78, 16.3% of the sample and 16.7% of the population) and consistently inclines until it reaches 80 to 84 years (n=66, 13.8%) for the survey respondents and 75 to 79 years old (8.7%). There was a greater amount of seniors 85 and over (n=95, 19.8%) in the sample population than in the service area senior

population (5.9%). (See Figure 4-2.) For this reason, further population figures only include seniors ages 65 and older.

FIGURE 4-2: AGE GROUP

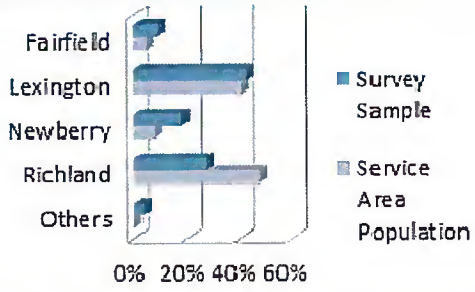
	Survey Sample	Service Area Population
Total	**480**	**161,644**
Under 55 years	2.1%	-
55 to 59 years	2.9%	27.4%
60 to 64 years	8.8%	23.6%
65 to 69 years	16.3%	16.7%
70 to 74 years	17.5%	11.4%
75 to 79 years	19.0%	8.7%
80 to 84 years	13.8%	6.3%
85 years and over	19.8%	5.9%



Larger proportions of the survey sample reside in Newberry (n=101, 18.1%), and Fairfield (n=51, 9.1%) counties than do seniors in those counties (7.5%, and 4.5%, respectively). Smaller proportions of the survey sample reside in Richland (n=152, 27.2%) than in the service area senior population (47.4%). This was done intentionally in order to ensure representation from the smaller counties and to increase the power of comparisons by county. (See Figure 4-3.)

FIGURE 4-3: COUNTY OF RESIDENCE

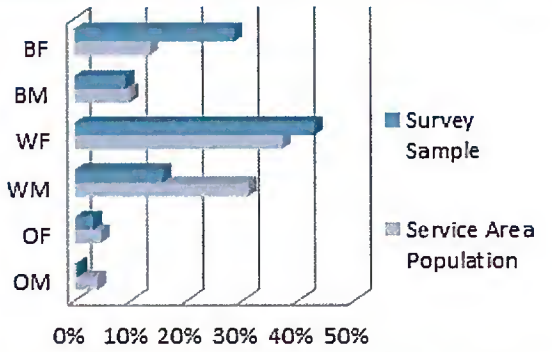
	Survey Sample	Service Area Population
Total	**559**	**79,176**
Fairfield	9.1%	4.5%
Lexington	42.2%	40.6%
Newberry	18.1%	7.5%
Richland	27.2%	47.4%
Others	3.4%	0.0%



A much larger percentage of the survey sample are White/Caucasian female (n=220, 42.7%) or African American female (n=147, 28.5%) than the service area population (37% and 13.4%, respectively). Conversely, a smaller percentage of the survey sample are White/Caucasian male (n=81, 15.7%) or African American male (n=47, 9.1%) compared to the service area population (31% and 10%, respectively). Very few respondents were of other races (females: n=17, 3.3%; males: n=3, 0.6%). These populations are also relatively small in the population (other females: 4.6%; other males: 4%). (See Figure 4-4.)

FIGURE 4-4: RACE AND GENDER OF SENIORS

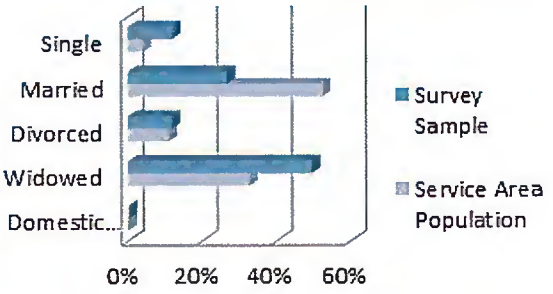
	Survey Sample	Service Area Population
Total	**515**	**161,644**
African American Female	28.5%	13.4%
African American Male	9.1%	10.0%
White Female	42.7%	37.0%
White Male	15.7%	31.0%
Other Female	3.3%	4.6%
Other Male	0.6%	4.0%



The survey sample has a much larger percentage of individuals who are single (n=62, 11.9%) or widowed (n=257, 49.4%) than exist in the service area population (4.1% and 32.7%, respectively). Conversely, there is a much smaller percentage of individuals who are married (n=139, 26.7% of the sample compared to 52.3% of the population). A similar percentage of respondents are divorced (n=61, 11.7%) as are in the service area population (11%). (See Figure 4-5.)

FIGURE 4-5: MARITAL STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**520**	**73,349**
Single	11.9%	4.1%
Married*	26.7%	52.3%
Divorced*	11.7%	11.0%
Widowed	49.4%	32.7%
Domestic Partner**	0.2%	-

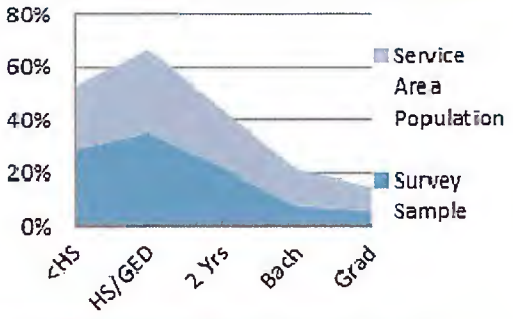


*Individuals in the service area population categorized as "Married, spouse absent, not separated" were excluded from the counts.
**Individuals who are in a domestic partnership were not included in the population counts as the Census does not include this category in the marital status calculation.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

The level of educational attainment of the survey sample is very similar to the educational attainment of the service area population. More than half of the respondents completed less than high school (n=153, 29.3%) or received a high school diploma or GED (n=187, 35.8%), compared to 23.3% and 31.3% of the service area population, respectively. There is no difference between the percentage of the respondents (n=115, 22%) who attended some college or earned as Associate's degree and the service area population (22%). The percentage of respondents who earned a Bachelor's degree (n=39, 7.5%) or an Advanced/Graduate degree (n=29, 5.5%) are about half of the percentage in the service area population (13.8% and 9.5%, respectively). (See Figure 4-6.)

FIGURE 4-6: EDUCATIONAL ATTAINMENT OF SENIORS

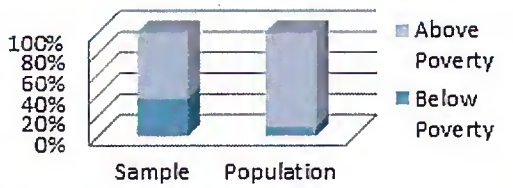
	Survey Sample	Service Area Population
Total	**523**	**74,717**
Less than high school	29.3%	23.3%
High school diploma/GED	35.8%	31.3%
Some college/Associate's	22.0%	22.0%
Bachelor's degree	7.5%	13.8%
Advanced/Graduate degree	5.5%	9.5%



In comparison to the service area population, respondents to the survey are estimated to more likely be below the poverty line (n=160, 36.4% compared to 9.8% of the service area population). (See Figure 4-7.)

FIGURE 4-7: POVERTY STATUS OF SENIORS

	Survey Sample	Service Area Population
Total	**439**	**71,540**
Below Poverty Line	36.4%	9.8%
Above Poverty Line	63.6%	90.2%



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

Demographic Characteristics of Individuals who have a Disability

Only 20 survey respondents from this region are considered to be disabled and 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 57.1% (n=329) 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 25.5% (n=66) of the sample. Caregivers comprise 25.5% (n=147) of the sample, are caring for another individual (senior, person with disability, or child under 18), and may or may not be over the age of 55. Persons with disabilities are the smallest group (n=34, 5.9%) 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 99 respondents (17% of the sample and 28.8% of those classified). Cluster 2 is comprised of 59 respondents (10.1% of the sample and 17.2% of those classified). Cluster 3 is comprised of 57 respondents (9.8% of the sample and 16.8% of those classified). Cluster 4 is comprised of 129 respondents (22.1% of the sample and 37.5% of those classified). The remaining 240 (41.1%) 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=2.23, median=1.89, n=329, sd=1.07*). The most important of these needs are transportation for errands (*mean=2.48, median=3.0, n=307, sd=1.37*), keeping warm or cool as the weather changes (*mean=2.54, median=3.0, n=319, sd=1.38*), and home modifications to improve safety (*mean=2.41, median=2.0, n=309, sd=1.35*). The least important services to seniors who are already receiving services are personal care (*mean=1.83, median=1.0, n=310, sd=1.24*) and in home housekeeping (specifically laundry) (*mean=1.91, median=1.0, n=313, sd=1.29*. (See Figure 4-8.)

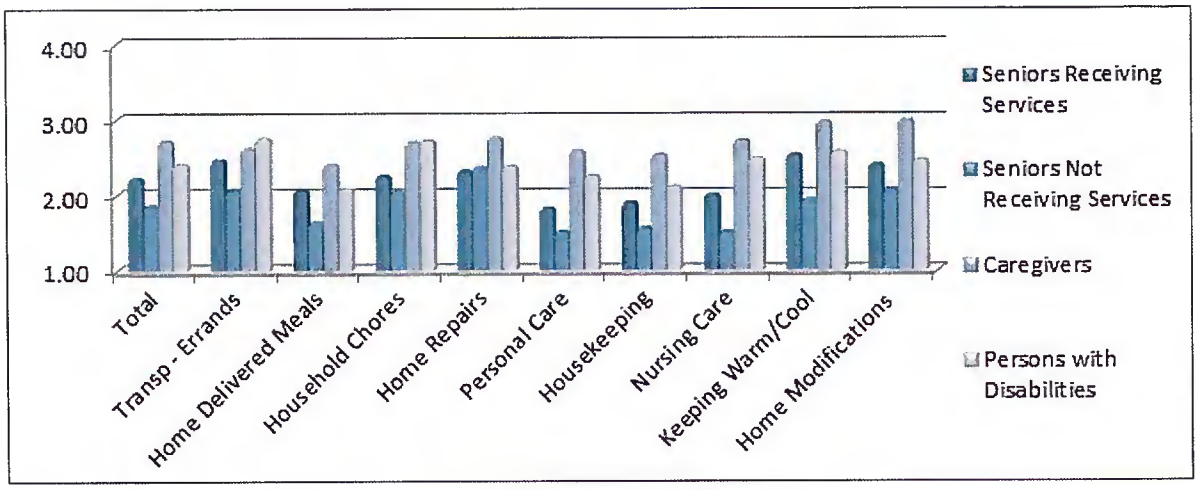
Seniors who have not received services view personal and home care needs to be a little important (*mean=1.87, median=2.89, n=144, sd=0.93*). The only service deemed to be a little important by most of the respondents is home repairs and maintenance (*mean=2.38, median=2.0, n=60, sd=1.38*). The least important services to seniors who are not already receiving services are personal care (*mean=1.52, median=1.0, n=60, sd=1.0*), housekeeping (specifically laundry) (*mean=1.57, median=1.0, n=61, sd=1.04*), and nursing care (specifically assistance with prescription medicine) (*mean=1.53, median=1.0, n=60, sd=1.03*). (See Figure 4-8.)

Caregivers view personal and home care needs to be a little less than quite a bit important (*mean=2.72, median=2.89, n=144, sd=0.93*). The most important of these needs are keeping warm or cool as the weather changes (*mean=2.97, median=4.0, n=137, sd=1.25*), and home modifications to improve safety (*mean=2.99, median=4.0, n=138, sd=1.2).* The least important service to caregivers is home delivered meals (*mean=2.41, median=2.0, n=140, sd=1.31*). (See Figure 4-8.)

Persons with disabilities view personal and home care needs to be between a little and quite a bit important (*mean=2.42, median=2.31, n=34, sd=0.98*). The most important service to persons with disabilities is transportation for errands (*mean=2.76, median=3.0, n=29, sd=1.32*) and household chores (specifically keeping home clean) (*mean=2.72, median=3.0, n=29, sd=1.19*). The least important services to persons with disabilities are home delivered meals (*mean=2.09, median=1.5, n=32, sd=1.25*) (See Figure 4-8.)

FIGURE 4-8: PERSONAL AND HOME CARE NEEDS BY TARGETED GROUP

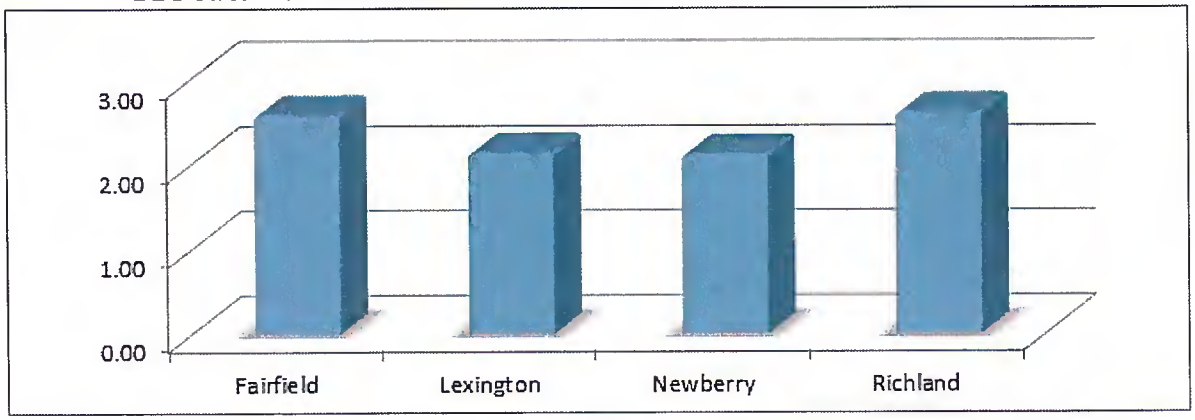
	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Personal and Home Care Composite	**2.23**	**1.87**	**2.72**	**2.42**
Transportation for Errands	2.48	2.07	2.63	2.76
Home Delivered Meals	2.07	1.65	2.41	2.09
Household Chores	2.26	2.05	2.70	2.72
Home Repairs/Maintenance	2.33	2.38	2.76	2.39
Personal Care	1.83	1.52	2.59	2.26
In-Home Housekeeping	1.91	1.57	2.54	2.12
Nursing Care/Prescription Assistance	2.01	1.53	2.73	2.50
Keeping Warm/Cool	2.54	1.95	2.97	2.58
Home Modifications	2.41	2.08	2.99	2.47



The difference in the personal and home care needs composite is significantly different between the targeted groups (*F=12.51, df=3, p<0.001*). Therefore, caregivers and persons with disabilities view personal and home care needs to be more important than do seniors who have not received services. However, the target group categorization only accounts for 5% of the variability in this composite (r^2*=0.062*).

African Americans, single respondents, those with a 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=33.06, df=1, p<0.001, F=2.91, df=3, p=0.031, F=4.46, df=4, p=0.001, and F=14.65, df=1, p<0.001, respectively*). For seniors, those who have a disability have a significantly greater need (*diff=0.24, t=2.26, df=391, p=0.024*). Individuals residing in Fairfield and Richland counties had significantly greater need than individuals residing in Newberry or Lexington counties (*F=8.7, df=3, p<0.001*). There are no differences by demographic cluster.

FIGURE 4-9: PERSONAL AND HOME CARE NEEDS BY COUNTY



Senior Center Activities

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

On average, seniors receiving services view senior center activities to be quite a bit important (*mean=3.2, median=3.3, n=326, sd=0.81*). The most important of these needs are having a senior center close to home (*mean=3.44, median=4.0, n=312, sd=1.03*), getting exercise (*mean=3.37, median=4.0, n=315, sd=1.01*), and recreation/social events (*mean=3.37, median=4.0, n=320, sd=1.04*). The least important service to seniors who are already receiving services is transportation to the senior center (*mean=2.66, median=3.0, n=314, sd=1.41*). (See Figure 4-10.)

Seniors who have not received services view senior center activities to be slightly less than quite a bit important (*mean=2.68, median=2.63, n=64, sd=0.93*). The most important of these needs are getting exercise (*mean=3.12, median=4.0, n=59, sd=1.1*). The least important service to seniors who are not already receiving services is transportation to the senior center (*mean=2.07, median=1.0, n=56, sd=1.32*). (See Figure 4-10.)

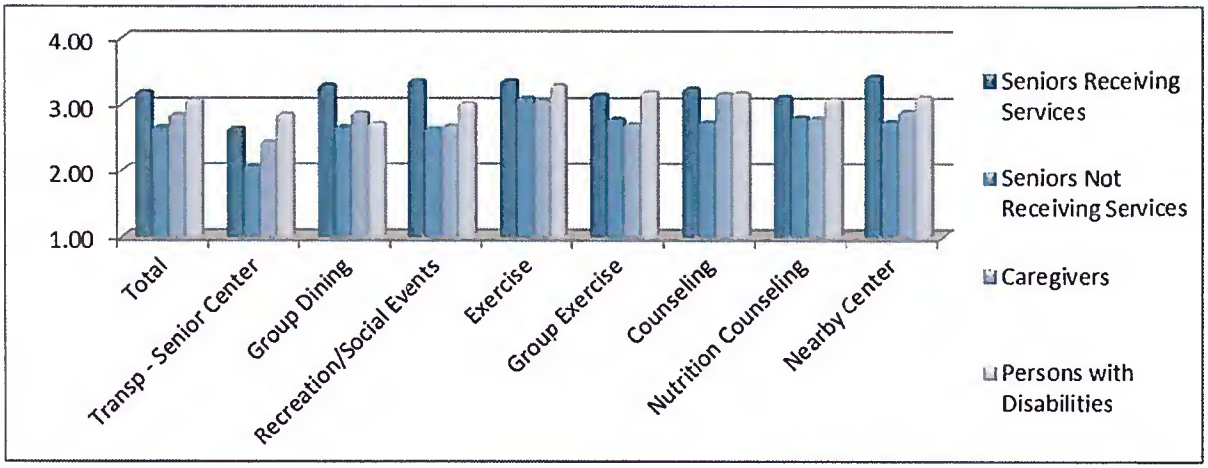
Caregivers view senior center activities to be slightly less than quite a bit important (*mean=2.86, median=2.9, n=144, sd=0.9*). The most important of these needs is counseling (having someone to talk to) (*mean=3.18, median=4.0, n=139, sd=1.02*). The least important service to caregivers is transportation to the senior center (*mean=2.45, median=2.0, n=137, sd=1.37*). (See Figure 4-10.)

Persons with disabilities view senior center activities to be quite a bit important (*mean=3.08, median=3.39, n=32, sd=0.89*). The most important services to persons with disabilities are getting exercise (*mean=3.3, median=4.0, n=30, sd=1.02*) and group exercise (*mean=3.20, median=4.0, n=30, sd=1.03*). The least important service to persons with disabilities is group dining (*mean=2.73, median=3.0, n=30, sd=1.26*) and transportation to the senior center (*mean=2.4, median=2.0, n=20, sd=1.35*). (See Figure 4-10.)

Transportation to the senior center is one of 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. Having a senior center nearby is far more important to keeping seniors receiving services where they are now.

FIGURE 4-10: SENIOR CENTER ACTIVITIES BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Senior Center Activities Composite	**3.21**	**2.68**	**2.86**	**3.08**
Transportation to the Senior Center	2.66	2.07	2.45	2.87
Group Dining	3.31	2.68	2.89	2.73
Recreation/Social Events	3.37	2.65	2.69	3.03
Exercise	3.37	3.12	3.06	3.30
Group Exercise	3.17	2.80	2.72	3.20
Counseling (someone to talk to)	3.26	2.75	3.18	3.19
Nutrition Counseling	3.14	2.83	2.81	3.10
Nearby Senior Center	3.44	2.76	2.91	3.13

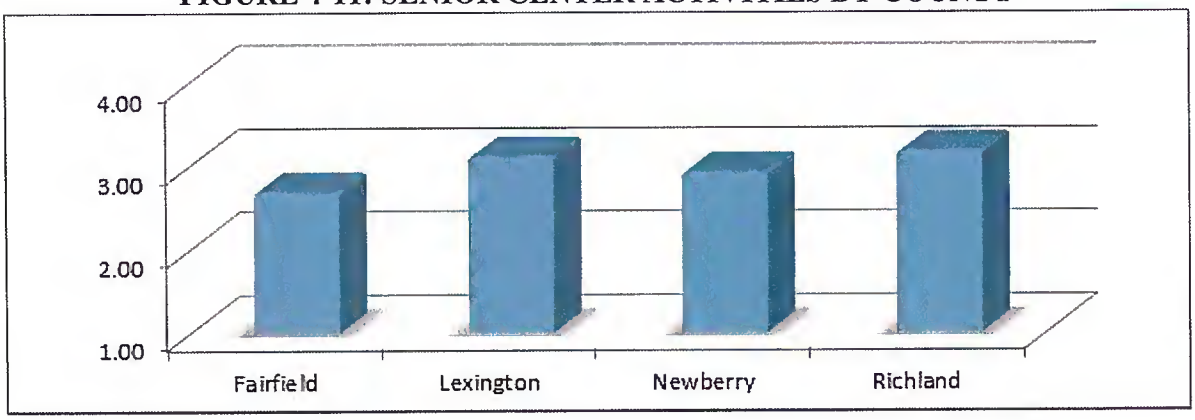


The difference in the senior center activities composite is significantly different between the targeted groups (*F=10.12, df=3, p<0.001*). Therefore, seniors receiving services and persons with disabilities view senior center activities to be more important than do seniors not receiving services and caregivers. However, the target group categorization only accounts for 5.1% of the variability in this composite (r^2*=0.051*).

African Americans and females rated these services as being of greater importance to them (*F=12.71, df=1, p<0.001; F=9.74, df=1, p=0.002, respectively*). Those who are single, widowed or divorced rated these services as being of greater importance to them than individuals who are married (*F=5.66, df=3, p=0.001*). Respondents who are below the poverty line and have a high school diploma or less rated these services as being of greater importance to them (*F=4.29, df=1, p=0.039; F=6.69, df=4, p<0.001, respectively*). Individuals who reside in Lexington and Richland County reported a greater need for senior center activities than did individuals residing in Fairfield (*F=5.16, df=3, p=0.002*).

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=3.6, df=3, p=0.014*). The second group to whom these services are important are individuals in Cluster 4 (White females, widowed, with a high school education, who are above the poverty line and most likely to be over the age of 85) who are receiving services.

FIGURE 4-11: 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 a little less than quite a bit important (*mean=2.77, median=3.0, n=322, sd=1.12*). The most important of these needs is having someone to call if feeling threatened or taken advantage of (*mean=2.88, median=4.0, n=314, sd=1.31*). Though thought to be between a little important and quite a bit important, healthcare directives was (*mean=2.51, median=3.0, n=310, sd=1.34*). (See Figure 4-12.)

Seniors who have not received services view services to help in maintaining independence to be a little important (*mean=2.25, median=2.0, n=63, sd=1.09*). The most important of these needs is having someone to call if feeling threatened or taken advantage of (*mean=2.52, median=3.0, n=62, sd=1.33*). The least important of these needs is preventing falls and accidents (*mean=2.06, median=1.5, n=62, sd=1.27*). (See Figure 4-12.)

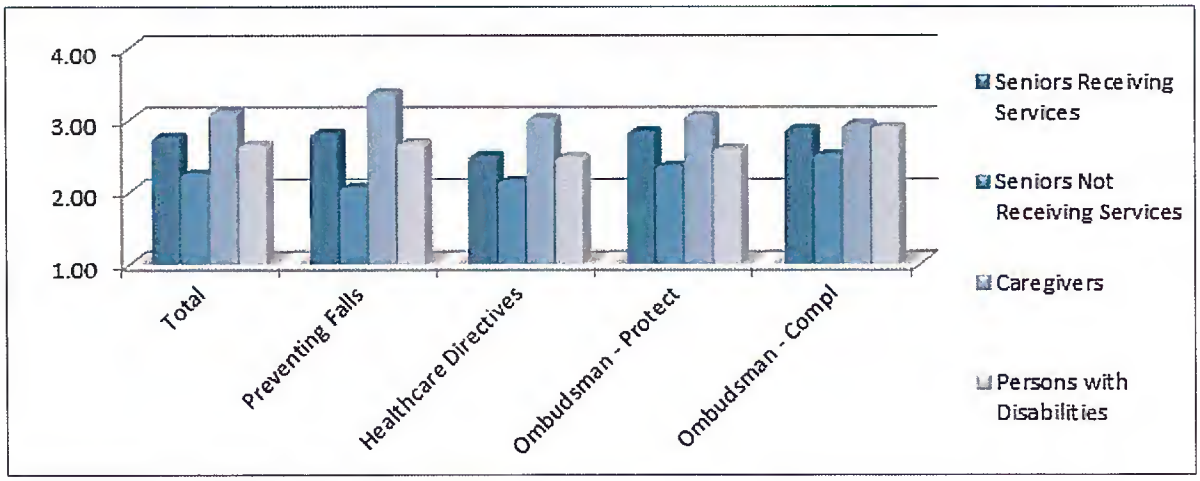
Caregivers view services to help in maintaining independence to be quite a bit important (*mean=3.11, median=3.25, n=141, sd=0.95*). The most important of these services is preventing falls (*mean=3.38, median=4.0, n=138, sd=0.99*). The least important of these needs is someone to call if feeling threatened or taken advantage of (*mean=2.94, median=4.0, n=138, sd=1.25*). (See Figure 4-12.)

Persons with disabilities view services to help in maintaining independence to be quite a bit important (*mean=2.65, median=2.63, n=32, sd=1.09*). The most important of these needs is someone to call if feeling threatened or taken advantage of (*mean=2.90, median=3.0, n=31, sd=1.17*). The least important of these needs is help making healthcare directives (*mean=2.48, median=3.0, n=29, sd=1.33*). (See Figure 4-12.)

Preventing falls is most important to caregivers; whereas having someone to call if feeling threatened or taken advantage of is most important to seniors (both those receiving services and those not receiving services). Persons with disabilities perceive the services of the ombudsman and preventing falls to be the most important.

FIGURE 4-12: MAINTAINING INDEPENDENCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Maintaining Independence Composite	**2.77**	**2.25**	**3.11**	**2.65**
Preventing Falls	2.82	2.06	3.38	2.68
Healthcare Directives	2.51	2.15	3.02	2.48
Ombudsman - Protection	2.84	2.36	3.06	2.60
Ombudsman - Complaints	2.88	2.52	2.94	2.90

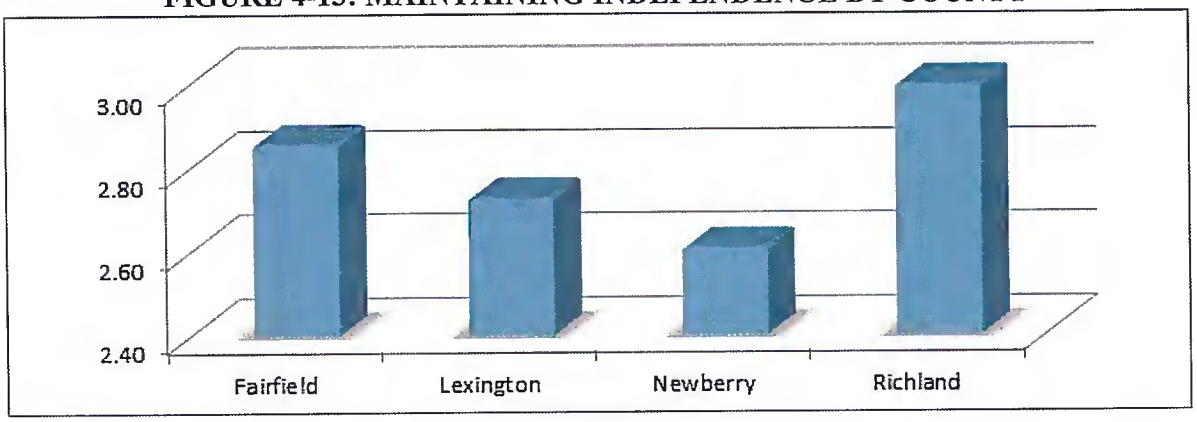


The difference in the maintaining independence composite is significantly different between the targeted groups (*F=9.68, df=3, p<0.001*). Therefore, caregivers view services to help maintaining

independence to be more important than do any other group. However, the target group categorization only accounts for 5% of the variability in this composite (r^2=*0.050*).

African Americans, single respondents, and individuals below the poverty line also rated these services as being of greater importance to them (*F=12.08, df=1, p=0.001, F=3.34, df=3, p=0.019, and F=7.89, df=1, p=0.005, respectively*). For seniors, those who have a disability have a significantly greater need (*diff=0.31, t=2.7, df=382.2, p=0.007*). Individuals who reside in Richland County expressed a greater need for these services than those residing in Fairfield, Lexington, and Newberry Counties (*F=2.89, df=3, p=0.035*). There are no significant differences by demographic cluster.

FIGURE 4-13: 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.

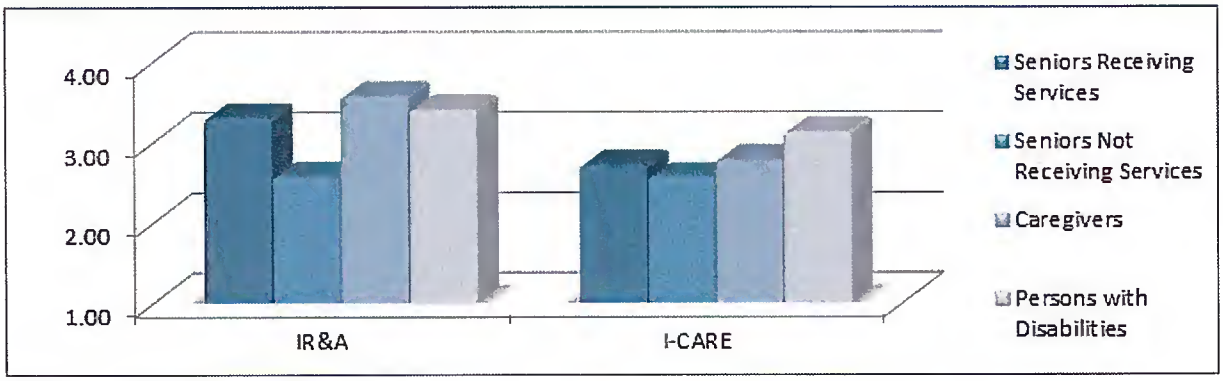
Of the 584 respondents, 549 reported on how important information, referral and assistance services are to keeping them where they are now. All of the targeted groups view IR&A to be very important (*mean=3.31-3.58, median=4.0*). The results of the Kruskal Wallis test indicate that there was significant differences between the target groups in how important it is to know what services are important and how to get them ($X^2_{K\text{-}W}$=*11.20, df=3, p=0.011*). In particular, caregivers view this service to be more important than do any other target group. (See Figure 4-I4.)

Of the 584 respondents, 529 reported on how important information or help applying for health insurance or prescription coverage (I-CARE) is to keeping them where they are now. Seniors receiving services, caregivers, and seniors not receiving services and persons with disabilities view this service to be quite a bit important (*mean=2.72, median=3.0, n=303, sd=1.29*; *mean=2.79, median=3.0, n=136, sd=1.27; mean=2.57, median=3.0, n=60, sd=1.3; and mean=3.13,*

median=4.0, n=30, sd=1.2, respectively). The results of the Kruskal Wallis test indicate that there were no significant differences between the target groups ($X^2_{K\text{-}W}$=*4.18, df=3, p=0.243*). (See Figure 4-14.)

FIGURE 4-14: IR&A AND I-CARE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Information, Referral & Assistance	3.31	2.58	3.58	3.41
Insurance Counseling (I-CARE)	2.72	2.57	2.79	3.13



Separately, there were no significant differences in the need for Information, Referral and Assistance by each demographic; however, there is a significant difference in the need based on demographic cluster ($X^2_{K\text{-}W}$=*9.86, df=3, p=0.020*). The demographic clusters of respondents who reported that IR&A services are of greatest importance to them are Cluster I (predominantly white male, above the poverty line, mostly married, with a high school diploma or GED) and Cluster 4 (predominantly African American female, above the poverty line, mostly married, with a high school diploma or GED).

African Americans, those with less than a High School Diploma/GED, and individuals below the poverty line rated I-CARE services as being of greater importance to them (*t=14.53, df=1, p<0.001; t=10.32, df=4, p=0.035; and t=7.97, df=1, p=0.005, respectively*). There are no significant differences by county.

Monetary Assistance

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

On average, seniors receiving services view monetary assistance to be a little important (*mean=2.06, median=1.88, n=310, sd=1.08*). The most important of these needs is dental care/dentures (*mean=2.18, median=1.0, n=295, sd=1.33*) and eye exams/eyeglasses (*mean=2.20, median=1.0, n=294, sd=1.34*). The least important services to seniors who are already receiving services are hearing exams and/or hearing aids (*mean=1.80, median=1.0, n=291, sd=1.18*). (See Figure 4-15.)

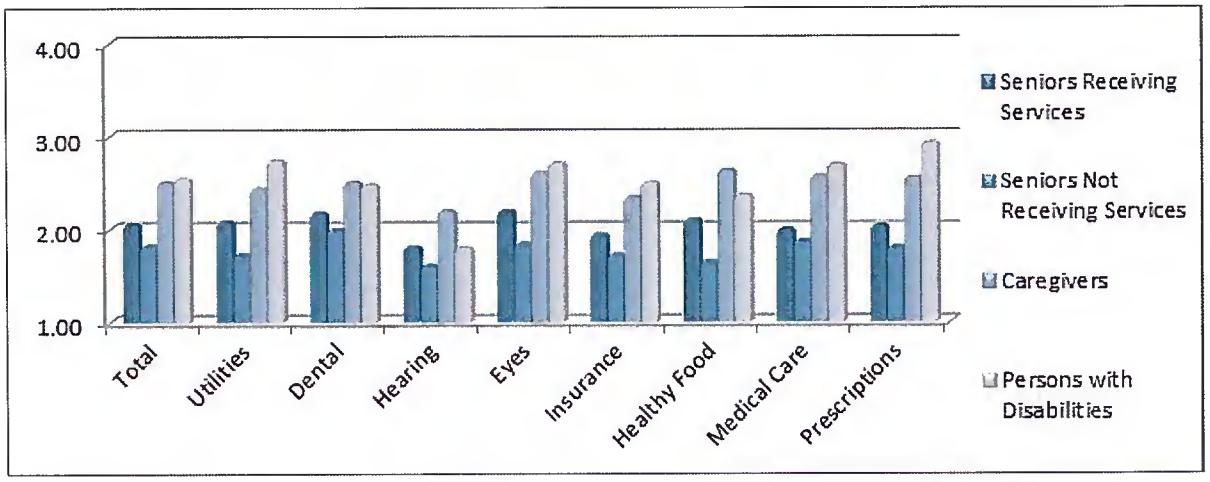
Seniors who have not received services view monetary assistance to be a little less than a little important (*mean=1.84, median=1.34, n=64, sd=1.04*). The most important of these needs is dental care/dentures (*mean=2.0-2.36, median=1.0, n=61, sd=1.28*). The least important service to seniors who are already receiving services is hearing exams and/or hearing aids (*mean=1.61, median=1.0, n=59, sd=1.07*). (See Figure 4-15.)

Caregivers view monetary assistance to be a little important (*mean=2.51, median=2.5, n=143, sd=1.05*). The most important of these needs is paying for healthy foods (*mean=2.64, median=3.0, n=136, sd=1.28*) and eye exams/eyeglasses (*mean=2.61, median=3.0, n=135, sd=1.28*). The least important service to caregivers is hearing exams and/or hearing aids (*mean=2.2, median=2.0, n=133, sd=2.2*). (See Figure 4-15.)

Persons with disabilities view monetary assistance to be between a little and quite a bit important (*mean=2.55, median=2.8, n=29, sd=1.04*). The most important of these needs are for utilities or an unexpected bill (*mean=2.74, median=3.0, n=27, sd=1.2*), eye exam and/or eyeglasses (*mean=2.71, median=3.0, n=28, sd=1.33*). The least important service to persons with disabilities is help paying for hearing exam and/or hearing aids (*mean=1.8, median=1.0, n=25, sd=1.26*). (See Figure 4-15.)

FIGURE 4-15: MONETARY ASSISTANCE BY TARGETED GROUP

	Seniors Receiving Services	Seniors Not Receiving Services	Caregivers	People with a Disability
Monetary Assistance Composite	**2.06**	**1.83**	**2.51**	**2.55**
Utilities or an unexpected bill	2.09	1.73	2.44	2.74
Dental Care and/or Dentures	2.18	2.00	2.51	2.48
Hearing Exam and/or Hearing Aids	1.81	1.61	2.20	1.80
Eye Exam and/or Eyeglasses	2.20	1.85	2.61	2.71
Health Insurance	1.95	1.73	2.35	2.50
Healthy Food	2.11	1.66	2.64	2.37
Medical Care	2.00	1.88	2.58	2.70
Prescriptions or Prescription Drug Coverage	2.04	1.81	2.56	2.93

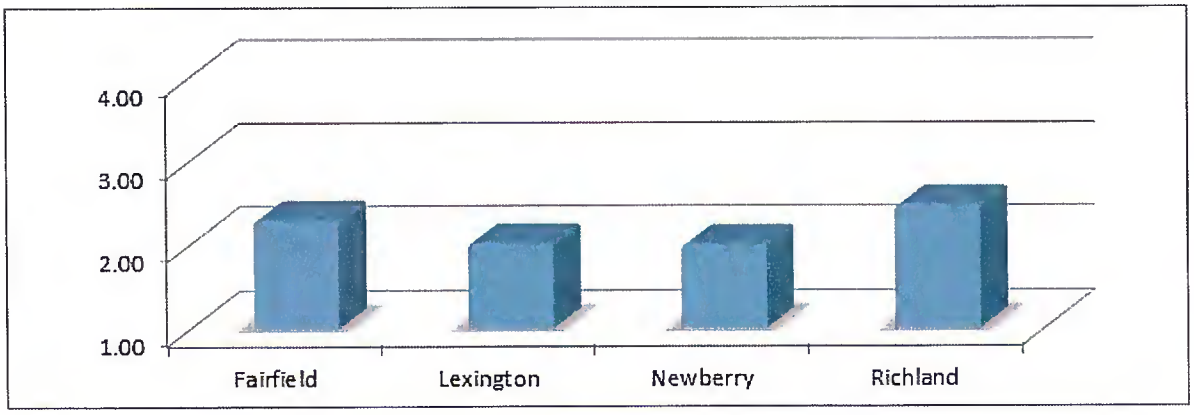


The difference in the monetary assistance composite is significantly different between the targeted groups (*F=9.35, df=3, p<0.001, r^2=0.049*). Therefore, caregivers and persons with disabilities have a significantly greater need for this service than seniors (both those receiving services and those not receiving services).

The age of the respondent has a significant impact on their perceived need for monetary assistance (*F=4.75, df=4, p<0.001*). This indicates that respondents who are in most need of these services are those who are 55 to 64 years old. African Americans, those who have 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=39.45, df=1, p<0.001; F=3.08, df=4, p=0.016; and F=25.09, df=1, p<0.001, respectively*). For seniors, those who have a disability have a significantly greater need (*diff=0.42, t=3.82, df=372, p<0.001*). Individuals residing in Richland county expressed the greatest need for monetary assistance (*F=6.11, df=3, p<0.001*).

Overall, the demographic clusters of respondents who reported that these services are of greatest importance to them are Cluster 1 (White males, married, with a high school education, who are above the poverty line) and Cluster 3 (African American females, widowed, with less than high school education, who are below the poverty line) (*F=5.94, df=3, p=0.001*).

FIGURE 4-16: MONETARY ASSISTANCE BY COUNTY



Caregiver Needs

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

Caregivers were asked to report the number of seniors, persons with disabilities, seniors with disabilities, and children for whom they care. These responses were used to categorize caregivers into four types: caregivers of seniors (*n=21, 16.3%*), caregivers of seniors with disabilities (*n=73, 56.6%*), caregivers of persons with disabilities (*n=22, 17.1%*), and caregivers of children (*n=13, 10.1%*). 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) agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.91, median=3.0, n=21, sd=0.88*). The most important need is monetary assistance for acquiring services (*mean=3.2, median=4.0, n=20, sd=1.06*). (See Figure 4-17.)

Caregivers of seniors who do have a disability agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.92, median=3.0, n=73, sd=0.88*). The most important of these needs is for temporary relief from caregiver duties (respite) (*mean=3.22, median=4.0, n=68, sd=1.14*), followed by monetary assistance for acquiring services (*mean=3.10, median=4.0, n=71, sd=1.1*). (See Figure 4-17.)

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=2.58, median=2.5, n=22, sd=1.02*). The most important of these needs are for monetary assistance in acquiring services (*mean=3.05, median=3.5, n=20, sd=1.15*), and temporary relief from caregiver duties (respite) (*mean=2.84, median=3.0, n=19, sd=1.3*). (See Figure 4-17.)

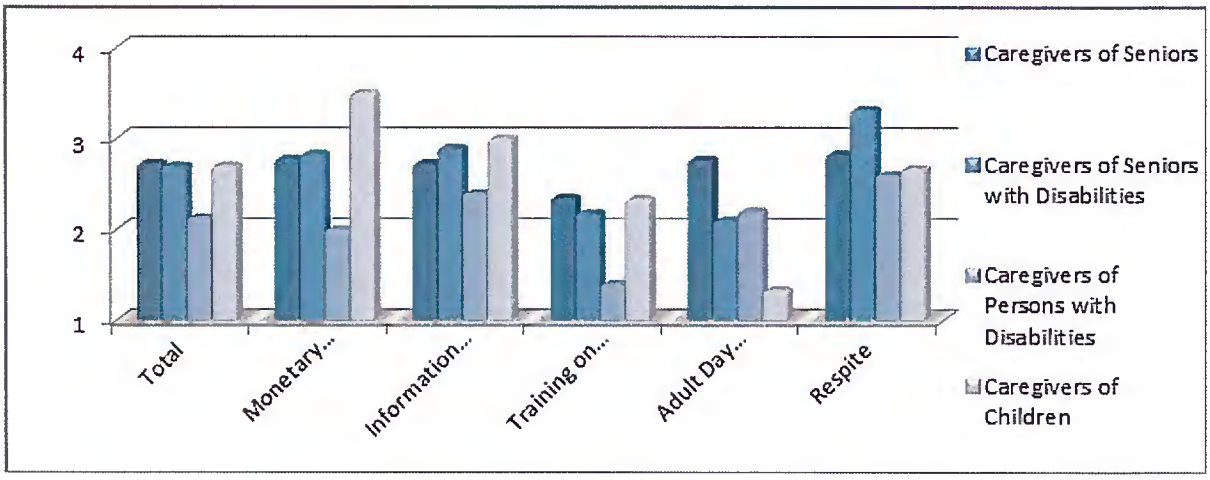
Seniors who are also caregivers of children agree that caregiver services are necessary to help them care for the individual(s) (*mean=2.66, median=2.0, n=13, sd=1.1*). The most important need is temporary relief from caregiver duties (respite) (*mean=2.92, median=3.5, n=12, sd=1.2*) for monetary assistance in acquiring services (*mean=2.85, median=3.0, n=13, sd=1.07*). Note that some of these senior caregivers of children also care for other seniors. (See Figure 4-17.)

The difference in the caregiver needs composite is not significantly different between the type of person being cared for (*F=0.964, df=3, p=0.412*) due to the fact that the overall need for these services is about the same regardless of who is being cared for. Monetary assistance and respite

are the services most needed by all types of caregivers, followed by information and referral. African Americans expressed a significantly greater need for caregiver services *(F=7.52, df=1, p=0.007).*

FIGURE 4-17: 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	**2.91**	**2.92**	**2.58**	**2.66**
Monetary Assistance	3.20	3.10	3.05	2.85
Information & Referral	2.95	3.04	2.40	2.54
Training on Caregiving	2.86	2.54	1.89	2.58
Adult Day Care	2.55	2.69	2.00	2.58
Respite	3.00	3.22	2.84	2.92



Partner/Professional Survey

Only one partner survey was completed for Region 4. This partner reported that Personal and Home Care services (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) as well as Other Supports (which consists of items related to insurance counseling, information on service eligibility, legal assistance, and caregiver supports) are very essential to helping seniors and those with disabilities remain independent. Senior Center Activities (which consists of items related to group dining services, activities and exercise, nutrition counseling, and opportunities to socialize) were reported to be only somewhat essential to helping seniors and those with disabilities remain independent.

Overall, the partner's perception of how their organization interacts with the AAA is positive. The partner is knowledgeable of the services offered, knows who is eligible to receive services,

understands how the AAA/ADRC sets priorities for which clients receive services, believes that the AAA is a critical partner for their organization, refers clients to the AAA/ADRC, stated that the services offered by the AAA/ADRC are easily accessible, and believes that there are not unmet needs for seniors, persons with disabilities, or caregivers. The partner did state that they are not aware of the AAA's strategic plan and that the clients are not able to pay part of the cost of their services. The partner agreed that the AAA/ADRC should offer providers the opportunity to contract for fixed reimbursement rates.

The most underserved areas stated were rural areas of the Midlands

The services most needed by seniors in the underserved areas are

- Transportation
- Meals on Wheels,
- Care services including daycare, in-home care, caregiver support, Medicaid Counseling

The services most needed by persons with disabilities are:

- Transportation
- Housing
- Care

Quote

> *Any service or agency that services seniors should be the last item to ever be cut in a budget. We do not have enough services now to help them now in SC, and our LTC Medicaid system is one of the poorest I have seen. With the increase of dementia and Alzheimer's, we need special focus funding on all levels for people with this disease including respite care grants, affordable daycare programs, and even a special Medicaid LTC bracket like NC has.*

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 4

Furthermore, priorities vary within the target groups in many instances depending upon demographic variables. Given this variation, service priorities need to follow priorities established by the staff and board of Region 1 following the needs identified as most important within each of the five components. This, in part will depend on where the planners wish to place their emphasis. The needs assessment for the Region provides a great deal of evidence of

what is important to each target group and to the demographic groups presently being served. It would be presumptuous of SWS to make recommendations to those responsible for the planning in the Region of which services and target populations should be emphasized. However, what the target groups believe is important is presented in the report.

Timelines for implementation are dependent upon the planning process, oversight of those conducting that process and availability of funds. SWS proposes the following timeline.

1. SWS prepare a 15-20 minute PowerPoint presentation of the findings for the Region's needs assessment after completion of the report.
2. The regional director notify SWS by October 26 if the Region would like to have a Webinar presentation of the PowerPoint.
3. The presentation be scheduled.

Discussion and Summary

As might be expected, the population in need is more poor, more female, less likely to have a spouse, older, and less well educated than the general senior population in the region. These demographic characteristics are often connected. After controlling for the underrepresentation of Richland County, it appears that of the two most heavily populated counties in the Region, this demographic description is slightly modified with a predominantly white service population in Lexington County and a predominantly African American population in Richland county. The analysis of the data indicates different needs expressed by these two populations around certain services.

Overall, respondents viewed Information, Referral, and Assistance to be the service most important to helping them stay where they are, followed by senior center activities, I-CARE (Insurance Counseling), services to help them maintain independence, caregiver services, 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, counseling (having someone to talk to), and having a senior center nearby to be the most valuable. Services to help in maintaining independence came in fifth, with the most important services being those of the Ombudsman. Personal and home care is only slightly more than a little important, with the most important of these being transportation for errands, keeping warm or cool as the weather changes, and home repairs and modifications (for both upkeep and for safety). Monetary assistance is viewed to be the least important, with the most important being help with payments for dental care or dentures and help with payments for eye exams or eyeglasses. .

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 what the age of the person(s) they are caring for is. Services to maintain independence, which is viewed as a little important to seniors who are not already receiving services, is viewed as quite a

bit important to caregivers. Needs within categories vary according to age, race and gender. 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 4 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 4 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.

Central Midlands Regional Long-Term Care Ombudsman Program

Two-Year History of Central Midlands Ombudsman Program Statistics

(And Current Stats)

Activity/Reports	2012-2013 (as of Mid-May)	2011-2012	2010-2011
Complaints	1700	2510	2738
Cases	621	862	907
Consultations	68	402	725
Trainings/Community Education	61	175	41
Resident/Family Councils	6	7	6
Facility/Routine Visits	284	522	464

Central Midlands Facility/Bed Statistics

The Ombudsman Program is responsible for 115 facilities and 6,751 beds.

FAIRFIELD COUNTY					
	CRCF	Nursing Homes	Rehab	Private Psych	Total
Facilities	1	2	-	-	3
Beds	20	262	-	-	282

LEXINGTON COUNTY					
	CRCF	Nursing Homes	Rehab	Private Psych	Total
Facilities	24	9	-	1	34
Beds	1,290	1,154	-	98	2,542

NEWBERRY COUNTY					
	CRCF	Nursing Homes	Rehab	Private Psych	Total
Facilities	2	2	-	-	4
Beds	80	264	-	-	344

RICHLAND COUNTY						
	CRCF	Nursing Homes	Rehab	Private Psych	DDSN	Total
Facilities	57	13	1	2	1	74
Beds	1,249	1,740	96	154	344	3,583

Sharon Seago

From: adrc-tae@lewin.com
Sent: Tuesday, April 30, 2013 4:03 PM
To: Sharon Seago
Subject: Your ADRC National Evaluation Survey Report for Central Midlands Aging and Disability Resource Center in South Carolina has been submitted to ACL

The ADRC National Evaluation Survey Report for Central Midlands Aging and Disability Resource Center in South Carolina has been submitted to ACL by sseago.

If you feel that the report was submitted in error, please contact the ADRC-TAE team as soon as possible.

Thank you very much.
The ADRC-TAE Team

APPENDIX D

Aging & Disability ResourceCenter
An initiative of the U.S. Department of Health and Human Services

TECHNICAL ASSISTANCE EXCHANGE

Submit National Evaluation Survey

Your National Evaluation Survey Report for Central Midlands Aging and Disability Resource Center was successfully submitted! Thank you for your time!

Return to the Report Start Page

ADRC National Evaluation Survey

Report for South Carolina.

Local Report for Central Midlands Aging and Disability Resource Center

Section A. Baseline Characteristics

1. Has your organization realized an improvement in ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community) since the start of the ADRC grant?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

2. Which have had the most positive impact on your organization's ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community)? (Select up to two)

- ☒ Partnerships developed/expanded
- ☐ Staffing changes
- ☐ Shared data
- ☐ Focus on providing person-centered, self-directed services
- ☐ Other, please specify

Specify Other:
☐

3. Which of the following best describes the reason your site became an ADRC?

To better integrate service provision systems	To develop or strengthen agency/organizational partnerships	To improve data or IT infrastructure	To improve marketing or awareness efforts related to Long Term Care Services and Supports (LTSS)	To expand services to additional populations	To expand services to additional geographic locations	Other, please specify
○	◉	○	○	○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

4. Please indicate the extent to which Federal (AoA/CMS) grants have enabled your ADRC to realize any of the following outcomes... (Select all that apply)

	Very much	Somewhat	Very little
...increase the skills of existing staff	○	◉	○
... recruit or attract more experienced staff	○	◉	○
... increase/expand populations served	○	○	◉
... increase the number of consumers served	○	○	◉
... increase the number of partnerships	○	◉	○
... increase range of services offered	○	○	◉
... make other changes (please specify)	○	○	◉

Specify Other:
☐

Click here to clear all radio buttons in the question above.

5. How has the ADRC grant(s) affected the resources or resource allocation at your organization or within your state? [IF THERE IS MORE THAN ONE ADRC IN THE STATE CHECK THE BOX IF THE ITEM IS TRUE OF AT LEAST ONE ADRC] (Check all that apply)

	At the Site or Local Level	At the State Level
Helped us leverage other funds	☐	☐
Improved staff training opportunities	☐	☐
Increased service efficiency	☐	☐

ADRC National Evaluation Survey

Report for South Carolina.

Local Report for Central Midlands Aging and Disability Resource Center

Section A. Baseline Characteristics

1. Has your organization realized an improvement in ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community) since the start of the ADRC grant?

Yes	No
○	◉

Click here to clear all radio buttons in the question above.

2. Which have had the most positive impact on your organization's ability to provide integrated, comprehensive access to long-term care services and supports (e.g., provide one-stop or streamlined benefits access, increase awareness of LTSS options, provide assistance to consumers such as counseling regarding LTSS choices or transitions from institutions back into the community)? (Select up to two)

- ☐ Partnerships developed/expanded
- ☐ Staffing changes
- ☐ Shared data
- ☐ Focus on providing person-centered, self-directed services
- ☐ Other, please specify

Specify Other:
☐

3. Which of the following best describes the reason your site became an ADRC?

To better integrate service provision systems	To develop or strengthen agency/organizational partnerships	To improve data or IT infrastructure	To improve marketing or awareness efforts related to Long Term Care Services and Supports (LTSS)	To expand services to additional populations	To expand services to additional geographic locations	Other, please specify
○	◉	○	○	○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

4. Please indicate the extent to which Federal (AoA/CMS) grants have enabled your ADRC to realize any of the following outcomes... (Select all that apply)

	Very much	Somewhat	Very little
...increase the skills of existing staff	○	◉	○
... recruit or attract more experienced staff	○	◉	○
... increase/expand populations served	○	○	◉
... increase the number of consumers served	○	○	◉
... increase the number of partnerships	○	◉	○
... increase range of services offered	○	○	◉
... make other changes (please specify)	○	○	◉

Specify Other:
☐

Click here to clear all radio buttons in the question above.

5. How has the ADRC grant(s) affected the resources or resource allocation at your organization or within your state? [IF THERE IS MORE THAN ONE ADRC IN THE STATE CHECK THE BOX IF THE ITEM IS TRUE OF AT LEAST ONE ADRC] (Check all that apply)

	At the Site or Local Level	At the State Level
Helped us leverage other funds	☐	☐
Improved staff training opportunities	☐	☐
Increased service efficiency	☐	☐

Contributed to the development of a statewide database of LTSS services and/or consumers	☐	☒
Promoted the development of standard operating procedures	☐	☐
Increased the level of coordination between organizations serving older individuals and individuals with disabilities	☒	☐
Improved awareness/marketing campaigns/activities	☐	☐

Section B. Populations Served

For the following items, please indicate the demographic composition of your service area. (This question applies to the community that Central Midlands Aging and Disability Resource Center serves)

6. Latino/Hispanic Origin

5.1 Yes %

☐ No %

7. Race

59.6 Caucasian/White %

33.9 Black or African American %

0.4 American Indian or Alaska Native %

1.8 Asian %

4.3 Nation Hawaiian or Other Pacific Islander %

8. If you have one or more significant racial/ethnic sub-populations in your service area please list it here:

Caucasian/White / Black or African American

9. What percentage of your service area is living at or below the poverty line?

At or below the poverty line %	Not sure, but a significant population lives under the poverty line	Not sure, but the population is small or negligible
◉	○	○

Specify Percentage:

Fairfield 5,295; Lexington 3,243; Newberry 7,317 and Richland 66,542

Click here to clear all radio buttons in the question above.

10. What percentage of your service area is uninsured/does not have health insurance coverage?

Uninsured %	Not sure, but a significant population is uninsured	Not sure, but the population is small or negligible
◉	○	○

Specify Percentage:

Fairfield 18.6%; Lexington 18%; Newberry 22.6% and Richland 16.7%

Click here to clear all radio buttons in the question above.

11. Within the last 12 months, has a community LTSS needs assessment been conducted?

Yes	No, but we did complete a community needs assessment within the past three years	No, a community needs assessment was not completed within the past three years
○	○	◉

Click here to clear all radio buttons in the question above.

This next set of questions is designed to gather information about the conditions in your service area.

12. Community Needs

Barriers to receiving Long Term Supports and Services

To what extent is each of the following a barrier for individuals seeking Long Term Supports and Services both prior to receiving an ADRC grant and currently?

	Prior	Currently
Lack of Long Term Supports and Services--Needed services are not offered	Often a Barrier	Often a Barrier
Lack of available Long Term Supports and Service slots--(e.g., There are long waitlists)	Often a Barrier	Often a Barrier
Poor service quality	Often a Barrier	Often a Barrier
Lack of health insurance	Often a Barrier	Often a Barrier
Providers not accepting consumers with Medicaid	Often a Barrier	Often a Barrier
Barriers based on consumer disabilities	Sometimes a Barrier	Sometimes a Barrier

Language barriers	Sometimes a Barrier	Sometimes a Barrier
Cultural barriers	Sometimes a Barrier	Sometimes a Barrier
Religious barriers	Sometimes a Barrier	Sometimes a Barrier
Sexual orientation barriers	Sometimes a Barrier	Sometimes a Barrier
People needing services do not have a permanent address	Sometimes a Barrier	Sometimes a Barrier
Consumers lack transportation	Often a Barrier	Often a Barrier
Stigma, discrimination and prejudice against older adults	Sometimes a Barrier	Sometimes a Barrier
Stigma, discrimination and prejudice against persons with disabilities	Sometimes a Barrier	Sometimes a Barrier
Providers have high staff turnover	Not a Barrier	Not a Barrier
Providers lack appropriately trained staff	Sometimes a Barrier	Sometimes a Barrier
Service provider hours/locations are hard to access	Not a Barrier	Not a Barrier
Other Please specify:	Please Select	Please Select

Specify Other:
☐

Section B. Populations Served, Continued

13. Service Availability/Choice

	Please indicate the Current availability of the following services within your service area	For the following services, to what extent is there provider choice? (Approximately 8 years ago or if you do not have information that goes back that far, as far back as you do have information)	For the following services, to what extent is there provider choice? (Currently)
Safe and affordable housing options	Available but inadequate to meet need	No	No
Peer support services/groups	Available but inadequate to meet need	Limited	Limited

HCBS Medicaid Waiver Programs	Available but inadequate to meet need	Limited	Limited
Caregiver Support (i.e. respite programs, support groups, or counseling)	Available but inadequate to meet need	Limited	Limited
Nutrition Programs	Available but inadequate to meet need	Limited	Limited
Employment services	Available but inadequate to meet need	Limited	Limited
Education services	Available but inadequate to meet need	Limited	Limited
Opportunities to develop advanced directives	Available but inadequate to meet need	Limited	Limited
Transportation services	Available but inadequate to meet need	Limited	Limited
Opportunities for socialization/recreation	Available but inadequate to meet need	Limited	Limited
Mental health services	Available but inadequate to meet need	Limited	Limited
Ombudsman services	Adequate availability	Adequate	Adequate
Health prevention and screening services	Available but inadequate to meet need	Limited	Limited
Services for emergent cases/Crisis intervention	Available but inadequate to meet need	Limited	Limited
Transition programs (from hospitals, nursing homes etc.)	Available but inadequate to meet need	Limited	Limited
Nursing home (institutional) diversion programs	Available but inadequate to meet need	Limited	Limited
Nursing home/residential beds	Available but inadequate to meet need	Limited	Limited
Income assistance	Available but inadequate to meet need	Limited	Limited
Energy assistance	Available but inadequate to meet need	Limited	Limited
Personal care services	Available but inadequate to meet need	Limited	Limited
Medicaid waivers	Available but inadequate to meet need	Limited	Limited
Independent Living services (e.g., skills training, peer support)	Available but inadequate to meet need	Limited	Limited
Other, please specify	Please Select	Please Select	Please Select

Specify Other:
☐

Section B. Populations Served, Continued

14. How many consumers of each type were served in the most recent 6 month period (October 2012-March 2013) NOTE: This question is specific to the consumers who access Central Midlands Aging and Disability Resource Center services such as I&R/I&A, benefits or options counseling, Information and referral services, services to support transitions from residential or institutional facilities to the community.

Number of Older Adults (60+) Total [1308]

15. How many consumers of each type were served in the most recent 6 month period (October 2012-March 2013) NOTE: This question is specific to the consumers who access Central Midlands Aging and Disability Resource Center services such as I&R/I&A, benefits or options counseling, Information and referral services, services to support transitions from residential or institutional facilities to the community.

	Consumers under 60 (Currently)	Consumers 60 and over (Currently)
Individuals with Disabilities		
Physical disabilities	[54]	[218]
Cognitive impairment	[3]	[44]
Intellectual disabilities	☐	☐
Developmental disabilities	☐	☐
Mental Illness	[16]	[15]
Multiple disabilities	[43]	[130]
Caregivers		
Informal/family caregiver	[16]	[42]
Paid Caregiver	☐	☐
Health & Human Service Professional (e.g., physician, hospital discharge planner, nursing home staff)	[13]	[39]
Special Subpopulations		
Traumatic Brain Injury (TBI)	[2]	☐
Emergent/Emergency Cases	☐	☐
Low income	[156]	[392]
Limited English proficiency	☐	[6]
Is the Central Midlands Aging and Disability Resource Center making any special efforts to target a particular population not listed above? If yes, please specify.		
Other (Please specify)	☐	[:Alianza Latina Interagency Meetings:::]

Specify Other:
☐

Other (Please specify) ☐ ☐

Specify Other:
☐

16. Since the start of the ADRC grant, the number of clients under 60 served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

17. Since the start of the ADRC grant, the number of consumers 60 and over served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

18. Since the start of the ADRC grant, the number of consumers with physical disabilities served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

19. Since the start of the ADRC grant, the number of consumers with mental/emotional disabilities served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

20. Since the start of the ADRC grant, the number of consumers with multiple disabilities served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

21. Since the start of the ADRC grant, the number of caregivers served by Central Midlands Aging and Disability Resource Center has:

Significantly increased	Significantly decreased	Stayed the same
◉	○	○

Click here to clear all radio buttons in the question above.

Section C. Service Provision

These questions are about the services provided by your organization/network

22. How frequently do consumers ask about the following? For each, indicate "frequently," "sometimes," "infrequently", or "never."

Topic	Frequency of consumer inquiry:
Advanced directives	Infrequently
Advocacy	Infrequently
Caregiver support	Sometimes
Respite services	Sometimes
Chronic health conditions	Sometimes
Education	Infrequently
Employment	Sometimes
Energy assistance	Frequently
Home modification	Frequently
Affordable housing	Frequently
Income assistance	Frequently
Medicaid eligibility and services	Sometimes
Medicare eligibility and services	Sometimes
Mental/behavioral health services	Sometimes
Nutrition services	Sometimes
Ombudsman/abuse or neglect issues	Sometimes
Independent living services	Frequently
Personal care/attendant care services	Frequently
Preventative health services	Frequently
Recreation opportunities	Sometimes
Services for emergent care/crisis intervention	Sometimes
Support groups	Infrequently
Transition services	Infrequently
Transportation	Frequently

Other, please specify | Frequently

Specify Other:
Dental, Vision and Hearing assistance

23. Does Central Midlands Aging and Disability Resource Center engage in advocacy activities for older adults?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

24. Does Central Midlands Aging and Disability Resource Center engage in advocacy activities for persons with disabilities?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

25. Is diversion from nursing homes or other institutional residential facilities an outcome sought to be achieved?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

26. How is Central Midlands Aging and Disability Resource Center measuring and tracking this?

Staff track using a standard electronic system	Staff track using a standard hardcopy/paper system	An external group (e.g., an evaluator, auditor) tracks using a standard system	Staff track using an informal system	Other, please specify
○	○	○	◉	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

CARE COORDINATION/TRANSITION ASSISTANCE PROGRAMS

27. Does your organization provide transition services to consumers discharged from an acute care setting?

Yes	No
○	◉

Click here to clear all radio buttons in the question above.

28. Care Coordination/Transition Assistance

	Central Midlands Aging and Disability Resource Center Clients Provided Care Coordination/Transition Assistance
Number individuals assisted with transition from hospital ONLY through formal care transitions program (evidence-based CT intervention or innovative model)	☐
Number of participants carried over from last 6 months (October 2012-March 2013) (started program within last 6 months and continued with the intervention)	☐
Number of participants whose cases were closed during the last 6 months (October 2012-March 2013) (i.e., participants whose transition services were ended either bacause of a readmission or new admission to a care facility or because the transition period ended)	☐
Number of participants that readmitted within 30 days of discharge	☐
Number of participants that readmitted within 30 days and re-entered the care transition program	☐

29. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program in this Central Midlands Aging and Disability Resource Center program service area in the past 6 months (October 2012-March 2013) by participating hospital?

☐ Name of Hospital 1
☐ No. of Individuals for Hospital 1
☐ Name of Hospital 2
☐ No. of Individuals for Hospital 2
☐ Name of Hospital 3
☐ No. of Individuals for Hospital 3

30. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Central Midlands Aging and Disability Resource Center program service area in the past 6 months (October 2012-March 2013) by age group?

☐ Aged 60 and Over
☐ Under Age 60

☐ Age Unknown

31. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Central Midlands Aging and Disability Resource Center program service area in the past 6 months (October 2012-March 2013) by health insurance source?

☐ Medicare
☐ Medicaid
☐ Dual-Eligible
☐ No insurance
☐ Private insurance
☐ Veterans Administration Services
☐ Other

32. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Central Midlands Aging and Disability Resource Center program service area in in the past 6 months (October 2012-March 2013) who were referred to one or more health/prevention programs?

☐ Chronic Disease Self Management Program
☐ Diabetes Self Management Program
☐ Exercise Program
☐ Mental Health and Substance Misuse
☐ Falls Management and Prevention
☐ Alzheimer's Programs
☐ Medication Management
☐ Home Injury/Risk Screenings
☐ Other

33. What is the number of individuals who were assisted with transitioning from the hospital through a formal care transition intervention program across all participating hospitals in this Central Midlands Aging and Disability Resource Center program service area in the past 6 months (October 2012-March 2013) that were referred to one or more of the following long term services or supports?

12 Additional Options Counseling
☐ Home delivered meals
☐ Nutrition services or nutrition counseling
☐ Care giver support
☐ Personal care/homemaker/choremaker services
☐ Transportation

34. Do you have a marketing plan?

Yes, our marketing plan is operational	Yes, we have a plan but it is not yet operational	No, we do not have a plan at this time

○ ○ ◉

Click here to clear all radio buttons in the question above.

35. Does Central Midlands Aging and Disability Resource Center utilize a standard operating procedure to assess consumer need?

Always	Sometimes	Never
○	◉	○

Click here to clear all radio buttons in the question above.

36. Is the consumer assessment tool and/or basic consumer needs assessment process common across partner organizations?

Yes, common across all partners	Yes, common across some partners	No, each partner organization uses their own assessment tool/process
○	○	◉

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

OPTIONS COUNSELING OR OTHER ONE ON ONE COUNSELING

37. Does your organization/network provide "Options Counseling" or other one-on-one counseling designed to support consumers' ability to make informed decisions about their long-term care?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

38. Referrals to Public and Private Services in the past 6 months (October 2012-March 2013)

	Referrals to Public and Private Services this Reporting Period
What is the number of Central Midlands Aging and Disability Resource Center clients referred to or given an application for a public program, including Older Americans Act; Medicare; Medicaid; Food Stamps; TANF; Social Security (SSI or SSDI); LI-HEAP; VDHCBS; Other State-funded and county-funded programs for Medicaid; Other?	195

What is the number of Central Midlands Aging and Disability Resource Center clients referred to some other type of service (non-public services, resources or program)?	172
What is the number of Central Midlands Aging and Disability Resource Center clients that were not referred to any type of service?	1862
What is the number of Central Midlands Aging and Disability Resource Center Unknown Clients (remainder of all Clients)?	☐
Total	2183

39. Clients Provided Options Counseling in the past 6 months (October 2012-March 2013)

Central Midlands Aging and Disability Resource Center Clients Provided Options Counseling By Age	
Central Midlands Aging and Disability Resource Center Clients Aged 60 and Over	1179
Central Midlands Aging and Disability Resource Center Clients Under Age 60	324
Central Midlands Aging and Disability Resource Center Clients Age Unknown	209
Total	1712
Central Midlands Aging and Disability Resource Center Clients Provided Options Counseling by Method	
In person	12
By phone	1688
Electronic Communication (e.g. email or website chat)	12
Total	1712
Central Midlands Aging and Disability Resource Center Clients Provided Options Counseling by Setting	
Central Midlands Aging and Disability Resource Center	1712
Hospital	☐
Nursing facility/Institution	☐
At the client's community residence	☐
Other	☐
Total	1712
Client Feedback About Options Counseling	
What is the number of Central Midlands Aging and Disability Resource Center Clients who report that options counseling enabled them to make well informed decisions about their long term support services?	☐
What is the number of Central Midlands Aging and Disability Resource Center Clients surveyed this reporting period?	☐

40. Does Central Midlands Aging and Disability Resource Center or network have a standardized tool or process to provide options counseling?

Yes	No	Do not know	Not applicable
○	◉	○	○

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

PUBLIC PROGRAMS

41. Average Monthly Public LTSS Program Enrollment in WHOLE Central Midlands Aging and Disability Resource Center SERVICE AREA

This set of questions is asking about all current enrollment levels in these programs in the Central Midlands Aging and Disability Resource Center service area. Enrollment fluctuates from month to month, so please calculate the average enrollment per month during the last 6 months.

	Average Monthly Public LTSS Program Enrollment in WHOLE Central Midlands Aging and Disability Resource Center SERVICE AREA
What is the average number of individuals enrolled in Medicaid HCBS Waivers in Central Midlands Aging and Disability Resource Center Service Area each month (should include Central Midlands Aging and Disability Resource Center Clients and might include Non-Central Midlands Aging and Disability Resource Center Clients)?	☐
What is the average number of individuals enrolled in Medicaid residing in institutions in Central Midlands Aging and Disability Resource Center Service Area each month (should include Central Midlands Aging and Disability Resource Center Clients and might include Non-Central Midlands Aging and Disability Resource Center Clients)?	☐
What is the average number of individuals enrolled in other public LTSS programs in Central Midlands Aging and Disability Resource Center Service Area each month (should include Central Midlands Aging and Disability Resource Center Clients and might include Non-Central Midlands Aging and Disability Resource Center Clients)?	☐

42. Please list LTSS programs and HCBS waivers (e.g. aged and disabled, MR/DD) that individuals are enrolled in.

☐

43. Total New Enrollment among Central Midlands Aging and Disability Resource Center CLIENTS ONLY in Public LTSS Programs

This set of questions is asking about the absolute number of Central Midlands Aging and Disability Resource Center clients who were newly enrolled into these programs during the past 6 months (October 2012-March 2013).

	Total New Enrollment among Central Midlands Aging and Disability Resource Center CLIENTS ONLY in Public LTSS Programs
What is the number of Central Midlands Aging and Disability Resource Center Clients who are newly enrolled into a Medicaid HCBS Waiver (including individuals enrolled by Central Midlands Aging and Disability Resource Center staff and individuals referred for assessment/application by Central Midlands Aging and Disability Resource Center staff)?	☐
What is the number of Central Midlands Aging and Disability Resource Center Clients who are newly enrolled into Medicaid institutional services (including individuals enrolled by Central Midlands Aging and Disability Resource Center staff and individuals referred for assessment/application by Central Midlands Aging and Disability Resource Center staff)?	☐
What is the total number of clients newly enrolled in other public LTSS programs in Central Midlands Aging and Disability Resource Center Service Area each month (should include Central Midlands Aging and Disability Resource Center Clients and might include Non-Central Midlands Aging and Disability Resource Center Clients)?	☐

44. Please list LTSS programs and HCBS waivers (e.g. aged and disabled, MR/DD) that individuals are enrolled in.

☐

45. For data collected on consumers, are staff required to follow the Alliance of Information and Referral Systems (AIRS) standards (Standard 13: Inquirer Data Collection)?

Yes with all consumers	Yes, with specific groups of consumers--Please specify:	Never
◉	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

46. Does Central Midlands Aging and Disability Resource Center have a database/MIS that does any of the following (Select all that apply)?

- ☒ Track consumer requests for information and referrals
- ☒ Track referrals made to consumers
- ☒ Maintain records on individual consumers
- ☒ Maintain a list of services/service providers

☐ Links to other databases (e.g., Medicaid waiver tracking systems, Money Follows the Person tracking system). If yes, specify:

Specify Other:
☐

☐ Other, please specify

Specify Other:
☐

47. Do operational partners have access to data they need for their operations such as data about your consumers/services? If yes, for what purpose? (review client information, input client demographic information, input referrals, input service utilization information, review client service utilization, obtain summary reports on clients and/or services)

Yes	No, but there are plans to develop that capacity	No, and there are no current plans to do this
○	○	◉

Specify Purpose:
☐

Click here to clear all radio buttons in the question above.

Section C. Service Provision, Continued

48. Do service providers have access to data about your consumers? If yes, for what purpose? (review client information, input client demographic information, input referrals, input service utilization information, review client service utilization, obtain summary reports on clients and/or services)

Yes (Specify)	No, but there are plans to develop that capacity	No, and there are no current plans to do this
○	○	◉

Specify Purpose:
☐

Click here to clear all radio buttons in the question above.

49. Do staff follow up with consumers after their initial contact with your organization?

Always	Sometimes--Under what circumstances:	Never
○	◉	○

Specify Circumstances:
Safety

Click here to clear all radio buttons in the question above.

50. How many times does staff follow up with consumers after their initial contact with your organization?

Once	Multiple times
◉	○

Click here to clear all radio buttons in the question above.

51. What is the approximate timing of the first follow up with consumers after their initial contact with your organization?

One to two weeks after service	Three weeks after service	One to two months after service	Three to five months after service	Six months after service	One year or longer after service
◉	○	○	○	○	○

Click here to clear all radio buttons in the question above.

52. What is the approximate timing of the last follow up with consumers after their initial contact with your organization?

One week after service	Two weeks after service	Three weeks after service	One to two months after service	Three to five months after service	Six months after service	One year or longer after service
◉	○	○	○	○	○	○

Click here to clear all radio buttons in the question above.

53. When consumers are referred to other agencies or organizations, are those providers contacted as part of the follow up procedure?

Always	Sometimes-Under what circumstances:	Never
○	○	◉

Specify Circumstances:
☐

Click here to clear all radio buttons in the question above.

54. Approximately what percentage of consumers who are referred to other organizations receive a "warm transfer" (e.g., Simultaneous transfer of a telephone call and its associated data from one agent to another agent or supervisor)?

☐

55. Does your organization routinely collect quantitative performance data about its services and consumers?

Yes	No
◉	○

Click here to clear all radio buttons in the question above.

56. Indicate any of the ways that your organization uses performance data: [check all that apply]

- ☒ To justify funding requests
- ☒ To improve consumer service
- ☒ To administer service provider contracts
- ☒ To provide information to stakeholders (governing board, advocacy organizations, local government, etc.)
- ☒ For program planning
- ☐ Do not use performance data

57. On which topics, if any, would you like to receive additional assistance from the technical assistance provider?

☐

Section C. Service Provision, Continued

Eligibility Screening Module: Initial Screening of ADRC Clients

58. When a client contacts the ADRC about long-term services and supports (LTSS), do ADRC staff administer a screening questionnaire to make a preliminary determination of eligibility and need for publicly-funded LTSS?

Yes	No	Other, please describe
○	◉	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

59. If yes, to which of the following populations is the eligibility screening instrument administered ? Check all that apply.

- ☐ Aged 65 and older
- ☐ Physical disability
- ☐ Intellectual Disability/Developmental Disability
- ☐ Brain injury
- ☐ HIV/AIDS
- ☐ Medically fragile
- ☐ Autism
- ☐ Mental illness
- ☐ Other (specify _____)

Specify Other:
☐

60. What kind of information is collected? Check all that apply.

- ☐ Demographic information (i.e., age, gender, ethnicity, marital status)
- ☐ Living arrangements
- ☐ Caregivers
- ☐ Health status
- ☐ Activities of daily living (ADL)
- ☐ Instrumental activities of daily living(IADL)
- ☐ Cognitive functions
- ☐ Troublesome behaviors
- ☐ LTSS currently received
- ☐ Income
- ☐ Assets
- ☐ Other, please list _____

Specify Other:
☐

Eligibility Screening Module: Financial Eligibility Determination

61. How do clients in your state/site complete and file applications for financial eligibility for Medicaid or publicly-funded LTSS? Check all that apply.

- ☒ Applications are accessed on-line, printed, completed by hand, and returned to a state or county office.
- ☐ Applications are accessed on-line, completed on-line, printed, and returned to a state or county office.

☐ Applications are accessed on-line, completed on-line, and submitted to the state or county electronically.

☒ Paper copy applications are obtained at various locations including ____ [SPECIFY LOCATIONS], completed by hand, and returned either in person or by mail to a state or county office.

Specify Locations:

Local office of DHHS

☐ Other

Specify Other:
☐

62. In what ways do ADRC staff assist clients with financial eligibility applications for Medicaid LTSS Programs? Check all that apply.

☐ We do not assist clients with financial eligibility applications
☒ Advise the client where s/he can obtain an application
☐ Assist the client in completing the application
☐ Assist the client in collecting the required financial documentation
☐ Check on the status of the client's application
☐ Notify the client when the application has been approved/disapproved
☐ Manage appeals by clients whose applications were not approved
☐ Other

Specify Other:
☐

63. In what ways do ADRC staff assist clients with financial eligibility applications for publicly-funded LTSS other than Medicaid LTSS? Check all that apply.

☐ We do not assist clients with financial eligibility applications
☒ Advise the client where s/he can obtain an application
☐ Assist the client in completing the application
☐ Assist the client in collecting the required financial documentation
☐ Check on the status of the client's application
☐ Notify the client when the application has been approved/disapproved
☐ Manage appeals by clients whose applications were not approved
☐ Other

Specify Other:
☐

64. Please describe the publicly funded LTSS services in your state. This includes LTSS programs funded solely by state or county

☐

65. Does your state/site permit presumptive financial eligibility in order to expedite the provision of LTSS to clients while their financial eligibility applications are being processed?

Yes	No	In Progress
○	○	○

Click here to clear all radio buttons in the question above.

Eligibility Screening Module: Functional Assessment

66. Does your state/site use a universal, comprehensive assessment instrument for functional (level of care) eligibility determinations for LTSS?

Yes	No	No, but in development
◉	○	○

Click here to clear all radio buttons in the question above.

67. If yes, what best describes the kind of instrument your state/site is using? Check one.

A custom-designed instrument developed by state staff	A custom-designed instrument developed by a vendor specifically for our state	An instrument developed by a vendor that is also used by other states	Other, please list:
○	○	○	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

68. What best describes the process for how the assessor completes the instrument? Check all that apply.

- ☐ The assessor completes a paper form while interviewing the client; there is no electronic data entry.
- ☐ The assessor completes a paper form while interviewing the client and later inputs the data on an electronic form at the office.
- ☐ The assessor completes an electronic form while interviewing the client, which is later downloaded into an electronic database.

☐ The assessor completes a web-based form while interviewing the client and the client's data is entered "real time" into an electronic database.

69. Do you work with consumers to develop a care plan?

Yes, with all consumers	Yes under certain circumstances (Please specify)	No, that is not part of this service
○	○	◉

Specify Other:
☐

Click here to clear all radio buttons in the question above.

70. For which of the following populations is the functional assessment used? Check all that apply.

- ☐ Aged 65 and older
- ☐ Physical disability
- ☐ ID/DD
- ☐ Brain injury
- ☐ HIV/AIDS
- ☐ Medically fragile
- ☐ Autism
- ☐ Mental illness
- ☐ Other

Specify Other:
☐

The Affordable Care Act requires states to implement Health Insurance Exchanges effective January 1, 2014. States are required to provide a single electronic portal for "real time" financial eligibility determinations for Medicaid and Qualified Health Plans offered through the Exchange.

71. Is your organization involved in planning for your state's Exchange?

Yes	No	Not sure
○	◉	○

If Yes, please describe your organization's role:
☐

Click here to clear all radio buttons in the question above.

72. Is your state/site examining ways to align functional eligibility determination for publicly-funded LTSS with Medicaid financial eligibility determination carried out through the Exchange website?

Yes	No	Not Sure
○	○	○

If Yes, please describe:
☐

Click here to clear all radio buttons in the question above.

73. Are any of your organization's functions reimbursed under Federal financial participation (FFP) or Federal medical assistance percentage (FMAP)? If so please specify the functions.

☐ No, none of our functions are reimbursed under FFP or FMAP
☐ Yes, the following functions are reimbursed under FFP

Specify Functions:
☐
☐ Yes, the following functions are reimbursed under FMAP

Specify Functions:
☐

Section D. Organizational Characteristics

74. For the current Fiscal Year, what is the approximate amount of funding from each of the following sources? (In $ amounts)

"Amount of funding during the current Fiscal Year" refers to the FY13 share of a grant awarded in FY13 (not the total grant) and if an existing grant, the funds allotted in FY13.

Check if you have received funding in prior Fiscal Years	Amount of funding during the current Fiscal Year	Funding source

☒	00.00	Administration on Aging Title IV ADRC Grant
☐	☐	Administration of Aging Title II Grant
☐	☐	CMS Real Choice Systems Change Grants
☐	☐	CMS Person-Centered Hospital Discharge Planning Grant
☐	☐	Patient protection and Affordable Care Act Grant
☐	☐	Veteran's Administration
☐	☐	Money Follows the Person Demonstration
☐	☐	State Transformation Grant
☐	☐	Alzheimer's Disease Demonstration Grant
☐	☐	Evidence-Based Disease Prevention Grant
☐	☐	Program of All-Inclusive Care for the Elderly (PACE)
☐	☐	Medicare Improvement for Patients and Providers Act (MIPPA)
☐	☐	Respite Care Act funds
☐	☐	Rehabilitation Services Administration (RSA)
☐	☐	Substance Abuse and Mental Health Services Administration (SAMHSA) - Mental Health Transformation Grant
☐	☐	Agency for Health Care Research and Policy - Chronic Disease Self-Management Grant
☐	☐	Administration for Children and Families, Office of Community Services - Low Income Home Energy Assistance Program (LIHEAP)
☐	☐	Health Resources and Services Administration HIV/AIDS Bureau - Ryan White Fund
☒	196467.00	State Unit on Aging
☒	2934.00	State General Revenue
☒	37692.00	County of local government
☐	☐	Private entities/grants - Hospitals or other businesses
☐	☐	Medicaid for Direct Services (state and federal)
☐	☐	Medicaid for Federal Financial Participation
☐	☐	Care Transitions Income
☐	☐	Consumer Fees or Cost Sharing
☐	☐	Charitable Donations
☐	☐	Other, please specify

Specify Other for funding received in prior Fiscal Years:
☐

Specify Other:
☐

☒	237093.00	Total Budget for FY 2013

75. What best characterizes the operation of your agency?

Single-point of entry: one agency maintains a knowledgebase on LTSS options and assists consumers in making decisions about the best and most feasible options for LTSS	No wrong door: multiple agencies are knowledgeable about LTSS options and cooperate to assist consumers regardless of which agency the consumer first contacts.
○	◉

Click here to clear all radio buttons in the question above.

76. Do you identify your structure as any of the following:

Independent, non-profit	Part of city government	Part of county government	Part of COG or RPDA	Other. Specify:
○	○	○	◉	○

Specify Other:
☐

Click here to clear all radio buttons in the question above.

77. What organizations comprise the core operating organizations?

Organization	Core Operating Organization?
AAA	Yes
State Unit on Aging	Please Select
Veterans Organization	Please Select
Alzheimer's Association	Please Select
Other Aging Services Organization	Please Select
Centers for Independent Living	Please Select
Vocational Rehabilitation Departments	Please Select
Other Disability Services Organization	Please Select
Community Mental Health	Please Select
County or Regional Council of Governments	Yes
County Government Office or Agency	Please Select
Local Housing Authority	Please Select
State or Local Medicaid Agency	Please Select
211	Please Select

Other Human Services of Social Service Provider (please specify) Please Select

Specify Other:
☐

78. [FOR EACH OF THE CORE OPERATING ORGANIZATIONS]: Please describe your relationship with other core operating organizations at your site and the functionality of the site in meeting the objective of improving and streamlining access to information, assistance, and long-term services and supports for older adults, persons with disabilities, and their families. Would you describe the current status as having a solid working relationship? Please provide as much detail as possible.

The AAA/ADRC is housed at a COG. The AAA/ADRC is responsible for Information, Referral and Assistance for seniors and those adults with disabilities.

Section D. Organizational Characteristics, Continued

79. With which organizations do Central Midlands Aging and Disability Resource Center have a partnership? What is the strength of the relationship, as well as the type of partnership agreement and shared resources?

	Partner	Functionality of Partnership	Partnership Agreement	Shared Resources
State Departments (with cabinet-level secretaries):				
Health	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Human Services	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐
State Agencies (located within state departments):

Aging	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☒Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☒Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Developmental Disabilities	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Acquired or Late-Onset Disabilities	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Mental Health	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Medicaid	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Housing	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Education	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐
Local Government Agencies

Area Agency on Aging	☐	Highly functional	☐Funding Relationship ☐Formal MOU ☐Contract ☒ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
County Health Department	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☒Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

County Medicaid office	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
County Department on Aging	☐	Moderately functional/functional in some areas	☐Funding Relationship ☐Formal MOU ☒Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

County Department on Disability	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
County Housing Office	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Library	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☒Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐
Federal Agencies:

Local Veterans Administration	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Local Indian Health Service	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐

Organizations Providing Direct Services:

211 or other call center	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Community Health Clinic	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Community Mental Health Clinic	☐	Weak functionality ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Deaf Service Center	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Hospital/Medical Center	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

School for the Blind	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
School for the Deaf	☐	Please Select ▼	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

The ARC	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
United Way	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Vocational/Rehabilitation Services	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐
Advocacy/Referral Organizations:

AIDS Coalition	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources
Alzheimer's Association	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

American Council of the Blind	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Autism Society state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Brain Injury Association state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other:	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Centers for Independent Living	☐	Weak functionality	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other:	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☒No shared resources

Easter Seals	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Epilepsy Foundation state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

National Association of Mental Illness state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
National Autism Association state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

National Multiple Sclerosis Society state/regional chapter	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
State Association for the Deaf	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

United Cerebral Palsy	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources
Other (specify):	☐	Please Select	☐Funding Relationship ☐Formal MOU ☐Contract ☐ Cooperative ☐Informal Working Relationship ☐Other (Please Specify) Specify Other: ☐	☐ Co-located staff ☐Shared monetary resource ☐Information sharing ☐Joint training ☐Joint sponsorship of programs ☐Shared non-monetary resources (i.e. office space) ☐Shared data ☐No shared resources

Specify Other:
☐

Section D. Organizational Characteristics, Continued

80. Approximately how many FTEs (Full-time equivalents) perform each of the following functions?

1 I&R/I&A

☐ Options counseling/counseling to provide in-depth person centered decision support

☐ Benefits counseling/eligibility determination

- ☐ Care transition services
- ☐ Crisis intervention services
- ☐ Independent Living services
- ☐ Advocacy services
- ☐ Providing administrative or other support for the above functions

81. How many front line staff are Alliance of Information and Referral Systems (AIRS) certified?

[4] Number of AIRS certified staff

[1] Total number of front line staff

82. Is your organization paid on a fee-for-service or per-unit basis for performing any of the following services for a client? (Please check all that apply)

- ☐ Information/referral
- ☐ Options counseling
- ☐ Screening
- ☐ Assessment
- ☐ Application assistance
- ☐ Transition support
- ☐ Other, please specify

Specify Other:
☐

83. What is the source of the fee-for-service or per-unit payments?

- ☐ Medicare
- ☐ Medicaid waiver
- ☐ Medicaid state plan
- ☐ Medicaid managed care organization
- ☐ State-funded program other than Medicaid
- ☐ Private health plan
- ☐ Provider
- ☐ Other, please specify

Specify Other:
☐

Section E. LTSS Environment

84. Since Central Midlands Aging and Disability Resource Center started serving consumers, has there been an impact on the LTSS or Home and Community-Based (HCBS) system in your community?

There has been an increase in the number of LTSS providers.	There has been a decrease in the number of LTSS providers.
◉	○

Click here to clear all radio buttons in the question above.

85. Since Central Midlands Aging and Disability Resource Center started serving consumers, has there been an impact on the LTSS or Home and Community-Based (HCBS) system in your community?

There has been an increase in the quality of LTSS services.	There has been a decrease in the quality of LTSS services.
◉	○

Click here to clear all radio buttons in the question above.

86. Please add any final thoughts about Central Midlands Aging and Disability Resource Center and either its operations and/or its results

All referrals are listed in SC Access case notes. They do not seem to be reflected as the report indicates that 1862 of the 2183 clients served in past six months have not been referred. This is not accurate.

I-CARE and Senior Medicare Patrol

The Central Midlands Council of Governments Area Agency's/ADRC I-CARE program includes providing accurate information on all Medicare issues, reaching beneficiaries who need help in understanding all facets of Medicare, and reaching beneficiaries who need all the "Extra Help" programs offered by the state and the federal government. The AAA/ADRC will strengthen the partnership with the Lieutenant Governor's Office on Aging I-CARE Program to assist with training and developing community contacts. The I-CARE program will explore contacts made through involvement with the Interagency Network in Richland and Fairfield counties. The I-CARE program will continue to strengthen the relationships with the faith based community, SC Hispanic Leadership Council and other civic organizations through the development of partnerships. The I-CARE program will also continue contacts with the local libraries in the communities; one partnership with a local library has already been established. With these resources, we should be able to reach some of the underserved populations.

The I-CARE/SMP program will work with other departments such as IRA, Family Caregiver, and Ombudsman to increase one on one contact. The 2012 Medicare & You newsletter was distributed at health fairs, presentations, one on one contact via face to face at counseling locations as well as through the US mail. This newsletter was developed for Open Enrollment to inform Medicare beneficiaries and family members regarding changes to Medicare for 2013 and also included information regarding Flu Prevention, along with fraud information. Approximately 1500 newsletters were distributed. Staff utilized the prevention benefits though the "Your Guide to Medicare's Preventive Services" booklet this information is discussed during presentations and the given to each participant. This publication is also distributed at our booth at all of our health fairs. This publication continues to be mailed to individuals during Open Enrollment and other SEP enrollments. The new prevention guidelines for 2013 will also be included in all activities. Fraud information is always a part of our presentations and booths. Information about fraud is included with the packet people get during enrollments. This agency does include prevention and fraud prevention in all aspects of service delivery. All mailings have a fraud brochure included. The prevention booklet is especially given to people who are new to Medicare. Information about pre-existing condition plans has not been included as yet in presentations or booths. Information is given out to one on one contacts as requested. This region is looking for information and needing some more training on this topic. Some materials on this topic have been ordered.

to keep us posted on new fraud trends in the community as well as work closely with the LGOA. We are in the process of sending out posters and brochures about the SMP program to churches, nonprofits, clinics, senior housing and senior centers to inform them of our services and ability to come their sites to conduct programs such as the Savvy Seniors informational guide. We are also exploring the idea of having the COA's input articles into their newsletters about fraud and scams. We will also hold a Medicare Fraud luncheon to educate volunteers on different fraud trends.

Additionally, we have promotional items that are used at all of our events, such as pens, plastic bottles, collapsible cups, water bottles and hand sanitizer with SMP/Senior Medicare Patrol imprinted on them. We also use the Personal Journals that we distribute at presentations and health fairs along with the SMP brochure and the Medicare folder with the fraud message for Medicare Plan Finder information that we mail out with each client contact and any other information as related to Medicare and we utilize the SMP Stop Health Care Fraud tip sheet from Smart Facts.

SMP Progress Report Guidelines
for
7/1/2012 thru 12/31/2012

Region Central Midlands

The SMP Grant is to support regions in achieving the following AOA outcomes. Please list your goals and describe activities to implement key requirements of the program.

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

   We use the Personal Journals that we give out at presentations and health fairs, we also use the Medicare folder with the fraud message for Medicare Plan Finder information that we mail out with each client contact as well as the SMP brochure when we do Plan Finders, Needy Meds any other information as related to Medicare. We continue to use the plastic bags with a printed fraud message for health fairs and presentations which we provide information about SMP. Our SMP brochure is included in every folder and bag that describes the SMP Program. We have copied the SMP Stop Health Care Fraud tip sheet from Smart Facts which is included in the bags that are distributed at health fairs, presentations etc as well as the poster from Smart Facts which we mail to the senior centers to be posted and some libraries that will allow us to post our information. We also distributed the CMS Fraud Prevention Initiative, and the Help Prevent Fraud worksheets at all presentations and health fairs.
   We have promotional items such as pens, collapsible cups and water bottles that we use at all presentations and health fairs. We also had a blurb in the Medicare Update Fall 2012.

   What were your regional marketing activities? Same as above

   Describe all efforts with the National SMP program such as webinars, ordering materials, etc.

   We ordered pens, collapsible cups, plastic bags and water bottles with SMP/Senior Medicare Patrol imprinted on them.

APPENDIX F

2. ***What did you do to improve beneficiary education and Inquiry resolution?***

Education: We have the SMP program component in all of our I-CARE presentations and at all of the health fairs. When someone wants to report an incident, we take the call and consult with the LGOA. A consent form is sent to the individual to request assistance if further investigation is required. When the form is returned, the complaint information and consent form is sent to the LGOA for further review.

Simple Inquiries: None since May 2012

Complex Inquiries: There were several that was forwarded over to the LGOA. They involved agents signing beneficiaries into unwanted plans, one involved beneficiary being solicited in hospital regarding DME equipment.

Include numbers served through Simple, Complex, Media and Group Education. List follow-ups, resolution process and intake process.

Are inquiries entered into SMART-Facts bi-weekly yes? If not, why?

3. ***How did you foster the National SMP Program Visibility?***

Do you have a link to the national SMP? We use the SMP logo on our brochures. We use materials from Smart Facts with the logo and we also have a link to the National SMP.

How do you market the national SMP (newspaper, promotional items, etc)?

We have promotional items such as pens, collapsible cups and water bottles that we use at all presentations and health fairs.

Number of group presentations conducted ___. What were your outreach goals? Did you meet or exceed your goals? What is your improvement plans?

4. *How did you improve efficiency*?

How many SMP volunteers do you have?3

Did contacts or inquiries increased or decreased? WHY?

What are your strategies to improve contacts for the next report period? Hopefully, additional staff to assist with this program. Not having additional staff to devote to doing outreach was and is an obstacle for us. We no longer have the Caregiver newsletter which served as a focal point regarding articles about fraud. We hope to do more radio interviews.

What were the prevalent fraud trends in your area and what did you do to inform or help consumers? We did not have any fraud trends reported in our region, however, at every presentation we inform beneficiaries to be careful about giving out personal information over the phone and also regarding unannounced agents. We explain to them that the agent must be invited by the beneficiary.

5. ***In addition to reaching all populations, how did you target underserved populations?***

We extend our outreach efforts to churches, civic groups, senior centers that are in rural areas as well.

6. ***Who were your targeted underserved populations?***

Churches especially in rural areas.

7. ***Who are your new partners since last report period*?**

No new partners.

8. ***What new approaches did you implement since last report period and what will you do different for the current period? What are you goals for the upcoming period?***

We will send out more letters this spring for presentations. There needs to be improvement on getting responses from our letters regarding speaking engagements to groups of Medicare beneficiaries. Improvement in the area of documenting our efforts into Smart Facts. Improvement on ways to use volunteers to keep them active and need to recruit more volunteers willing to do SMP work. At all of our presentations we include volunteer recruitment for SMP.

9. ***Please list all events and trainings for the upcoming period.***

New to Medicare workshop- April, July & September, booth at Fairfield Memorial Hospital, Goodwill Baptist Church, Winnsboro Senior Center, Little Mountain Senior Center, Eastover Senior Center.

10. ***Please list your process for maintaining the confidentiality of client's records and SMP information.***

All client records are kept in a locked file cabinet with locked offices.

Midlands Technical College

B. Structured, Supervised experience

1. Student will continue to be trained on handling complex Medicare calls.

2. Student will be trained on Medicare Fraud and other scams and fraud as it relates to the elderly.

3. Student will be trained more on Medicaid as it relates to Medicare.

C. Independent, Supervised experience

1. Student will be expected to enter required information into Medicare website.

2. Student will be expected to review and assist with Medicare plans.

3. Student will prepare packets for community & education outreach presentations/seminars and health fairs.

I also agree to provide weekly supervision through individual and group consultation.

Date: _____ Student: _____

Date: _____ Site Supervisor: _____

Date: _____ Supervising Professor: _____

Updated: 03-10 - #5

South Carolina
SMP Capacity Building Grant # 90MP0074

SMP Expansion Activity for
10/1/2010 thru 9/30/2012
Central Midlands Council of Governments/ ADRC
Submitted by: Shelia Bell-Ford
December 18, 2012

Please summarize SMP Expansion activities rendered for the above period using the format below.

I. How did you expand and enhance your volunteers or counselor work-force? We had 3 volunteers to assist with Open Enrollment this year.

- Number of trainings
  Training was provided through the SHIP & SMP Basic Training course.

- Topic discussed
  Medicare Fraud was discussed along with other health care fraud and different types of fraud and scams in the community.

- Number of counselors/volunteers trained
  There were approximately 25 counselors/volunteer trained through the SHIP & SMP Basic Training course.

- Types of services rendered by volunteers/counselors
  Volunteers assisted with Open enrollment running Part D and Advantage Plans for beneficiaries. They also assisted with some outreach events such as preparing packets and disseminating information at outreach events. Volunteers also answered incoming calls and returned calls to beneficiaries.

- Background or screening procedure.
  Each volunteer had a SLED background report conducted on their behalf.

- How many consumers reached?
  The number of consumers reached was 4,683

II. **How did you expand outreach and education?**
We continue to be a focal point in the community through presentations at local churches, senior centers, health fairs other civic organizations etc. We established a partnership with the Richland County Library-North Main location.

- List strategies employed.
  Presentations held in the community, health fairs, symposium, seminars and expos.

- List tools and resource used, which was most effective.
  Letters were mailed to churches and medical clinics. The SMP brochure is always distributed at health fairs, expos, etc, to include all public presentations in the community. The I-CARE folder has information how to Protect Yourself Against Fraud, also tip sheet on ways to prevent fraud and a 2012 Medicare Newsletter was developed and it included information on Medicare Fraud.

- List efforts to expand into new areas to disseminate information.
  Establish partnerships with local community programs such as senior groups inside neighborhoods.

- Number of outreach events
  25

- Number of Media events
  Media events will be scheduled in the near future.

III. **How did you handle simple and complex inquiries?**
All complex issues are forwarded to the LGOA.

- Number of complex cases and what was the issues?
  There was only one complex issue and it was forwarded over to Talvin Herbert. It involved beneficiary giving his Medicare number over the phone to get a gluocometer.

- Number of simple inquiries and what were the major issues?
  There was only one simple issue and it was a complaint regarding DME and it was resolved.

IV. How will you enhance your performance?
Continue to be provide information to the community through presentations at local churches, senior centers, health fairs other civic organizations etc. Seek out new partnerships with other agencies.

- What worked and what didn't?
  The volunteers were very helpful, however it involves much training getting them prepared to assist with open enrollment.

- What will you do different in 2012-2013?
  Remember to count volunteers hours. Attend more trainings as it relates to SMP and Smart Facts. There were sessions available for Smart Facts, however the training was during open enrollment and I was unavailable to attend the sessions.
  Plan enrollment events and schedule more media events such as hosting a phone bank during open enrollment.

- What are your expected outcomes?
  With the reduction in staff, more staff is needed to assist with the program. Space for interns and volunteers to work in.

- How is the project making an impact in your region?
  More people are becoming aware of how to protect their valuable information.

Senior Medicare Patrol Expansion Grant
South Carolina Lt. Governor's Office on Aging

Submitted by: Shelia Bell-Ford

Central Midlands COG/ADRC

April 30, 2013

Request for Proposal

For Grant Period

October 1, 2013 – September 30, 2014

ACL and CMS recognize the need to increase the capacity to reach larger numbers of Medicare beneficiaries, their caregivers and family members with the SMP message of fraud prevention. The purpose of this grant is to recruit and train volunteers to conduct outreach and education to empower consumers to detect and report fraud or errors.

I. *Expand and Enhance the SMP project's volunteer work force:*

- *Describe in detail how your agency will recruit, utilize and manage volunteers/counselors to provide coverage in all counties in your region. What role will volunteers handle and how will you provide training? Will you have at least two volunteers per county?*
  This agency will try to have two volunteers per county to provide educational events at least in the beginning of their volunteer experience. We will work with the COAs to provide a list of volunteers that may be interested in taking the taking to be SMP volunteers. After the volunteers are trained, they can provide the services such as exhibits and presentations. The volunteers will be responsible to report their work back to the regional coordinator to record into Smart Facts correctly.
- *How will you provide SMP updates to volunteers?*
  This agency will conduct quarterly update trainings for volunteers.

- *How will you serve dual-English populations and those with visual or hearing impairment?*
  We did have a staff member who was fluent in Spanish. We have one staff member that attends the Hispanic/Latino interagency meeting on a monthly basis. We will coordinate our efforts to partner with this group regarding assisting the dual-English populations. For other languages, we would work with USC to help us translate, as well as ordering materials from SMP.

- *How will you expand partnership to spread fraud awareness? Who will be your new partners?*
  We will continue to work with the COA's to spread fraud awareness through the senior centers to spread fraud awareness. We will seek partnership with the Department of Consumer Affairs and SLED to keep us updated on new fraud trends in the community as well as the LGOA.

Senior Medicare Patrol Expansion Grant
South Carolina Lt. Governor's Office on Aging

II. Expand SMP Outreach and Education

- *Describe how media spots, newsletters, new materials and other innovative methods will be used to increase awareness about the SMP program as well as recruit volunteers.*
  This agency will work with a local radio station to recruit new volunteers to talk about SMP program. We will also work with Senior Connections the local TV station that provides information to the senior population to recruit volunteers and increase awareness.

- *Describe efforts and written materials to target multi-cultural populations.*
  This agency is in the process of sending out posters and brochures about the SMP program to churches, non profits, clinics, senior housing and senior centers to inform them of our services and ability to come to their sites to conduct programs such as the Savvy Seniors. We are also looking into having the COA's input articles into their newsletters about fraud and scams. We will also hold a Medicare Fraud luncheon to educate volunteers on different fraud trends.

III. Expand SMP Ability to Manage Beneficiary Inquiries and Complaints in a timely Manner

- *Describe how fraud reports in your area are handled and resolved.*
  When a complaint comes into the office, it is resolved by the regional coordinator, if it is a simple issue. If it is a complex issue, the complaint is forwarded to the Lt. Governor's Office on Aging to assist in resolving their complaint.
- *What challenges did you face and how did you address the challenges?*
  One of the biggest challenges is to get people to report complaints. Most people believe that it's not important to report a complaint because it's Medicare's (the government) money that is being mishandled.
- *What are your SMP training needs?*
  Although we have a component of SMP training in the I-CARE course, possibly having an annual training on fraud trends and scams.
- *What sources do you use to track fraud trends and activities for your region?*
  This agency relies on the LGOA to inform on trends and activities for the region.

IV. Enhance SMP capacity for performance management

- *How do you measure your program's efficiency and monitor performance?*
  This agency measures the program's efficiency by the response generated from our efforts through mailings, newsletters, presentations or exhibits as increase in calls or conversations as a result of a presentation.
- *Are you correctly entering data into SMARTS-FACTS and in a timely fashion?*
  Yes, we are entering data into Smart Facts correctly and in a timely fashion.
- *What are your objectives for increasing performance by 5%?*
  Continue to work with current volunteers to secure presentations in the community. Conducting a training or workshop for interested individuals regarding SMP.

South Carolina
Family Caregiver Support Program

Quarterly Report – FY2013 Quarter 3

Report Period: **January 1, 2013 – March 31, 2013**

Due Date: April 30, 2013

Date of Submission: 05/08/13

Area Agency on Aging: Central Midlands COG

Signature of Director: Thomas A Vargo

Attached please find our Family Caregiver Support Program Report for the period which includes the following Quarterly Data Reports and source documents.

[X] **FCSP Data Report for Fiscal Year 2013** – Caregiver Expanded to include PI + Other $ + Salary

[X] **FCSP Data Report for Fiscal Year 2013** – Seniors Raising Children (SRC) Expanded to include PI + Other $ + Salary

Source documents:	AIM-CG Report **LG107a SRC Activity Group – All Undup**
	AIM-CG Report **LG107b CG Activity Group – All Undup**,
Source documents:	AIM-CG Report **LG120 SRC Activity Group – All Undup**
	AIM-CG Report **LG120 CG Activity Group – All Undup**
Source documents:	Central Midlands COG "Revenue & Expenses Report"

SC FAMILY CAREGIVER SUPPORT PROGRAM: DATA REPORT **Region: Central Midlands COG AAA/ADRC**

January 1, 2013 - March 31, 2013

	Seniors Raising Children						
	III-E Expenditures	Program Income	Other Funding	TOTAL EXPENDITURES	People Served		Units Provided
I Information (To Groups)							
Community / Public Education				0			
Participation in Community Events				0			
Publicity Campaign				0			
Resource Development	700			700		Unduplicated CGs Served	
TOTAL	700	0	0	700	0		0
STAFFING	0			0			
TOTAL INFO TO GROUPS	**700**	**0**	**0**	700			
II Assistance							
Assessment / Screening	4,017			4,017			
Assessment / Screening -Home				0	1	1	1
Care Coordination	1,200			1,200	24		36
Follow-Up / Evaluation	100			100			
Information & Assistance				0	1	25	25
TOTAL	5,317	0	0	5,317	26		62
STAFFING				0			
TOTAL ASSISTANCE	**5,317**	0	0	5,317			
III Counseling							
Group Counseling (Sessions)	0			0			
Individual Counseling				0		Unduplicated CGs Served	
TOTAL	0	0	0	0	0		0
Support Groups							
Support Group (Sessions)	2,036			2,036	2		2
Individual Support				0	8	10	10
TOTAL	2036	0	0	2,036	10		12
Training							
Group Training				0			
Individual Training				0		Unduplicated CGs Served	
TOTAL	0	0	0	0	0		0
STAFFING for CST				0			
TOTAL FOR CST	**2,036**	0	0	2,036			

SC FAMILY CAREGIVER SUPPORT PROGRAM: DATA REPORT **Region: Central Midlands COG AAA/ADRC**

July 1, 2012 - March 31, 2012

	Seniors Raising Children						
	III-E Expenditures	Program Income	Other Funding	TOTAL EXPENDITURES	People Served		Units Provided
IV Respite							
Child Day Care (Hours)				0			
After School / Summer Programs (Hours)				0			
Emergency Respite (Hours)				0			
Group Respite (Hours)				0			
In-Home Respite (Hours)				0			
Facility Respite (Hours)				0		Unduplicated CGs Served	
TOTAL	0	0	0	0	0		0
STAFFING				0			
TOTAL RESPITE	0	0	0	0			
V Supplemental Services							
Assistive Technology (Piece of equipment)				0			
Chore (Hours)				0			
Emergency Response (Harbison funds)		1,242	0	1,242	4	4	4
Home Health (1 hour)				0			
Homemaker/Housekeeping (1 hour)				0			
Home Modification (Hours)				0			
Chore (Hours)				0			
Home Modification (Hours)				0			
Incontinence Supplies (1 case)				0			
Legal Services (Hours)				0			
Medication Management (1 contact)				0			
Nutrition, Meals (1 meal)				0			
Nutrition, Supplements (1 meal)				0			
Other (1 item) Supplemental Servcies	299			299	3		33
Personal Care (1 hour)				0			
Shopping (1 round trip)	1,339			1,339	7		127
Transportation, Assisted (1 one-way trip)				0			
Transportation (1 one-way trip)				0			
Volunteer Services (1 volunteer service hour)				0		30	
TOTAL	1,638	0	0	1,638	10		160
STAFFING				0			
TOTAL SUPP. SERVICES	1,638	0	0	1,638			
*****TOTAL**	9,691	0	0	9,691	0	0	234

***The total of $ represents what has been allocated from CMCOG Accounting System for the FCSP, however the amount of $ in AIM differs.

J/Forms & Source Docs/FORM -FCSP Data Report 2-7-13

SC FAMILY CAREGIVER SUPPORT PROGRAM: DATA REPORT

Region: Central Midlands COG AAA/ADRC

January 1, 2013 - March 31, 2013

Caregivers

	III-E Expenditures	Program Income	Other Funding	TOTAL EXPENDITURES	People Served		Units Provided
I Information (To Groups)							
Community / Public Education				0			
Participation in Community Events				0			
Publicity Campaign				0			
Resource Development	1,000			1,000		Unduplicated CGs Served	
TOTAL	1,000	0	0	1,000	0		0
STAFFING				0			
TOTAL INFO TO GROUPS	1,000	0	0	1,000			
II Assistance							
Assessment / Screening	6,600			6,600	13		12
Assessment / Screening -Home	1,200			1,200	4		203
Care Coordination	2,800			2,800	44		54
Follow-Up / Evaluation				0			
Information & Assistance	800			800	5	Unduplicated CGs Served	5
TOTAL	11,400	0	0	11,400	66		274
STAFFING				0			
TOTAL ASSISTANCE	11,400	0	0	11,400			
III Counseling							
Group Counseling (Sessions)				0	1		1
Individual Counseling	1400			1,400	1	Unduplicated CGs Served	1
TOTAL	1400	0	0	1,400	2		2
Support Groups							
Support Group (Sessions)				0			
Individual Support				0		Unduplicated CGs Served	
TOTAL	0	0	0	0	0		0
Training							
Group Training				0			
Individual Training				0		Unduplicated CGs Served	
TOTAL	0	0	0	0	0		0
STAFFING for CST				0			
TOTAL FOR CST	1,400	0	0	1,400			

SC FAMILY CAREGIVER SUPPORT PROGRAM: DATA REPORT

Region: Central Midlands COG AAA/ADRC

July 1, 2012 - March 31, 2012

	Caregivers						
	III-E Expenditures	Program Income	Other Funding	TOTAL EXPENDITURES	People Served		Units Provided
IV Respite							
Child Day Care (Hours)				0			
After School / Summer Programs (Hours)				0			
Emergency Respite (Hours)				0			
Group Respite (Hours)				0			
In-Home Respite (Hours)	14,075			14,075	41		1,482
Facility Respite (Hours)	2,246			2,246	5	93	785
TOTAL	16,321	0	0	16,321	46		2,267
STAFFING				0			
TOTAL RESPITE	**16,321**	0	0	16,321			
V Supplemental Services							
Assistive Technology (Piece of equipment)				0			
Chore (Hours)				0			
Emergency Response (Harbison funds)		9,289		9,289	14	14	14
Home Health (1 hour)				0			
Homemaker/Housekeeping (1 hour)				0			
Home Modification (Hours)	0			0	2		2
Chore (Hours)				0			
Home Modification (Hours)				0			
Incontinence Supplies (1 case)	1,830			1,830	10		42
Legal Services (Hours)				0			
Medication Management (1 contact)	343			343	1		3
Nutrition, Meals (1 meal)				0			
Nutrition, Supplements (1 meal)				0	1		61
Other (1 item) Other supportive Links to CG role	141			141	1		13
Personal Care (1 hour)				0			
Shopping (1 round trip)	883			883	3		44
Transportation, Assisted (1 one-way trip)				0			
Transportation (1 one-way trip)				0			
Volunteer Services (1 volunteer service hour)				0		Unduplicated CGs Served	
TOTAL	3,197	0	0	3,197	16	107	163
STAFFING				0			
TOTAL SUPP. SERVICES	**3,197**	0	0	3,197			
*****TOTAL**	**33,318**	0	0	33,318	0	107	2706

***The total of $ represents what has been allocated from CMCOG Accounting System for the FCSP, however the amount of $ in AIM differs.

J/Forms & Source Docs/FORM -FCSP Data Report 2-7-13

SRC Activity Group - All Undup

Central Midlands Council of Governments

Unduplicated Count - Total Units

From: 01/01/2013
To: 03/31/2013

Activity Group / Activity	Funding Source	Clients	$ Amount	QTY Units
CMCOG Caregiver				
SRC Access assistance		**24**	**0.00**	**36**
A Care Coordination SRC IIIE	Title III E	24	0.00	36
SRC Access assistance		**1**	**0.00**	**1**
A Assess/Screen -Home SRC IIIE	Title III E	1	0.00	1
SRC Access assistance		**1**	**0.00**	**1**
A Information & Assistance SRC IIIE	Title III E	1	0.00	1
SRC Counseling/Support Groups/Training		**2**	**0.00**	**2**
S Group Support SRC IIIE	Title III E	2	0.00	2
SRC Counseling/Support Groups/Training		**8**	**0.00**	**10**
C Group Counseling SRC IIIE	Title III E	8	0.00	10
SRC Supplemental Services		**7**	**1,333.29**	**127**
SS Shopping SRC IIIE	Title III E	7	1,333.29	127
SRC Supplemental Services		**3**	**299.80**	**33**
SS Other Support Linked to CG Role SRC IIIE	Title III E	3	299.80	33
SRC Access assistance		**1**	**0.00**	**1**
A Assess/Screen SRC IIIE	Title III E	1	0.00	1
Duplicated Count, Sum of Units for CMCOG Caregiver		47	1,633.09	211
	SRC Unduplicated Count	**30**		

Caregiver Activity Group - All Undup

Central Midlands Council of Governments

From: 01/01/2013
To: 03/31/2013

Unduplicated Count - Total Units

Activity Group / Activity	Funding Source	Clients	$ Amount	QTY Units
CMCOG Caregiver				
Caregiver Supplemental Services		**2**	**0.00**	**2**
SS Home Modification CG IIIE	Title III E	2	0.00	2
Caregiver Supplemental Services		**10**	**1,830.98**	**42**
SS Incontinence Supplies CG IIIE	Title III E	10	1,830.98	42
Caregiver Supplemental Services		**1**	**343.23**	**3**
SS Medications Management CG IIIE	Title III E	1	343.23	3
Caregiver Supplemental Services		**1**	**0.00**	**61**
SS Nutrition -Supplements CG IIIE	Title III E	1	0.00	61
Caregiver Supplemental Services		**1**	**140.96**	**13**
SS Other Support Linked to CG Role CG IIIE	Title III E	1	140.96	13
Caregiver Access Assistance		**13**	**0.00**	**12**
A Assess/Screen CG IIIE	Title III E	13	0.00	12
Caregiver Access Assistance		**44**	**0.00**	**54**
A Care Coordination CG IIIE	Title III E	44	0.00	54
Caregiver Access Assistance		**4**	**500.00**	**203**
A Assess/Screen -Home CG IIIE	Title III E	4	500.00	203
Caregiver Access Assistance		**5**	**0.00**	**5**
A Information & Assistance CG IIIE	Title III E	5	0.00	5
Caregiver Counseling/Support Groups/Caregiver Training		**1**	**0.00**	**1**
C Group Counseling CG IIIE	Title III E	1	0.00	1
Caregiver Counseling/Support Groups/Caregiver Training		**1**	**0.00**	**1**
C Individual Counseling CG IIIE	Title III E	1	0.00	1
Caregiver Respite		**41**	**14,075.48**	**1,482**
R In-Home Respite CG IIIE	Title III E	41	14,075.48	1,482
Caregiver Respite		**5**	**2,246.00**	**785**
R Facility Respite CG IIIE	Title III E	5	2,246.00	785
Caregiver Supplemental Services		**3**	**882.75**	**44**
SS Shopping CG IIIE	Title III E	3	882.75	44
Duplicated Count, Sum of Units for CMCOG Caregiver		132	20,019.40	2,708
Caregiver Unduplicated Count		**93**		

LG120 - Caregiver Group Services for Between 1/1/2013 To 3/31/2013

Description:	Service Date	Purpose of Service	People Served	Units Served	Group County	$ Amount	Program Income	Check Number	Event Comment

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
525 Title IIIE Caregiver Services				
Revenue				
525 220 3299 09 Federal Revenue-Pass Through	4,760.05	24,276.20	0.00	24,276.20
Total Revenue	4,760.05	24,276.20	0.00	24,276.20
Expenses				
525 220 5363 43 In-Home Respite	500.00	1,000.00	0.00	(1,000.00)
525 220 5364 43 In-Home Respite	843.25	4,749.00	0.00	(4,749.00)
525 220 5364 44 Institutional/Residential Respite	0.00	800.00	0.00	(800.00)
525 220 5364 52 Nutrition Supplements	0.00	25.47	0.00	(25.47)
525 220 5364 55 Supplies-Incontinence	82.60	91.13	0.00	(91.13)
525 220 5364 57 Other Supplemental Services	0.00	397.75	0.00	(397.75)
525 220 5364 59 Grands-Supplemental	599.80	641.00	0.00	(641.00)
525 220 5365 43 In-Home Respite	0.00	500.00	0.00	(500.00)
525 220 5365 55 Supplies-Incontinence	0.00	98.36	0.00	(98.36)
525 220 5366 40 Adult Day Care/Adult Health	500.00	500.00	0.00	(500.00)
525 220 5366 43 In-Home Respite	984.50	10,006.86	0.00	(10,006.86)
525 220 5366 44 Institutional/Residential Respite	0.00	1,946.00	0.00	(1,946.00)
525 220 5366 50 Home Modification	214.00	214.00	0.00	(214.00)
525 220 5366 55 Supplies-Incontinence	735.90	1,359.63	0.00	(1,359.63)
525 220 5366 57 Other Supplemental Services	0.00	140.96	0.00	(140.96)
525 220 5366 59 Grands-Supplemental	300.00	1,806.04	0.00	(1,806.04)
Total Expenses	4,760.05	24,276.20	0.00	(24,276.20)
Excess Revenue Over (Under) Expenditures	0.00	0.00	0.00	48,552.40

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
525 Title IIIE Caregiver Services				
Revenue				
Expenses				
525 220 5363 43 In-Home Respite	500.00	1,000.00	0.00	(1,000.00)
525 220 5364 43 In-Home Respite	843.25	4,749.00	0.00	(4,749.00)
525 220 5364 44 Institutional/Residential Respite	0.00	800.00	0.00	(800.00)
525 220 5365 43 In-Home Respite	0.00	500.00	0.00	(500.00)
525 220 5366 40 Adult Day Care/Adult Health	500.00	500.00	0.00	(500.00)
525 220 5366 43 In-Home Respite	984.50	10,006.86	0.00	(10,006.86)
525 220 5366 44 Institutional/Residential Respite	0.00	1,946.00	0.00	(1,946.00)
Total Expenses	2,827.75	19,501.86	0.00	(19,501.86)
Excess Revenue Over (Under) Expenditures	(2,827.75)	(19,501.86)	0.00	19,501.86

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
525 Title IIIE Caregiver Services				
Revenue				
Expenses				
525 220 5364 52 Nutrition Supplements	0.00	25.47	0.00	(25.47)
525 220 5364 55 Supplies-Incontinence	82.60	91.13	0.00	(91.13)
525 220 5364 57 Other Supplemental Services	0.00	397.75	0.00	(397.75)
525 220 5365 55 Supplies-Incontinence	0.00	98.36	0.00	(98.36)
525 220 5366 50 Home Modification	214.00	214.00	0.00	(214.00)
525 220 5366 55 Supplies-Incontinence	735.90	1,359.63	0.00	(1,359.63)
525 220 5366 57 Other Supplemental Services	0.00	140.96	0.00	(140.96)
Total Expenses	1,032.50	2,327.30	0.00	(2,327.30)
Excess Revenue Over (Under) Expenditures	(1,032.50)	(2,327.30)	0.00	2,327.30

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
525 Title IIIE Caregiver Services				
Revenue				
Expenses				
525 220 5364 59 Grands-Supplemental	599.80	641.00	0.00	(641.00)
525 220 5366 59 Grands-Supplemental	300.00	1,806.04	0.00	(1,806.04)
Total Expenses	899.80	2,447.04	0.00	(2,447.04)
Excess Revenue Over (Under) Expenditures	(899.80)	(2,447.04)	0.00	2,447.04

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
520 Title IIIE Family Caregiver				
Revenue				
520 220 3120 00 Transfer To/(From) General Fund	830.34	2,410.71	0.00	2,410.71
520 220 3299 00 Federal Revenue-Title IIIE 88.24%	6,230.37	18,088.51	0.00	18,088.51
Total Revenue	7,060.71	20,499.22	0.00	20,499.22
Expenses				
520 220 4105 00 Salaries	3,753.62	10,991.28	0.00	(10,991.28)
520 220 4540 00 Professional & Agency Dues	100.00	100.00	0.00	(100.00)
520 220 4615 00 Mileage & Subsistence	0.00	17.00	0.00	(17.00)
520 220 4910 00 Fringe Allocation	1,951.88	5,715.46	0.00	(5,715.46)
520 220 4930 00 Indirect Cost Allocation	1,255.21	3,675.48	0.00	(3,675.48)
Total Expenses	7,060.71	20,499.22	0.00	(20,499.22)
Excess Revenue Over (Under) Expenditures	0.00	0.00	0.00	40,998.44

Revenue & Expenses-Aging Total (EM)
Central Midlands Council of Governments
For 3/31/2013

	M-T-D Actual	Y-T-D Actual	Y-T-D Budget	Variance
521 P&A Caregiver Staff				
Revenue				
521 220 3120 00 Transfer To/(From) General Fund	132.74	338.54	0.00	338.54
521 220 3299 00 Federal Revenue	398.22	1,015.63	0.00	1,015.63
Total Revenue	530.96	1,354.17	0.00	1,354.17
Expenses				
521 220 4105 00 Salaries	286.32	730.24	0.00	(730.24)
521 220 4910 00 Fringe Allocation	148.89	379.73	0.00	(379.73)
521 220 4930 00 Indirect Cost Allocation	95.75	244.20	0.00	(244.20)
Total Expenses	530.96	1,354.17	0.00	(1,354.17)
Excess Revenue Over (Under) Expenditures	0.00	0.00	0.00	2,708.34

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REGION: 04	CENTRAL MIDLANDS COG AAA/ADRC 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	III-D AAA Direct Services (See Note) 85/5/10	State Admin	State HCBS	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 Services Staff 88.24/11.76	III-E Caregiver Services 100
3	Personnel Salaries	$382,602	$101,092	$8,776	$1,848	$7,699		$52,143	$74,969	$26,487	$7,062	$28,698	$15,538	$34,120	
4	Fringe Benefits	$198,953	$52,568	$4,563	$961	$4,003		$27,114	$38,984	$13,773	$3,673	$14,923	$8,080	$17,742	
5	Contractual	$49,500	$3,700				$45,000		$800						
6	Travel	$9,713	$4,854					$200	$4,059	$100	$100	$100	$200	$0	
7	Equipment	$3,000	$3,000									$0			
8	Supplies	$2,000	$200					$100	$1,100	$100	$100	$200	$100	$0	
9	Indirect Costs	$127,939	$33,805	$2,935	$618	$2,574		$17,436	$25,070	$8,857	$2,362	$9,596	$5,195	$11,409	
10	Allocated Costs	$142,035													$142,035
11	Other Direct Costs	$33,049	$19,504					$200	$13,145				$200		
12	TOTAL OPERATING BUDGET	$948,791	$218,723	$16,274	$3,427	$14,276	$45,000	$97,193	$158,127	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
13	LESS: In-kind Above Match	$0													
14	LESS: Local Cash Above Match	$21,619	$21,372						$247						
15	TOTAL AREA PLAN BUDGET: LGOA	$927,172	$197,351	$16,274	$3,427	$14,276	$45,000	$97,193	$157,880	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
16	COMPUTATION OF GRANT														
17	APPROVED AREA PLAN BUDGET	$927,172	$197,351	$16,274	$3,427	$14,276	$45,000	$97,193	$157,880	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
18	LESS: State 5%Match	$13,739		$814	$171			$4,860	$7,894						
19	LESS: Required Grantee Match	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
20	Federal Share	$705,640	$148,013	$13,833	$2,913			$82,614	$134,198	$49,317	$13,297		$21,985	$55,830	$142,035
21	BREAKOUT OF LOCAL MATCH (L19):	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
22	Local Cash Match Resources	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
23	Local In-kind Match Resources	$0													
24	State Funds Used as Local Match	$0													
25	Total Local Match (Must = Line 25)	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	$0
27	FRINGE RATE AS % OF SALARIES: 52.00%														22.00%
28	Yellow cells are calculated values-DO NOT enter data in these cel Blue Indicates cells in which data normally should not be entered. Use of State funds for local match must be approved BEFORE budget is submitted.														

APPENDIX H

CENTRAL MIDLANDS COG AAA/ADRC COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2013 - 2014 Page 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 PD	Information Referral and Assistance	III-D AAA Direct Services (See Note)	Ombudsman	FCSP	Insurance Counseling	TOTAL AAA BUDGET	LINE ITEM
$16,855				$7,315		$119,415	$52,143	$1,848	$137,216	$49,658	$24,170	$384,450	Personnel Salaries
$8,765				$3,804		$57,131	$27,114	$961	$71,353	$25,822	$12,569	$194,950	Fringe Benefits
						$3,700	$0	$0	$800	$0	$0	$4,500	Contractual
				$100		$4,854	$200	$0	$4,359	$200	$100	$9,713	Travel
						$3,000	$0	$0	$0	$0	$0	$3,000	Equipment
$100						$200	$100	$0	$1,500	$100	$100	$2,000	Supplies
$5,636				$2,446		$36,740	$17,436	$618	$45,885	$16,604	$8,082	$125,365	Indirect Costs
						$0	$0	$0	$0	$142,035	$0	$142,035	Allocated Costs
						$19,504	$200	$0	$13,145	$200	$0	$33,049	Other Direct Costs
$31,356	$0	$0	$0	$13,665	$0	$244,544	$97,193	$3,427	$274,258	$234,619	$45,021	$899,062	TOTAL OPERATING BUDGET
						$0	**$0**	**$0**	**$0**	**$234,619**	**$0**	**$234,619**	**LESS: In-kind Above Match**
						$21,372	**$0**	**$0**	**$247**	**$0**	**$0**	**$21,619**	**LESS: Local Cash Above Match**
$31,356	$0	$0	$0	$13,665	$0	$223,172	$97,193	$3,427	$274,011	$0	$45,021	$642,824	TOTAL AREA PLAN BUDGET: LGO

COMPUTATION OF GRANT

$31,356	$0	$0	$0	$13,665	$0
				$3,416	
$31,356	$0	$0	$0	$10,249	$0
				$3,416	
				$3,416	
	$0	$0	$0	$3,416	

NOTE: Legal Assistance, Case Management, Minor Home Repair, Consumer Directed Services, and Pilot Project Services

Use this space to breakout the non-contracted 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 27 in the appropriate column.

Services	III-B	III-D	HCBS	TOTAL
Legal Assistance	$0			$0
Medication Management		$0		$0
Case Management	$0			$0
Minor Home Repair			$0	$0
Consumer Directed HCBS	$0		$0	$0
Pilot Project Services	$0		$0	$0
5% Match	$0	$0		$0
10% Match	$0	$0	$0	$0

REPLACE SAMPLE ENTRIES WITH ACTUAL BUDGETED FIGURES (or Zeros) AS APPLICABLE

Central Midlands Council of Governments AAA/ADRC
Budget Narrative

The Central Midlands Council of Governments AAA/ADRC's operating budget as presented in the Area Plan includes the total projected costs to operate efficiently. The total AAA/ADRC operating budget as submitted in the Area Plan is $927,172.

CMCOG will apply a fixed fringe rate throughout the year for both fringes and indirect costs. Fringe benefits will be charged as a percentage of direct salaries. Fringes include FICA, Medicare, health insurance, dental insurance, group life, retirement, workers compensation, and release time. Release time is paid time off such as annual leave, sick leave, holidays, funeral leave, jury duty, and military leave. CMCOG will apply a fixed indirect cost rate as a percentage of salaries and fringes. After the actual fringe and indirect cost rates are determined for FY2012-13, the actual rates for FY2012-13 will be applied during FY2013-14. CMCOG uses a fixed rate with carry forward provision. The U. S. Department of Commerce is CMCOG's cognizant agency and is responsible for reviewing and approving CMCOG's indirect cost plans.

Since CMCOG is anticipating having to provide client selection, CMCOG has included funding in contractual services to provide these services.

The travel line item consists of training for the AAA/ADRC staff. This would include required meetings in addition to staff development and training. CMCOG reimburses Regional Aging Advisory Committee members for mileage and allows for travel to conferences as deemed appropriate and necessary.

The supplies budget includes supplies that are specific to the aging program. A portion of the budgeted costs for travel and supplies are included in the budget. The remaining expenses will be covered by local dollars that CMCOG receives through its member governments.

The allocated costs listed in the AAA Operating Budget are for the caregivers. Other direct costs are specific to the Ombudsman program. This will include medical records.

The indirect costs include items that are not easily assigned to specific grants and/or projects such as general office supplies, utilities, janitorial service, lawn maintenance, telephone charges, administration and finance salaries, etc.

Other direct costs include supplies, medical records, postage, printing, equipment and software maintenance.

CENTRAL MIDLANDS COG AAA/ADRC SUMMARY PROGRAM BUDGET-COMPUTATION OF GRANTS SFY13/14

NOTE: Match Ratio if using III-E is 8.24(F) to 11.76(L)	IN-HOME & COMMUNITY-BASED SERVICES											NUTRITION SERVICES	
	Transportation	Chore or House-keeping	Homemaker with Some Personal Care	Personal Care with Limited Medical Assistance	Home Living Support	Adult Day Services See NOTE Upper Left	Legal Assistance	Information & Assistance See NOTE Upper Left	Respite Care See NOTE Upper Left	Case Manage-ment	TOTAL Supportive Services	Congregate Meals	Home Delivered Meals
CONTRACTED UNITS	85,330	2,742	3,086	0	0	2,002	542	5,946	0	0	N/A	46,992	102,120
Title III Federal B, C	$128,069	$17,740	$19,961	$0	$0	$24,960	$23,202	$82,614	$0	$0	$296,546	$300,056	$560,157
Title III Federal E								$0	$0		$0		
State 5% Match B and C	$7,533	$1,044	$1,174	$0	$0	$1,468	$1,365	$4,860	$0	$0	$17,444	$17,650	$32,950
Local:Cash match	$13,721	$2,024	$2,348	$0	$0	$924	$2,730	$9,719	$0	$0	$31,466	$24,590	$48,103
Local:In-kind match	$1,346	$63	$0	$0	$0	$2,013	$0	$0	$0	$0	$3,422	$10,710	$17,797
Total Local Match	$15,067	$2,087	$2,348	$0	$0	$2,936	$2,730	$9,719	$0	$0	$34,888	$35,301	$65,901
ACE-Bingo		$32,332	$32,332	$0	$0	$0			$0	$0	$64,664		$0
State H&C-B Services (ACE-CS)		$0	$0	$0	$0	$0			$0	$0	$0		$0
ISIP (Estimate)												$69,050	$121,825
Cost Share/GRI -State Services	$0	$787	$298	$0	$0	$0	$0		$0	$0	$1,085		$0
GRI for Title III (Estimate)	$6,307	$165	$176	$0	$0	$332	$0		$0		$6,980	$25,852	$9,246
Total Contracted Funds	$156,976	$54,155	$56,289	$0	$0	$29,697	$27,297	$97,193	$0	$0	$421,607	$447,908	$790,078
Contracted Rate	$1.8396	$19.7500	$18.2402	#DIV/0!	#DIV/0!	$14.8338	$50.3300	$16.3459	#DIV/0!	#DIV/0!	N/A	$9.5316	$7.7368

NOTE: Contracted rate Includes Local Match

COMPUTATION OF NET (AIM) UNIT COST AND UNITS PER FUNDING SOURCE

Net Contracted (AIM) Rate	$1.8396	$19.7500	$18.2402	#DIV/0!	#DIV/0!	$14.8338	$50.3300	$16.3459	#DIV/0!	#DIV/0!	NA	$9.5316	$7.7368
AIM Units: ACE-BINGO		1,637	1,773	#DIV/0!	#DIV/0!	0			#DIV/0!	#DIV/0!			0
AIM Units:State H&CB Svs	0	0	0	#DIV/0!	#DIV/0!	0			#DIV/0!	#DIV/0!			0
AIM Units: State Cost Share/GRI	0	40	16	#DIV/0!	#DIV/0!	0			#DIV/0!	#DIV/0!			0
ISIP Share of Meal Unit Cost												$1.4694	$1.1930
AIM Title III Meal Rate												$8.0622	$6.5438
AIM Units: Title III GRI (Estimate)	3,428	8	10	#DIV/0!	#DIV/0!	22	0	0	#DIV/0!	#DIV/0!		3,207	1,413
AIM Units:Title III (F+S+L)	81,902	1,057	1,287	#DIV/0!	#DIV/0!	1,980	542	5,946	#DIV/0!	#DIV/0!		43,786	100,707
TOTAL CONTRACT UNITS	85,330	2,742	3,086	#DIV/0!	#DIV/0!	2,002	542	5,946	#DIV/0!	#DIV/0!	N/A	46,992	102,120

NOTE: Contracted Units for All Services Include Units Projected for GRI and State Services Income

Total of All Other Resources by Service	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	NA	$0	$0
Total of Units Served with those Other Resources	0	0	0	0	0	0	0	0	0	0	NA	0	0
TOTAL SERVICE BUDGET	$156,976	$54,155	$56,289	$0	$0	$29,697	$27,297	$97,193	$0	$0	N/A	$447,908	$790,078
Total Unit Cost	$1.8396	$19.7500	$18.2401	#DIV/0!	#DIV/0!	$14.8340	$50.3300	$16.3458	#DIV/0!	#DIV/0!	NA	$9.5316	$7.7368

	P	Q	R	S	T	U	V	W	X	Z	AA	AC
1	CENTRAL MIDLANDS COG AAA/ADRC SUMMARY PROGRAM BUDGET-COMPUTATION OF GRANTS SFY13/14											Page 2
2		PREVENTION AND WELLNESS SERVICES								INSURANCE COUNSELING		TOTALS
3	CONTRACTED FUNDS	Health Screening	Nutrition Risk Follow-up	Health Promotion	Evidence Based Physical Fitness	Home Injury Prevention	Medication Management	Minor Home Repair (State Funds)	TOTAL Wellness	Medicare Fraud (SMP)	I-CARE SHIP and MIPPA	All Sources (Both Pages)
4	CONTRACTED UNITS	0	0	0	4,276	0	0	0	N/A		2,120	N/A
5	Title III Federal D, SMP, I-CARE	$0	$0	$0	$26,049	$0	$2,913		$28,962	$10,249	$31,356	$1,227,326
6	Title III Federal E								$0			$0
7	State 5% Match D	$0	$0	$0	$1,532	$0	$171		$1,704			$69,748
8	Local:Cash match	$0	$0	$0	$3,065	$0	$343		$3,408	$3,416		$110,983
9	Local:In-kind match	$0	$0	$0	$0	$0	$0		$0			$31,929
10	Total Local Match	$0	$0	$0	$3,065	$0	$343		$3,407	$3,416		$142,913
11	ACE-Bingo		$0			$0		$0	$0			$64,664
12	State H&C-B Services (ACE-CS)		$0			$0		$0	$0			$0
13												
14	NSIP (Estimate)								$0			$190,875
15	Cost Share/GRI -State Services		$0			$0		$0	$0			$1,085
16	GRI for Title III	$0	$0	$0	$0	$0			$0			$42,078
17	Total Contracted Funds	$0	$0	$0	$30,646	$0	$3,427	$0	$34,074	$13,665	$31,356	$1,738,688
18	Contracted Rate	#DIV/0!	#DIV/0!	#DIV/0!	$7.1670	#DIV/0!	#DIV/0!	#DIV/0!	N/A	#DIV/0!	$14.7906	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!	#DIV/0!	$7.1670	#DIV/0!	#DIV/0!	#DIV/0!	NA	#DIV/0!	$14.7906	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												
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!	#DIV/0!	0	#DIV/0!						
29	AIM Units:Title III (F+S+L)	#DIV/0!	#DIV/0!	#DIV/0!	4,276	#DIV/0!	#DIV/0!					
30	CONTRACTED UNITS	#DIV/0!	#DIV/0!	#DIV/0!	4,276	#DIV/0!	#DIV/0!	#DIV/0!	N/A	0	2,120	N/A
31	NOTE: Contracted Units for All Services Include Units Projected for GRI and Fees											
32	Total Other Resources per Service	$0	$0	$0	$0	$0	$0	$0	NA	$0	$0	NA
33	Total Units Served with Other Resources	0	0	0	0	0	0	0	NA	0	0	NA
34	TOTAL SERVICE BUDGET	$0	$0	$0	$30,646	$0	$3,427	$0	NA	$13,665	$31,356	NA
35	Total Unit Cost	#DIV/0!	#DIV/0!	#DIV/0!	$7.1670	#DIV/0!	#DIV/0!	#DIV/0!	NA	#DIV/0!	$14.7906	NA

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	REGION: 04	CENTRAL MIDLANDS COG AAA/ADRC COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2014 - 2017 Page 1													
2	LINE ITEM	100% AAA Budget	III- B &C Planning & Admin. 75/25	III-B Program Developmen t 85/5/10	III-D AAA Direct Services (See Note) 85/5/10	State Admin	State HCBS	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 Services Staff 88.24/11.76	III-E Caregiver Services 100
3	Personnel Salaries	$382,602	$101,092	$8,776	$1,848	$7,699		$52,143	$74,969	$26,487	$7,062	$28,698	$15,538	$34,120	
4	Fringe Benefits	$198,953	$52,568	$4,563	$961	$4,003		$27,114	$38,984	$13,773	$3,673	$14,923	$8,080	$17,742	
5	Contractual	$49,500	$3,700				$45,000		$800						
6	Travel	$9,713	$4,854					$200	$4,059	$100	$100	$100	$200	$0	
7	Equipment	$3,000	$3,000									$0			
8	Supplies	$2,000	$200					$100	$1,100	$100	$100	$200	$100	$0	
9	Indirect Costs	$127,939	$33,805	$2,935	$618	$2,574		$17,436	$25,070	$8,857	$2,362	$9,596	$5,195	$11,409	
10	Allocated Costs	$142,035													$142,035
11	Other Direct Costs	$33,049	$19,504					$200	$13,145				$200		
12	TOTAL OPERATING BUDGET	$948,791	$218,723	$16,274	$3,427	$14,276	$45,000	$97,193	$158,127	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
13	LESS: In-kind Above Match	$0													
14	LESS: Local Cash Above Match	$21,619	$21,372						$247						
15	TOTAL AREA PLAN BUDGET: LGOA	$927,172	$197,351	$16,274	$3,427	$14,276	$45,000	$97,193	$157,880	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
16	COMPUTATION OF GRANT														
17	APPROVED AREA PLAN BUDGET	$927,172	$197,351	$16,274	$3,427	$14,276	$45,000	$97,193	$157,880	$49,317	$13,297	$53,517	$29,313	$63,271	$142,035
18	LESS: State 5%Match	$13,739		$814	$171			$4,860	$7,894						
19	LESS: Required Grantee Match	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
20	Federal Share	$705,640	$148,013	$13,833	$2,913			$82,614	$134,198	$49,317	$13,297		$21,985	$55,830	$142,035
21	BREAKOUT OF LOCAL MATCH (L19):	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
22	Local Cash Match Resources	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	
23	Local In-kind Match Resources	$0													
24	State Funds Used as Local Match	$0													
25	Total Local Match (Must = Line 25)	$95,000	$49,338	$1,627	$343			$9,719	$15,788				$7,328	$7,441	$0
27	FRINGE RATE AS % OF SALARIES: 52.00%														22.00%
28	Yellow cells are calculated values-DO NOT enter data In these cel Blue indicates cells in which data normally should not be entered. Use of State funds for local match must be approved BEFORE budget is submitted.														

APPENDIX K

	P	Q	R	S	T	U	W	X	Y	Z	AA	AB	AC	AD
1	CENTRAL MIDLANDS COG AAA/ADRC COMPREHENSIVE OPERATING BUDGET STATE FISCAL YEAR 2014 - 2017 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 PD	Information Referral and Assistance	III-D AAA Direct Services (See Note)	Ombudsman	FCSP	Insurance Counseling	TOTAL AAA BUDGET	LINE ITEM
3	$16,855				$7,315		$119,415	$52,143	$1,848	$137,216	$49,658	$24,170	$384,450	Personnel Salaries
4	$8,765				$3,804		$57,131	$27,114	$961	$71,353	$25,822	$12,569	$194,950	Fringe Benefits
5							$3,700	$0	$0	$800	$0	$0	$4,500	Contractual
6					$100		$4,854	$200	$0	$4,359	$200	$100	$9,713	Travel
7							$3,000	$0	$0	$0	$0	$0	$3,000	Equipment
8	$100						$200	$100	$0	$1,500	$100	$100	$2,000	Supplies
9	$5,636				$2,446		$36,740	$17,436	$618	$45,885	$16,604	$8,082	$125,365	Indirect Costs
10							$0	$0	$0	$0	$142,035	$0	$142,035	Allocated Costs
11							$19,504	$200	$0	$13,145	$200	$0	$33,049	Other Direct Costs
12	$31,356	$0	$0	$0	$13,665	$0	$244,544	$97,193	$3,427	$274,258	$234,619	$45,021	$899,062	TOTAL OPERATING BUDGET
13							**$0**	**$0**	**$0**	**$0**	**$234,619**	**$0**	**$234,619**	**LESS: In-kind Above Match**
14							**$21,372**	**$0**	**$0**	**$247**	**$0**	**$0**	**$21,619**	**LESS: Local Cash Above Match**
15	$31,356	$0	$0	$0	$13,665	$0	$223,172	$97,193	$3,427	$274,011	$0	$45,021	$642,824	TOTAL AREA PLAN BUDGET: LGO

16	COMPUTATION OF GRANT					
17	$31,356	$0	$0	$0	$13,665	$0
18						
19					$3,416	
20	$31,356	$0	$0	$0	$10,249	$0
21					$3,416	
22					$3,416	
23						
24						
25		$0	$0	$0	$3,416	
27						
28						

NOTE: Legal Assistance, Case Management, Minor Home Repair, Consumer Directed Services, and Pilot Project Services

Use this space to breakout the non-contracted 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 27 in the appropriate column.

Services	III-B	III-D	HCBS	TOTAL
Legal Assistance	$0			$0
Medication Management		$0		$0
Case Management	$0			$0
Minor Home Repair			$0	$0
Consumer Directed HCBS	$0		$0	$0
Pilot Project Services	$0		$0	$0
5% Match	$0	$0		$0
10% Match	$0	$0	$0	$0

REPLACE SAMPLE ENTRIES WITH ACTUAL BUDGETED FIGURES (or Zeros) AS APPLICABLE

REGION: #4 Central Midlands COG AAA/ADRC 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 described in the OAA	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		4680	4680	0	7703	2632	2340	2048	0	1447
Aging Unit Director	Sharon Seago	1950	1950							0
Program Manager		0	0							0
Program Developer		0	0	0			0		0	0
Aging Fiscal Accounting	Ethel Montgomery (M)	1950	1950				0		0	0
Clerical Support Staff	Tasha Milhouse (M)	1950	780			390	390	390		
Clerical Support Staff	Fretorla Williams (M)	1950	0		1950					
Clerical Support Staff		0								
Clerical Support Staff		0								
FTEs by AAA ACTIVITIES		2.40	2.40	0.00	3.95	1.35	1.20	1.05	0.00	0.74
Ombudsman		7703			5753					0
Senior Ombudsman	Anna Harmon (M)	1,853	0		1853	0				97
Other Ombudsman Staff	Shirley Thomas (M)	1,950			1950					
Other Ombudsman Staff	LaToya Buggs-Williams (M)	1,950			1950					
Other Ombudsman Staff		0								
Other Ombudsman Staff		0								
Other Ombudsman Staff		0			0					
FTEs		3.95	0.00	0.00	3.95	0.00	0.00	0.00	0.00	0.05
I & A		2632				1365	292	293		0
Primary I&A and R	Carol Boykin	1,950				1365	292	293		0
Backup I&R		0					0	0		
FTEs		1.35		0.00	0.00	0.70	0.15	0.15	0.00	0.00
Insurance Counseling/SMP		2048			0	585	292	1073		0
Primary Counsellor	Shelia Bell-Ford (M)	1,950				585	292	1073		0
Backup Counsellor										0
		0								
FTEs		1.05		0.00	0.00	0.30	0.15	0.55	0.00	0.00
Family Caregiver Program		2340				292	1366	292		0
Caregiver Advocate	Joe Ritchey	1,950	0.00			292	1366	292		0
		0				0		0		1350
FTEs		1.20	0.00	0.00	0.00	1.35	1.20	1.05	0.00	0.69
Other AAA Direct Services		0							0	
Case Manager		0							0	0
Medication Management		0							0	
FTEs		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.74
COMBINED SERVICE DELIVERY		14723								
Intern Hours		1440	0			0	1,440	0	0	
Volunteer Hours		576			576			0	0	
TOTAL PAID HOURS		19,403								
TOTAL PAID FTEs		9.95								

Enter Staff Names	Annual Payroll Hours All Sources
AGENCY'S FTE	1950
Bell-Ford	1950
Boykin	1950
Buggs-Williams	1950
Harmon	1950
Milhouse	1950
Montgomery	1950
Ritchey	1950
Seago	1950
Sparks	1950
Thomas	1950
Williams	1950
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
Paid Hours	21450
Interns	1440
Volunteers	576
Total Hours	23,466

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.

APPENDIX L

REGION: 04 Central Midlands COG AAA/ADRC

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2013, July 1, 2014, July 1, 2015, and July 1, 2016

State Fiscal Year Beginning July	County or Contractor	Transportation Contracted Funds	Transportation Contracted Units	Transportation Contracted Unit Cost	Chore, House-keeping Funds	Chore, House-keeping Units	Chore, House-keeping Unit Cost	Homemaker limited Pers.Care Funds	Homemaker limited Pers.Care Units	Homemaker limited Pers.Care Unit Cost	Personal Care ltd Med. Asst. Funds	Personal Care ltd Med. Asst. Units	Personal Care ltd Med. Asst. Unit Cost	Home Living Support Funds	Home Living Support Units	Home Living Support Unit Cost
2013-2014	Fairfield County COA	$21,838	12,132	$1.8000	$4,777	236	$20.2500	$9,585	473	$20.2500			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Lexington County RAC	$56,034	30,788	$1.8200	$13,574	652	$20.8200			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Newberry County COA	$20,581	14,001	$1.4700	$14,202	686	$20.6900	$10,738	519	$20.6900			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Senior Resources, Inc	$58,522	28,409	$2.0600	$21,602	1,168	$18.5000	$22,861	1,188	$19.2500			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Corporate Care, LLC			#DIV/0!			#DIV/0!	$13,106	906	14.4700			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	REGIONWIDE	$156,976	85,330	$1.8396	$54,155	2,742	$19.7502	$56,289	3,086	$18.2401	$0	0	#DIV/0!	$0	0	#DIV/0!
2014-2015	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2015-2016	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2016-2017	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!

REGION: 04 Central Midlands COG AAA/ADRC

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2013, July 1, 2014, July 1, 2015, and July 1, 2016

State Fiscal Year Beginning July	County or Contractor	Legal Assistance Funds	Legal Assistance Units	Legal Assistance Unit Cost	Adult Day Service Contracted Funds	Adult Day Service Contracted Units	Adult Day Service Contracted Unit Cost	Respite Care Contracted Funds	Respite Care Contracted Units	Respite Care Contracted Unit Cost	I, R and A Contracted Funds	I, R and A Contracted Units	I, R and A Contracted Unit Cost	Care Management Contracted Funds	Care Management Contracted Units	Care Management Contracted Unit Cost
2013-2014	SC Legal Services	$27,297	542	**$50.3300**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014	Newberry County COA			**#DIV/0!**	$20,457	1,291	**$15.8400**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014	Traditions Elder Day Care			**#DIV/0!**	$9,240	711	**$13.0000**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2014-2015				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2015-2016				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2016-2017				**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**			**#DIV/0!**
2013-2014	REGIONWIDE	$27,297	542	**$50.3300**	$29,697	2,002	**$14.8337**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2014-2015	REGIONWIDE	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2015-2016	REGIONWIDE	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**
2016-2017	REGIONWIDE	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**	$0	0	**#DIV/0!**

REGION: 04 Central Midlands COG AAA/ADRC

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2013, July 1, 2014, July 1, 2015, and July 1, 2016

State Fiscal Year Beginning July	County or Contractor	Congregate Meals Contracted Funds	Congregate Meals Contracted Units	Congregate Meals Contracted Unit Cost	Home Delivered Meals Contracted Funds	Home Delivered Meals Contracted Units	Home Delivered Meals Contracted Unit Cost	Health Screening Contracted Funds	Health Screening Contracted Units	Health Screening Contracted Unit Cost	Nutrition Risk Assessment Contracted Funds	Nutrition Risk Assessment Contracted Units	Nutrition Risk Assessment Contracted Unit Cost	Health Promotion Contracted Funds	Health Promotion Contracted Units	Health Promotion Contracted Unit Cost
2013-2014	Fairfield County COA	$49,121	5,428	$9.0500	$136,453	16,846	$8.1000			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Lexington County RAC	$157,236	16,980	$9.2600	$255,312	31,676	$8.0600			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Newberry County COA	$104,552	9,277	$11.2700	$153,716	18,148	$8.4700			#DIV/0!			#DIV/0!	$20,431	2,233	$9.1500
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	Senior Resources, Inc	$136,999	15,307	$8.9500	$244,598	35,449	$6.9000			#DIV/0!			#DIV/0!	$10,216	2,043	$5.0000
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	REGIONWIDE	$447,908	46,992	$9.5316	$790,079	102,120	$7.7368	$0	0	#DIV/0!	$0	0	#DIV/0!	$30,646	4,276	$7.1670
2014-2015	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2015-2016	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2016-2017	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!

REGION: 04 Central Midlands COG AAA/ADRC

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2013, July 1, 2014, July 1, 2015, and July 1, 2016

State Fiscal Year Beginning July	County or Provider	Physical Fitness Contracted Funds	Physical Fitness Contracted Units	Physical Fitness Contracted Unit Cost	Home Injury Prevention Contracted Funds	Home Injury Prevention Contracted Units	Home Injury Prevention Contracted Unit Cost	Senior Games Contracted Funds	Senior Games Contracted Units	Senior Games Contracted Unit Cost	Minor Home Repair Contracted State Funds	Minor Home Repair Contracted State Units	Minor Home Repair Contracted Unit Cost	Medication Management Contracted Funds	Medication Management Contracted Units	Medication Management Contracted Unit Cost
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2014-2015				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2015-2016				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2016-2017				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
2013-2014	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2014-2015	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2015-2016	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
2016-2017	REGIONWIDE	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!

EGION: 04 Central Midlands COG/ADRC

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012

ate Fiscal Year eginning July	County or Contractor	Transportation Contracted Funds	Transportation Contracted Units	Transportation Contracted Unit Cost	Chore, House-keeping Funds	Chore, House-keeping Units	Chore, House-keeping Unit Cost	Homemaker limited Pers.Care Funds	Homemaker limited Pers.Care Units	Homemaker limited Pers.Care Unit Cost	Personal Care ltd Med. Asst. Funds	Personal Care ltd Med. Asst. Units	Personal Care ltd Med. Asst. Unit Cost	Home Living Support Funds	Home Living Support Units	Home Living Support Unit Cost
09-2010	Fairfield County COA	$44,923	59,897	$0.7500	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Fairfield County COA	$42,464	56,619	$0.7500	$0	0	#DIV/0!	$20,193	1,266	$15.9500	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012	Fairfield County COA	$34,544	46,059	$0.7500	$0	0	#DIV/0!	$20,193	1,266	$15.9500			#DIV/0!			#DIV/0!
12-2013	Fairfield County COA	$43,950	58,600	$0.7500	$38,272	2,466	$15.5200	$20,193	1,266	$15.9500			#DIV/0!			#DIV/0!
09-2010	Lexington County RAC	$109,998	159,417	$0.6900	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Lexington County RAC	$126,298	183,043	$0.6900	$32,600	2,135	$15.2700	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012	Lexington County RAC	$125,607	182,039	$0.6900	$32,600	2,135	$15.2700			#DIV/0!			#DIV/0!			#DIV/0!
12-2013	Lexington County RAC	$115,528	167,162	$0.6900	$33,070	2,135	$15.2700			#DIV/0!			#DIV/0!			#DIV/0!
09-2010	Newberry County COA	$49,662	84,173	$0.5900	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Newberry County COA	$50,129	84,964	$0.5900	$27,947	1,803	$15.5000	$20,757	1,258	$16.5000	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012	Newberry County COA	$47,502	80,512	$0.5900	$30,488	1,967	$15.5000	$22,654	1,373	$16.5000			#DIV/0!			#DIV/0!
12-2013	Newberry County COA	$44,788	75,912	$0.5900	$30,488	1,967	$15.5000	$22,654	1,373	$16.5000			#DIV/0!			#DIV/0!
09-2010	Senior Resources, Inc	$108,011	168,767	$0.6400	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Senior Resources, Inc	$130,609	204,077	$0.6400	$41,245	2,661	$15.5000	$44,286	2,684	$16.5000	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012	Senior Resources, Inc	$129,302	202,034	$0.6400	$44,996	2,903	$15.5000	$47,580	2,928	$16.2500			#DIV/0!			#DIV/0!
12-2013	Senior Resources, Inc	$120,882	188,878	$0.6400	$44,997	2,903	$15.5000	$47,579	2,928	$16.2500			#DIV/0!			#DIV/0!
09-2010	Carepro Health Systems			#DIV/0!	$115,723	7,589	$15.2500	$162,740	10,203	$15.9500	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Carepro Health Systems			#DIV/0!	$6,192	406	$15.2500	$8,516	534	$15.9500	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012				#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!			#DIV/0!
12-2013	Addus (SC) dba Carepro			#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$59,880	3,592	$16.6700			#DIV/0!
09-2010				#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
10-2011	Corporate Care			#DIV/0!	$0	0	#DIV/0!	$27,869	1,926	$14.4700	$0	0	#DIV/0!	$0	0	#DIV/0!
11-2012	Corporate Care			#DIV/0!	$0	0	#DIV/0!	$30,404	2,101	$14.4700			#DIV/0!			#DIV/0!
12-2013	Corporate Care			#DIV/0!			#DIV/0!	$30,402	2,101	$14.4700			#DIV/0!			#DIV/0!
09-2010	Senior Matters			#DIV/0!	$38,278	2,466	$15.5200	$0	0	#DIV/0!	$59,879	3,592	$16.6700	$0	0	#DIV/0!
10-2011	Senior Matters			#DIV/0!	$38,272	2,466	$15.5200	$0	0	#DIV/0!	$59,877	3,592	$16.6700	$0	0	#DIV/0!
11-2012	Senior Matters			#DIV/0!	$38,272	2,466	$15.5200	$0	0	#DIV/0!	$58,146	3,488	$16.6700			#DIV/0!
12-2013				#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!			#DIV/0!
09-2010	REGIONWIDE	$312,594	472,254	$0.6619	$154,001	10,055	$15.3159	$162,740	10,203	$15.9502	$59,879	3,592	$16.6700	$0	0	#DIV/0!
10-2011	REGIONWIDE	$349,500	528,703	$0.6611	$146,256	9,471	$15.4425	$121,621	7,668	$15.8609	$59,877	3,592	$16.6700	$0	0	#DIV/0!
11-2012	REGIONWIDE	$336,955	510,644	$0.6599	$146,356	9,471	$15.4531	$120,831	7,668	$15.7578	$58,146	3,488	$16.6700	$0	0	#DIV/0!
12-2013	REGIONWIDE	$325,148	490,552	$0.6628	$146,827	9,471	$15.5028	$120,828	7,668	$15.7574	$59,880	3,592	$16.6700	$0	0	#DIV/0!

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012

ate Fiscal Year ieginning July	County or Contractor	Legal Assistance Funds	Legal Assistance Units	Legal Assistance Unit Cost	Adult Day Service Contracted Funds	Adult Day Service Contracted Units	Adult Day Service Contracted Unit Cost	Respite Care Contracted Funds	Respite Care Contracted Units	Respite Care Contracted Unit Cost	I, R and A Contracted Funds	I, R and A Contracted Units	I, R and A Contracted Unit Cost	Care Management Contracted Funds	Care Management Contracted Units	Care Management Contracted Unit Cost
)09-2010	SC Legal Services	$58,132	1,155	$50.3300			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)10-2011	SC Legal Services	$59,583	1,184	$50.3300			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)11-2012	SC Legal Services	$59,692	1,186	$50.3300			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	SC Legal Services	$60,447	1,201	$50.3300			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010	Newberry County COA			#DIV/0!	$39,125	2,568	$15.2356	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011	Newberry County COA			#DIV/0!	$47,410	3,111	$15.2356	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012	Newberry County COA			#DIV/0!	$45,458	2,984	$15.2339			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	Newberry County COA			#DIV/0!	$45,114	2,961	$15.2361			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010	Traditions Elder Day Care			#DIV/0!	$44,941	4,494	$10.0000	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011	Traditions Elder Day Care			#DIV/0!	$42,000	4,200	$10.0000	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012	Traditions Elder Day Care			#DIV/0!	$42,000	4,200	$10.0000			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	Traditions Elder Day Care			#DIV/0!	$42,000	4,200	$10.0000			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010	REGIONWIDE	$58,132	1,155	$50.3300	$84,066	7,062	$11.9040	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011	REGIONWIDE	$59,583	1,184	$50.3300	$89,410	7,311	$12.2295	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012	REGIONWIDE	$59,692	1,186	$50.3300	$87,458	7,184	$12.1740	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)12-2013	REGIONWIDE	$60,447	1,201	$50.3300	$87,114	7,161	$12.1651	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!

REGION: 04 Central Midlands COG/AAA

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012

State Fiscal Year Beginning July	County or Contractor	Congregate Meals Contracted Funds	Congregate Meals Contracted Units	Congregate Meals Contracted Unit Cost	Home Delivered Meals Contracted Funds	Home Delivered Meals Contracted Units	Home Delivered Meals Contracted Unit Cost	Health Screening Contracted Funds	Health Screening Contracted Units	Health Screening Contracted Unit Cost	Nutrition Risk Assessment Contracted Funds	Nutrition Risk Assessment Contracted Units	Nutrition Risk Assessment Contracted Unit Cost	Health Promotion Contracted Funds	Health Promotion Contracted Units	Health Promotion Contracted Unit Cost
009-2010	Fairfield County COA	$94,492	13,815	$6.8400	$133,072	22,516	$5.9100	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011	Fairfield County COA	$63,483	9,281	$6.8400	$147,245	24,915	$5.9100	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012	Fairfield County COA	$50,860	7,436	$6.8400	$101,890	17,240	$5.9100			#DIV/0!			#DIV/0!			#DIV/0!
012-2013	Fairfield County COA	$46,318	6,772	$6.8400	$91,813	15,535	$5.9100			#DIV/0!			#DIV/0!			#DIV/0!
009-2010	Lexington County RAC	$230,587	30,261	$7.6200	$288,163	44,676	$6.4500	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011	Lexington County RAC	$211,397	27,742	$7.6200	$259,361	40,211	$6.4500	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012	Lexington County RAC	$188,111	24,686	$7.6200	$248,517	38,530	$6.4500			#DIV/0!			#DIV/0!			#DIV/0!
012-2013	Lexington County RAC	$184,692	24,238	$7.6200	$174,935	27,121	$6.4500			#DIV/0!			#DIV/0!			#DIV/0!
009-2010	Newberry County COA	$112,501	16,095	$6.9900	$158,820	28,929	$5.4900	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011	Newberry County COA	$119,870	17,149	$6.9900	$140,020	25,505	$5.4900	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012	Newberry County COA	$123,134	17,616	$6.9900	$127,631	23,248	$5.4900			#DIV/0!			#DIV/0!			#DIV/0!
012-2013	Newberry County COA	$126,835	18,145	$6.9900	$112,153	20,429	$5.4900			#DIV/0!			#DIV/0!			#DIV/0!
009-2010	Senior Resources, Inc	$213,456	26,850	$7.9500	$313,095	50,745	$6.1700	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011	Senior Resources, Inc	$192,982	24,123	$8.0000	$291,829	47,298	$6.1700	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012	Senior Resources, Inc	$160,823	20,229	$7.9500	$226,167	36,656	$6.1700			#DIV/0!			#DIV/0!			#DIV/0!
012-2013	Senior Resources, Inc	$162,470	20,436	$7.9500	$171,245	27,754	$6.1700			#DIV/0!			#DIV/0!			#DIV/0!
009-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
012-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
009-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
012-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
009-2010	REGIONWIDE	$651,036	87,020	$7.4815	$893,150	146,867	$6.0814	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
010-2011	REGIONWIDE	$587,732	78,295	$7.5066	$838,455	137,929	$6.0789	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
011-2012	REGIONWIDE	$522,928	69,967	$7.4739	$704,205	115,674	$6.0878	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
012-2013	REGIONWIDE	$520,315	69,591	$7.4768	$550,146	90,839	$6.0563	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!

EGION: 04 Central Midlands COG/AAA

Four Year History of Contracted UNITS and UNIT COST of Services - State Fiscal Years Beginning on July 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012

ate Fiscal Year ieginning July	County or Provider	Physical Fitness Contracted Funds	Physical Fitness Contracted Units	Physical Fitness Contracted Unit Cost	Home Injury Prevention Contracted Funds	Home Injury Prevention Contracted Units	Home Injury Prevention Contracted Unit Cost	Senior Games Contracted Funds	Senior Games Contracted Units	Senior Games Contracted Unit Cost	Minor Home Repair Contracted State Funds	Minor Home Repair Contracted State Units	Minor Home Repair Contracted Unit Cost	Medication Management Contracted Funds	Medication Management Contracted Units	Medication Management Contracted Unit Cost
)09-2010	Newberry County COA	$17,605	2,081	$8.4599			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)10-2011	Newberry County COA	$17,848	2,110	$8.4588			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)11-2012	Newberry County COA	$17,784	2,102	$8.4600			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	Newberry County COA	$20,431	2,415	$8.4600			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010	Senior Resources, Inc	$8,804	1,760	$5.0000			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)10-2011	Senior Resources, Inc	$8,924	1,785	$5.0000			#DIV/0!			#DIV/0!			#DIV/0!	$0	0	#DIV/0!
)11-2012	Senior Resources, Inc	$8,892	1,778	$5.0000			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	Senior Resources, Inc	$10,216	2,043	$5.0000			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011		$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013				#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)09-2010	REGIONWIDE	$26,409	3,841	$6.8756	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)10-2011	REGIONWIDE	$26,772	3,895	$6.8734	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!	$0	0	#DIV/0!
)11-2012	REGIONWIDE	$26,676	3,880	$6.8753			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
)12-2013	REGIONWIDE	$30,647	4,458	$6.8746			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

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	$156,976	85,330	$1.8396
Housekeeping or Chore	$54,155	2,742	$19.7502
Homemaker with Limited Personal Care	$56,289	3,086	$18.2401
Personal Care with Limited Medical Assistance	$0	0	#DIV/0!
Home Living Support	$0	0	#DIV/0!
Adult Day Care	$29,697	2,002	$14.8337
Legal Assistance	$27,297	542	$50.3635
Information, Referral & Assistance	$97,193	5,946	$16.3459
Respite Care	$0	0	#DIV/0!
Care Management	$0	0	#DIV/0!
Group Dining	$447,908	46,992	$9.5316
Home Delivered Meals	$790,078	102,120	$7.7368
Health Screening	$0	0	#DIV/0!
Nutrition Risk Follow-Up	$0	0	#DIV/0!
Evidence Based Health Promotion Program	$30,646	4,276	$7.1670
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	$3,427	0	#DIV/0!
Outreach	$0	0	#DIV/0!
I-Care Calls/Contacts	$31,356	2,120	$14.7906
SMP Calls/Contacts	$13,665	0	#DIV/0!
Caregiver Services	$142,035	635	$223.6772

All entries must include both AAA delivered services and contracted services

NUMBER OF MINORITY PROVIDERS	2
NUMBER OF RURAL PROVIDERS	4
TOTAL NUMBER OF PROVIDERS	7

REGION: 04 Central Midlands COG AAA/ADRC

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 71% In-Home Services 13% Legal Assistance 8%

Enter Total III B after Transfers for SFY 2011-2012	$560,000	**and SFY 2013-2014**	$296,546

ACCESS SERVICES	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
A. Transportation	$269,804	48%	$128,069	43%
B. Information & Assistance (**III-B funding Only**)	$82,614	15%	$82,614	28%
C. Case Management	$0	0%	$0	0%
D. Outreach	$0	0%	$0	0%
TOTAL ACCESS EXPENDITURES	$352,418	63%	$210,683	71%

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	$51,244	9%	$17,740	6%
B. Level II Homemaker with Limited Personal Care	$39,744	7%	$19,961	7%
C. Level III Personal Care with Limited Medical Assistance	$27,098	5%	$0	0%
TOTAL IN-HOME EXPENDITURES	$118,086	21%	$37,701	13%

LEGAL ASSISTANCE	FUNDS EXPENDED SFY 2012-2013	% OF III - B	FUNDS BUDGETED FY 2013-2014	% OF III - B
LEGAL ASSISTANCE EXPENDITURES	$51,321	9%	$23,202	8%

REQUESTED TRANSFER OF FEDERAL FUNDS SFY 2013-2014

Per requirements of the Older Americans Act, the Area Agency on Aging may, without a waiver, elect to transfer not more than 40% of the funds received under Title III-C between subpart 1 and subpart 2, for use as the Area Agency considers appropriate to purchase services that meet the nutritional needs of older adults in the area served.

If the Area Agency on Aging determines that a transfer of more than 40% is required to purchase services at a level that satisfies the need for III-C-1 or III-C-2 services, the agency must request a waiver that justifies the transfer of an additional amount, not to exceed an additional 10% of the funds received under Title III-C, between Subpart 1 and Subpart 2.

To comply with OAA, Maintenance of Effort provisions for Ombudsman funding, LGOA transferred Title III-C-1 to Title III-B prior to allocating Title III services funds to the regions; therefore, **the AAA may not transfer for state fiscal year 2014.**

The AAA may **not** transfer the Title III-C-2 allocation to III-B for use as the Area Agency considers necessary to purchase services to meet the need for in-home and community based services **for the state fiscal year 2014.**

The AAA may **not** transfer a portion of the Title III-C-1 allocation to Title III-C-2 **provided enough remains in III-C-1 to maintain a cost effective and viable group dining program** for older adults in the region **for the state fiscal year 2014.**

REQUESTED TRANSFERS

TITLE	ORIGINAL ALLOCATION (See Note Below)	REQUESTED TRANSFER	REQUESTED ALLOCATION	% OF TRANSFER
III-B	$213,932		$213,932	0.00%
III-C-1	$300,056		$300,056	0.00%
III-C-2	$560,157		$560,157	0.00%
TOTAL	$1,074,145	$0	$1,074,145	

INSTRUCTIONS

Total of ORIGINAL ALLOCATION column must total the Title III-B plus III-C-1 plus III-C-2 allocations for services transmitted to the region in the ALLOCATIONS FOR SERVICE PROVISION - AREA PLAN PERIOD 2013-2014.

Total of REQUESTED TRANSFER column must be **ZERO**

Total of REQUESTED ALLOCATION column must equal total of the ORIGINAL ALLOCATION column

A formula will compute the % of TRANSFER based on the OAA provisions cited at the top of this form.

All Title III-B service funds allocated to the AAA must be included on the III-B line in the Original and Requested Allocations columns including any III-B funds expended **at the AAA** for III-B community-based services to older adults. (*Do not include Program Development or III-B Ombudsman funds*)

Regional Summary of Unit Costs

The region's unit costs have remained the same for the past four years. Increases in some services have been requested and granted due to increase in the Consumer Price Index and changes in the scope of work. Over the past four years, there was an increase in the number of units served when stimulus funds were received. Subsequently, there was a decrease in units served when these funds were no longer available.

Summary of Four Year History

Prices remained the same during the four year period.

Transportation miles decreased to 431,498 miles during state fiscal year **2008-2009**. Group Dining meals have increased to 63,482; while Home Delivered meals have increased to 125,501. Health Promotion and Disease Prevention hours have decreased to 2,989.

Home Care hours decreased to 6,865 in Level I; increased to 7,001 in Level II and decreased to 1,528 in Level III; Adult Day Care hours have increased to 3,956 and Legal Assistance hours have decreased to 1,142 hours.

Transportation units increased to 634,705 miles during state fiscal year **2009-2010.** Group Dining meals increased to 88,690; while Home Delivered meals increased to 139,709. Health Promotion and Disease Prevention hours increased to 3,868.

Home Care hours increased to 9,866 in Level I; increased to 8,521 in Level II and increased to 1,717 in Level III; Adult Day Care increased to 8,254 and Legal Assistance hours increased to 1,276. These increases were due to stimulus funds and state supplemental funds.

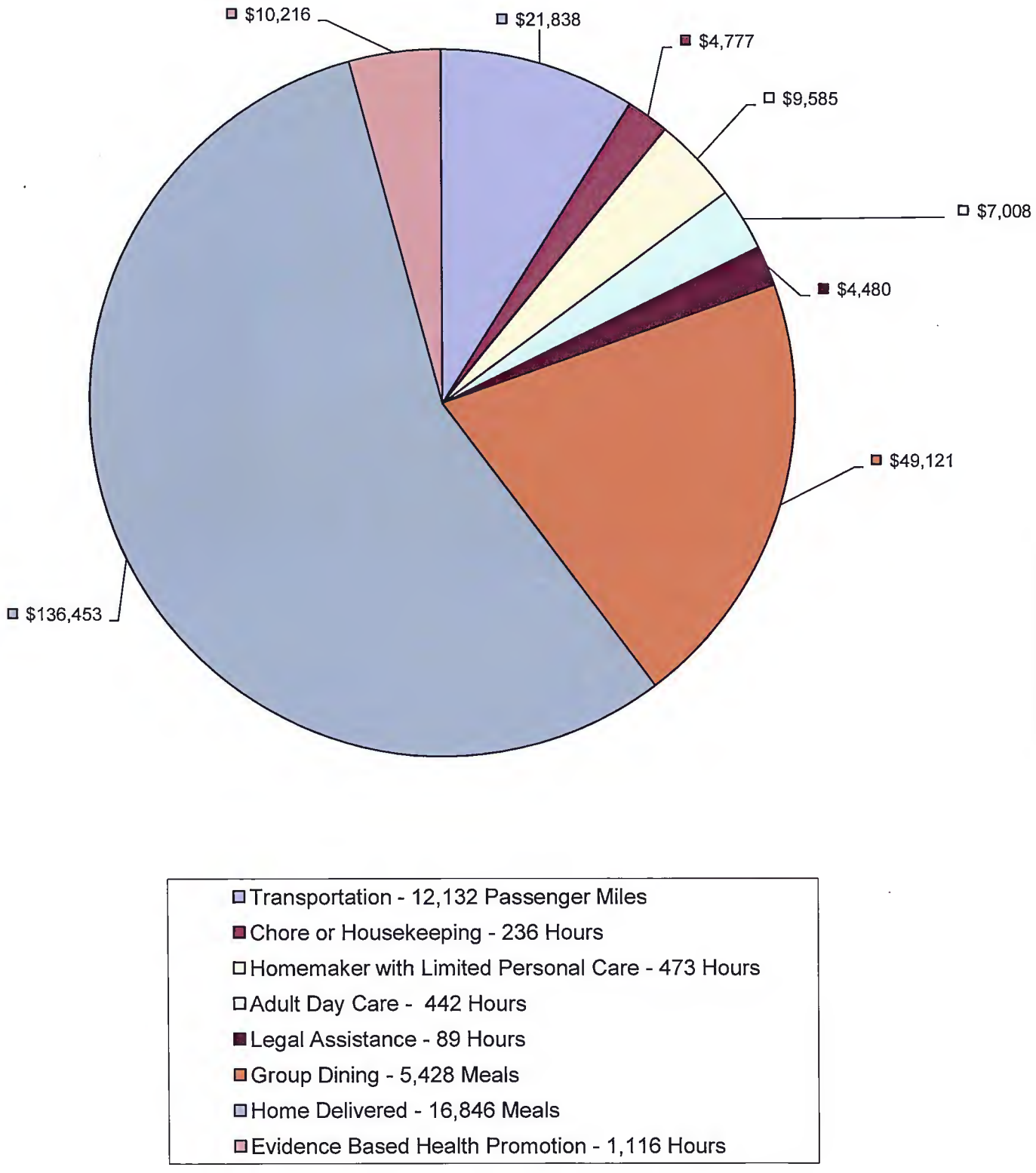
Transportation miles decreased to 493,227 miles during state fiscal year **2010-2011**. Group Dining meals have decreased to 66,272; while Home Delivered meals have decreased to 96,728. Health Promotion and Disease Prevention hours have increased to 3,886.

Home Care hours have decreased to 8,302 in Level I; decreased to 7,972 in Level II and increased to 3,566 in Level III; Adult Day Care hours have decreased to 6,976 and Legal Assistance hours have increased to 1,304 hours.

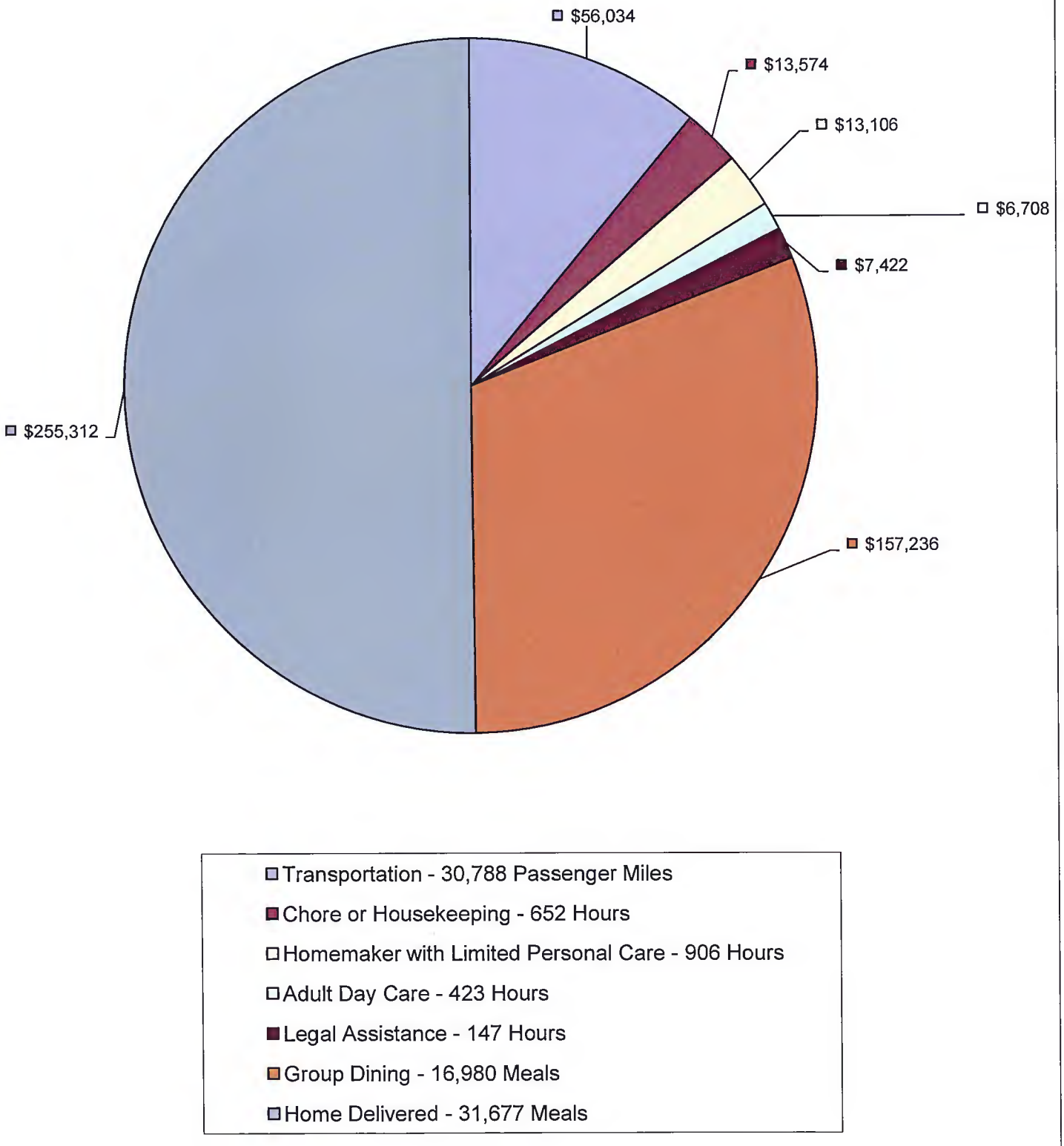
Transportation miles decreased to 483,817 miles during state fiscal year **2011-2012.** Group Dining meals have increased to 81,643; while Home Delivered meals have decreased to 113,361. Health Promotion and Disease Prevention hours have decreased to 3,880.

Home Care hours have decreased to 7,927 in Level I; decreased to 5,353 in Level II and decreased to 2,645 in Level III; Adult Day Care hours have decreased to 11,053 and Legal Assistance hours have decreased to 1,201hours.

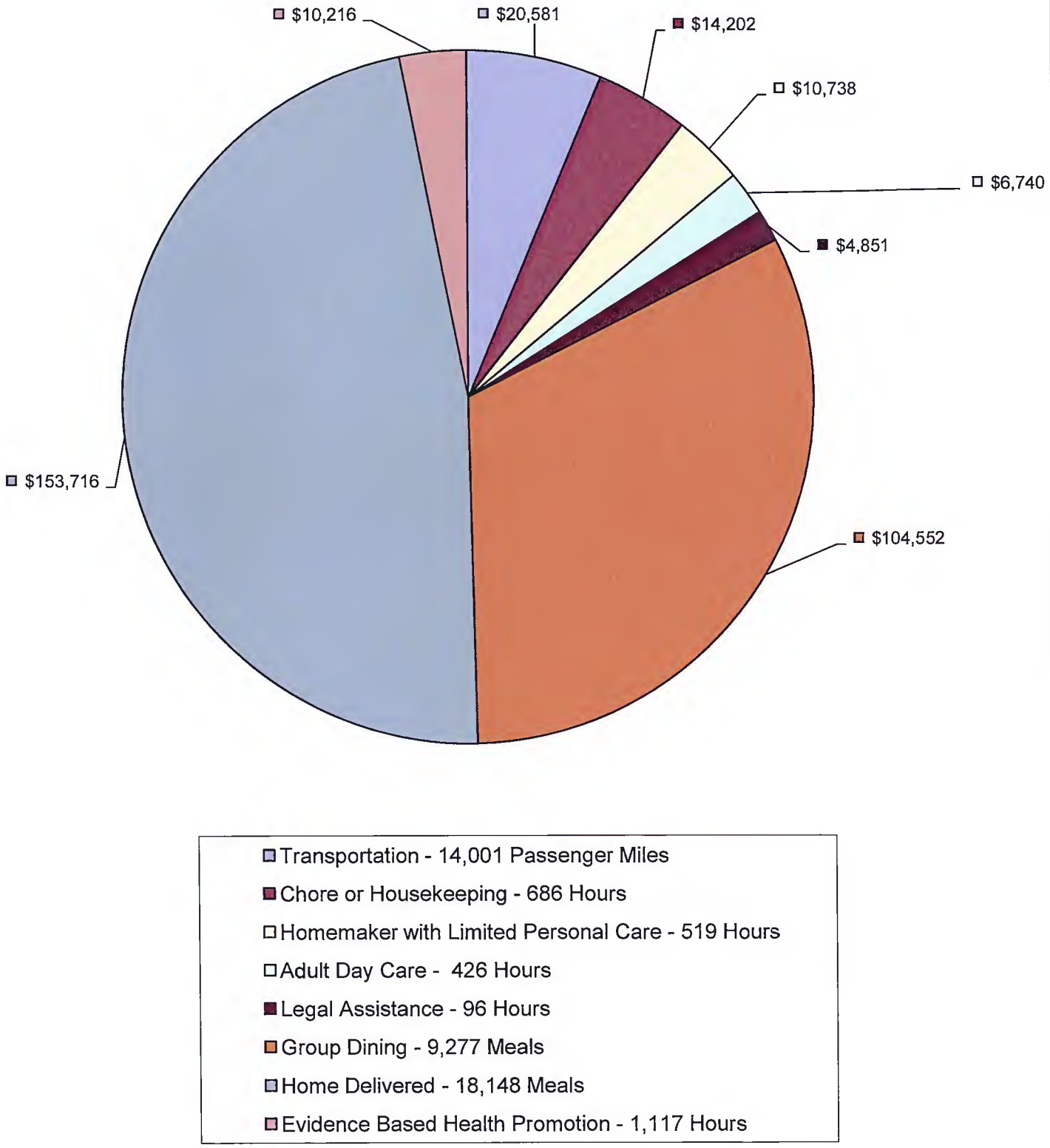
CENTRAL MIDLANDS COG AAA/ADRC
Fairfield County Flow Through Funding for Services SFY2014



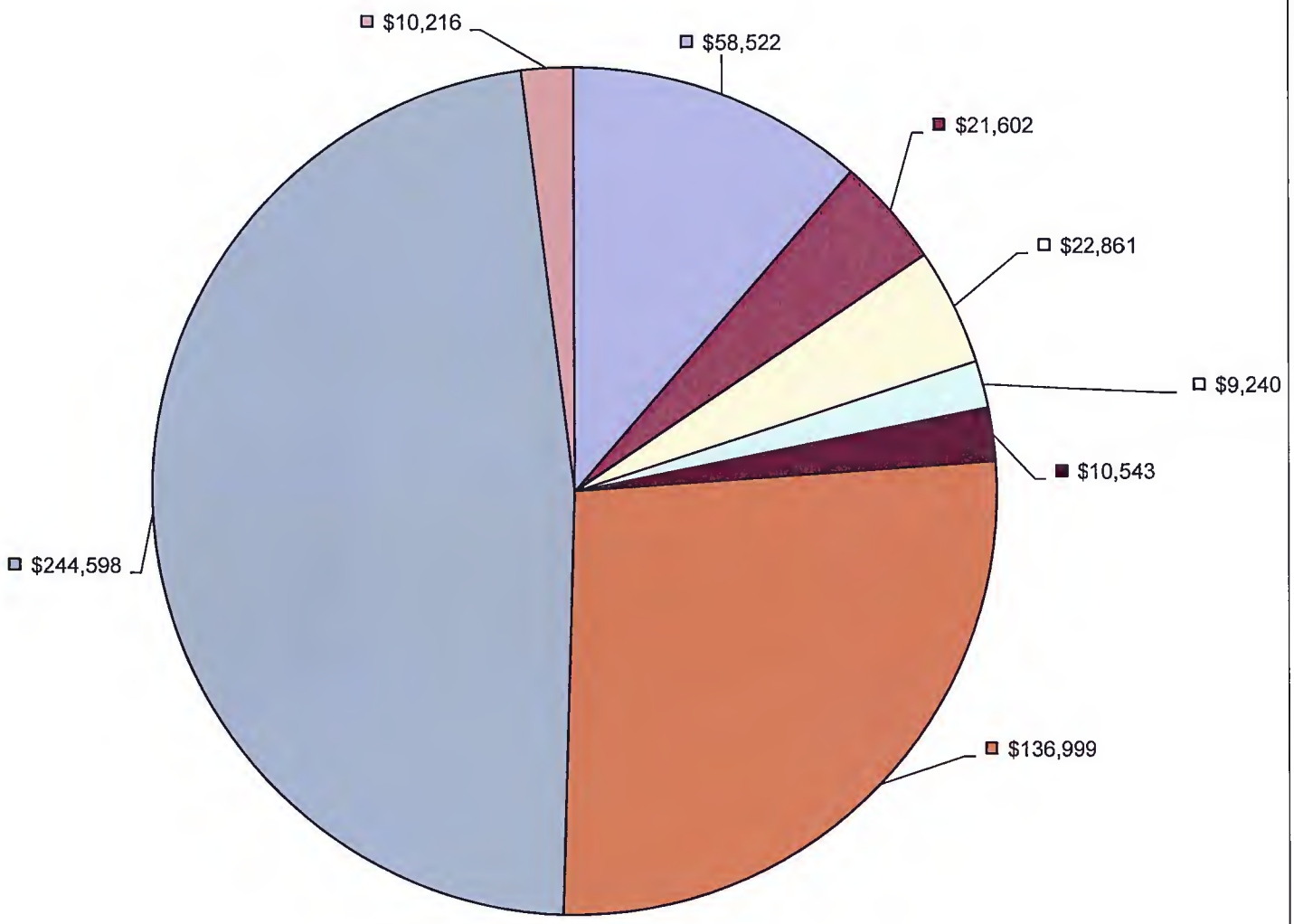
CENTRAL MIDLANDS COG AAA/ADRC
Lexington County Flow Through Funding for Services SFY2014



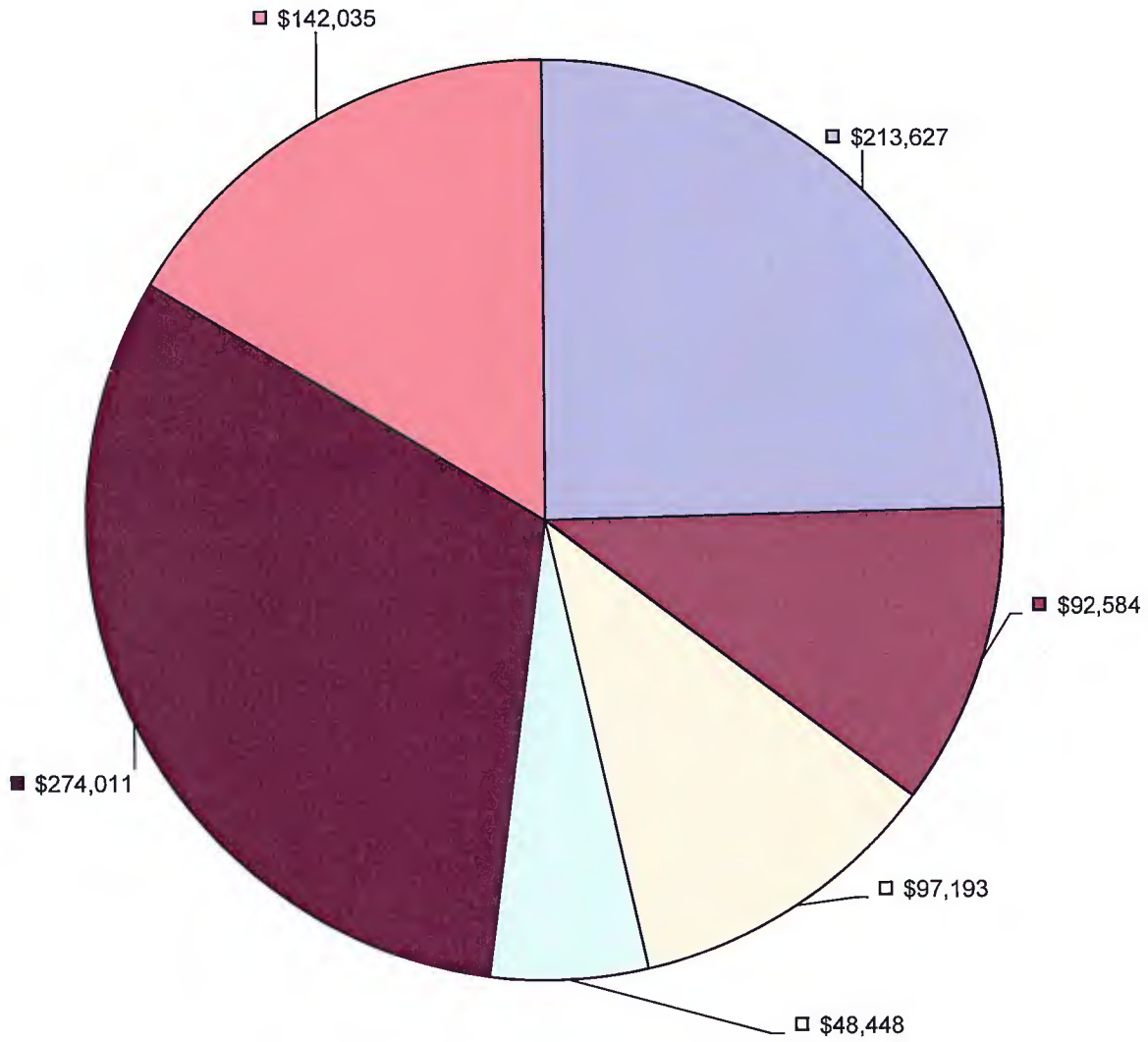
CENTRAL MIDLANDS COG AAA/ADRC
Newberry County Flow Through Funding for Services SFY2014



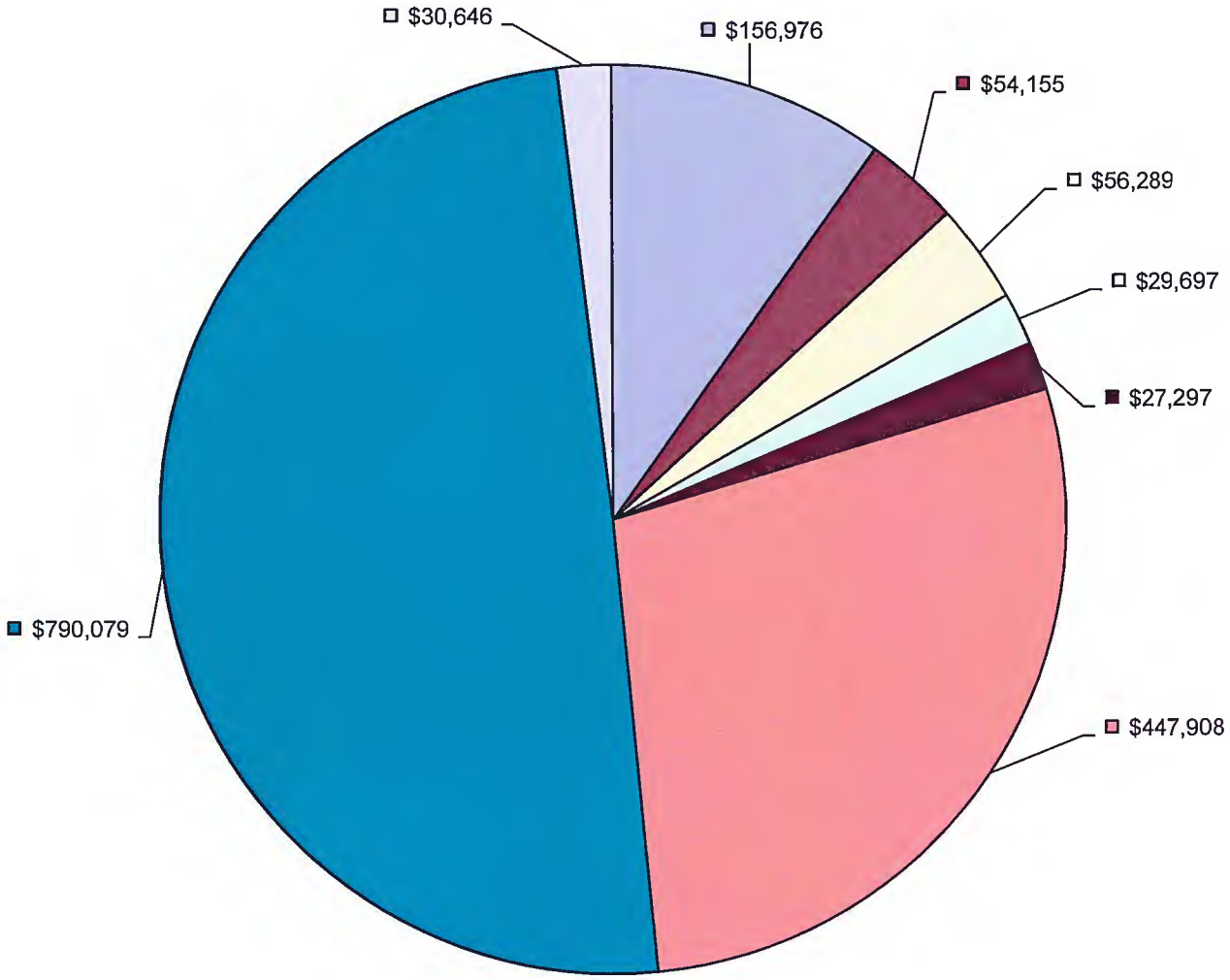
CENTRAL MIDLANDS COG AAA/ADRC
Richland County Flow Through Funding for Services SFY2014



CENTRAL MIDLANDS COG AAA/ADRC
Internal Operations and Family Caregiver Services Funding SFY2014



CENTRAL MIDLANDS COG AAA/ADRC
Flow Through Funding for
Contracted Services SFY2014



REGION: #4 Central Midlands COG AAA/ADRC 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 described in the OAA	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		4680	4680	0	7703	2632	2340	2048	0	1447
Aging Unit Director	Sharon Seago	1950	1950							0
Program Manager		0	0							0
Program Developer		0	0	0			0		0	0
Aging Fiscal Accounting	Ethel Montgomery (M)	1950	1950				0		0	0
Clerical Support Staff	Tasha Milhouse (M)	1950	780			390	390	390		
Clerical Support Staff	Fretoria Williams (M)	1950	0		1950					
Clerical Support Staff		0								
Clerical Support Staff		0								
FTEs by AAA ACTIVITIES		2.40	2.40	0.00	3.95	1.35	1.20	1.05	0.00	0.74
Ombudsman		7703			5753					0
Senior Ombudsman	Anna Harmon (M)	1,853	0		1853	0				97
Other Ombudsman Staff	Shirley Thomas (M)	1,950			1950					
Other Ombudsman Staff	LaToya Buggs-Williams (M)	1,950			1950					
Other Ombudsman Staff		0								
Other Ombudsman Staff		0								
Other Ombudsman Staff		0			0					
FTEs		3.95	0.00	0.00	3.95	0.00	0.00	0.00	0.00	0.05
I & A		2632				1365	292	293		0
Primary I&A and R	Carol Boykin	1,950				1365	292	293		0
Backup I&R		0					0	0		
FTEs		1.35		0.00	0.00	0.70	0.15	0.15	0.00	0.00
Insurance Counseling/SMP		2048			0	585	292	1073		0
Primary Counsellor	Sheila Bell-Ford (M)	1,950				585	292	1073		0
Backup Counsellor										0
		0								
FTEs		1.05		0.00	0.00	0.30	0.15	0.55	0.00	0.00
Family Caregiver Program		2340				292	1366	292		0
Caregiver Advocate	Joe Ritchey	1,950	0.00			292	1366	292		0
		0				0		0		1350
FTEs		1.20	0.00	0.00	0.00	1.35	1.20	1.05	0.00	0.69
Other AAA Direct Services		0							0	
Case Manager		0							0	0
Medication Management		0							0	
FTEs		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.74
COMBINED SERVICE DELIVERY		14723								
Intern Hours		1440	0			0	1,440	0	0	
Volunteer Hours		576			576			0	0	
TOTAL PAID HOURS		19,403								
TOTAL PAID FTEs		9.95								

Enter Staff Names	Annual Payroll Hours All Sources
AGENCY'S FTE	1950
Bell-Ford	1950
Boykin	1950
Buggs-Williams	1950
Harmon	1950
Milhouse	1950
Montgomery	1950
Ritchey	1950
Seago	1950
Sparks	1950
Thomas	1950
Williams	1950
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
	0
Paid Hours	21450
Interns	1440
Volunteers	576
Total Hours	23,466

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.

TARGETING OBJECTIVES

Using the client demographics tables "Target populations served shown as percentage of total persons served" chart, SC Legal Services (16.46%) and Lexington County (24.08%) Recreation and Aging Commission serve the lowest percentage of total persons who are a minority. Fairfield County Council on Aging serves 24.79% for total persons who are below poverty. Senior Resources, Inc. serves a lower percentage of 15.03 % of total persons who live in rural areas. Senior Resources, Inc. services 82.11% total minority who are poor. Lexington County Recreation and Aging Commission serves the highest number of non- minority who are poor. All contractors need to focus on targeting older individuals from minority groups other than African American. Outreach efforts need to be done to reach those in greatest social need who are unaware of services.

AAA will explore Hispanic services and will use them as outreach efforts to increase services for all contractors. The Area Agency on Aging will attempt to reach 3% more Hispanics in need of services, if seniors in need can be located. The Area Agency on Aging has met with the South Carolina Hispanic Leadership Council to forge a new relationship with this community.

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

REGION: 04 Central Midlands COG AAA/ADRC — **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'13
Senior Resources, Inc.	599	476	79.47%	90	15.03%	274	45.74%	231	48.53%	101	82.11%	0	0.00%
Fairfield County Council on Aging	234	126	53.85%	83	35.47%	58	24.79%	39	30.95%	107	99.07%	0	0.00%
Lexington County Recreation & Aging Comm	706	170	24.08%	564	79.89%	178	25.21%	57	33.53%	533	99.44%	0	0.00%
Newberry County Council on Aging	427	173	40.52%	415	97.19%	148	34.66%	68	39.31%	253	99.61%	0	0.00%
Traditions Elder Day Care	4	3	75.00%		0.00%	2	50.00%	2	66.67%	1	100.00%	0	0.00%
Addus HealthCare (SC), Inc. dba CarePro Health Services	25	11	44.00%	20	80.00%	6	24.00%	3	27.27%	14	100.00%	0	0.00%
SC Legal Services	276	158	57.25%	250	90.58%	41	14.86%	26	16.46%	118	100.00%	0	0.00%
Corporate Care	12	1	8.33%	12	100.00%	3	25.00%		0.00%	11	100.00%	0	0.00%
	0		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	0	#DIV/0!
	0		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	0	#DIV/0!
Regionwide	2283	1118	48.97%	1434	62.81%	710	31.10%	426	38.10%	1138	97.68%	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'13.

(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 2010 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, 2012**

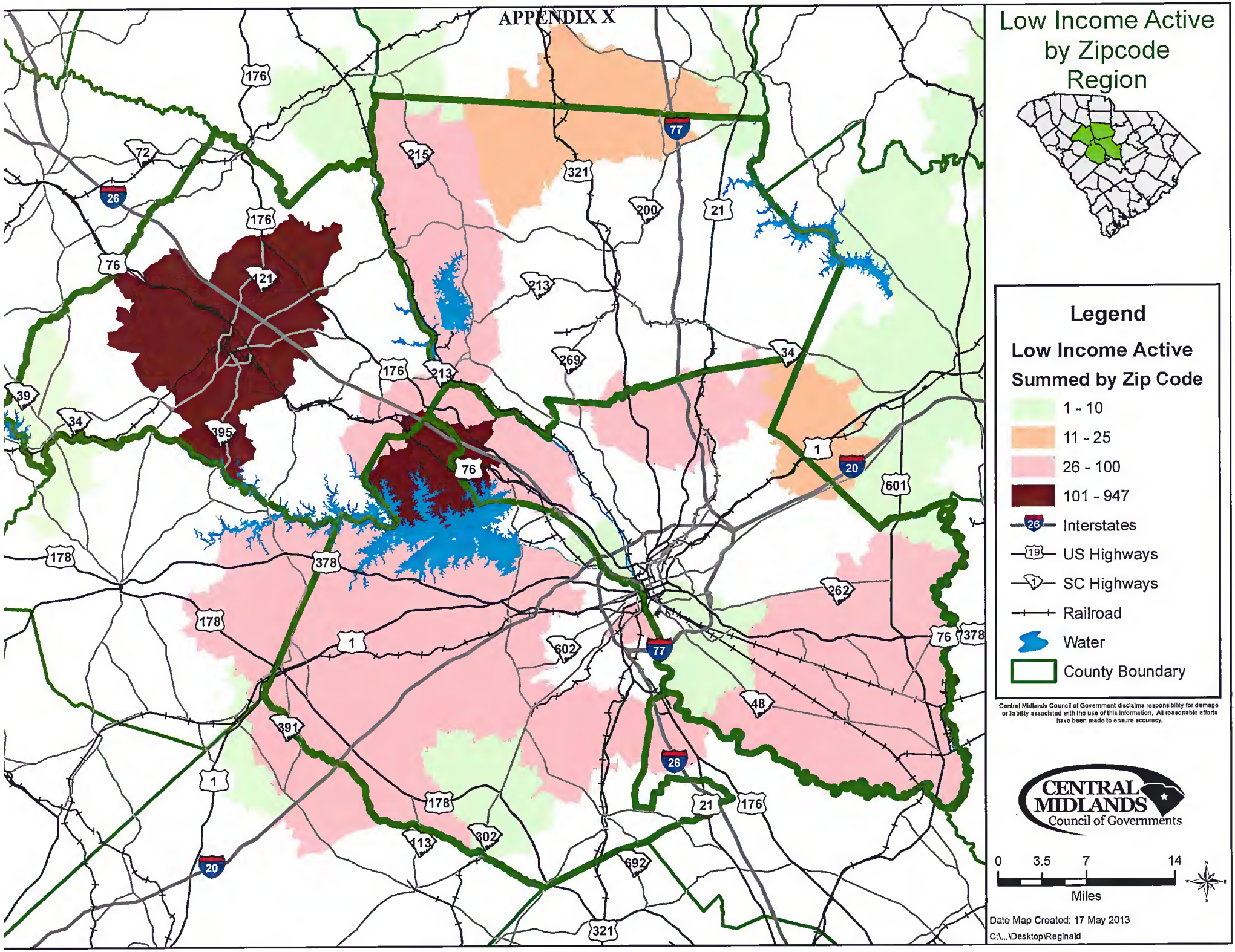
SUPPLEMENTAL DETAIL - Breakout of the ethnicity of the Minority Population SERVED in SFY 2012-2013					
Service Delivery Contractors	**African-American**	**Hispanic**	**Native American or Alaskan Native**	**Asian/ Pacific Islander**	**Unknown Ethnicity**
Senior Resources, Inc.	471	2			27
Fairfield County Council on Aging	124		2		1
Lexington County Recreation & Aging Comm	164	4		1	8
Newberry County Council on Aging	167	5	1	1	5
Traditions Elder Day Care	3				
Addus HealthCare (SC), Inc. dba CarePro Health Cervices	11				
SC Legal Services	151	3	1	3	3
Corporate Care, LLC	1				
Regionwide	1092	14	4	5	44

APPENDIX V

DESIGNATED AND UNDESIGNATED FOCAL POINTS IN THE PSA				
County	**Focal Point Organization**	**Focal Point Address**	**AAA Designated Focal Point**	**Type of Organization or Facility**
Fairfield	Fairfield County Council on Aging	210 East Washington Street Winnsboro, SC 29180	Yes	Not-for-profit
Lexington	Brookland Baptist Church	1066 Sunset Blvd. West Columbia, SC 29169	No	Faith Based
Lexington	Lexington County Recreation and Aging Commission	125 Parker Street Lexington, SC 29072	Yes	Quasi-Governmental
Lexington	Irmo- Chapin Recreation Commission-Crooked Creek Park	1098 Old Lexington Hwy. Chapin, SC 29036	Yes	Quasi-Governmental
Lex/Rich Co.	Shepherd Centers	Ashland, Trenholm Methodist Churches	No	Interfaith
Newberry	Newberry County Council on Aging	1300 Hunt Street Newberry, SC 29180	Yes	Not-for-profit
Richland	Bibleway Church of Atlas Road	2440 Atlas Road Columbia, SC 29209	No	Faith Based
Richland	Captial Senior Center	1650 Park Circle Columbia, SC 29201	Yes	Not-for-profit
Richland	Senior Resources, Inc.	2817 Millwood Avenue Columbia, SC 29205	Yes	Not-for-profit

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.

APPENDIX X


Low Income Active by Zipcode Region
Legend
Low Income Active
Summed by Zip Code
1 - 10
11 - 25
26 - 100
101 - 947
Interstates
US Highways
SC Highways
Railroad
Water
County Boundary
Central Midlands Council of Government disclaims responsibility for damage or liability associated with the use of this information. All reasonable efforts have been made to ensure accuracy.
CENTRAL MIDLANDS Council of Governments
0 3.5 7 14
Miles
Date Map Created: 17 May 2013
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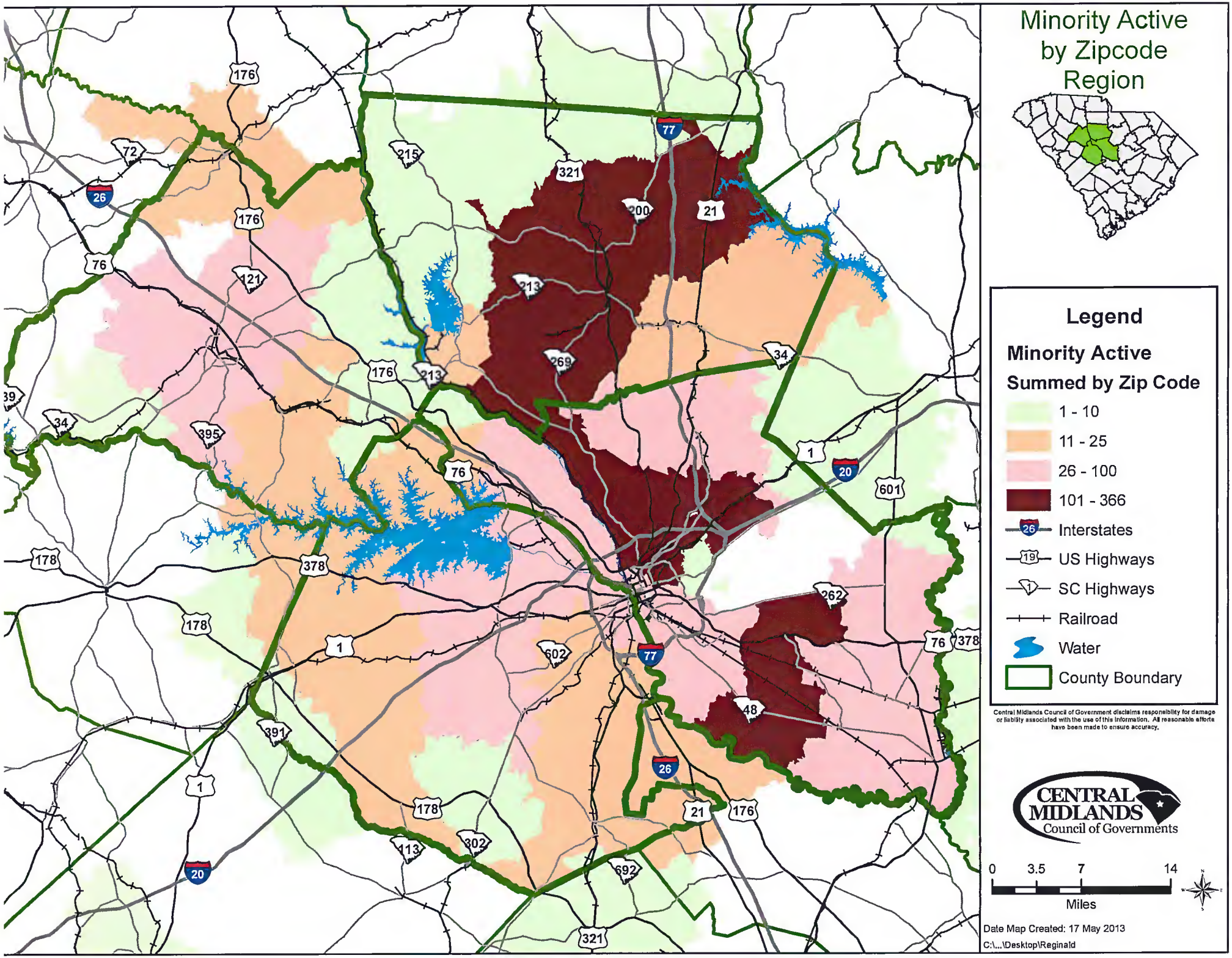
Minority Active by Zipcode Region
Legend
Minority Active
Summed by Zip Code
1 - 10
11 - 25
26 - 100
101 - 366
Interstates
US Highways
SC Highways
Railroad
Water
County Boundary
Central Midlands Council of Government disclaims responsibility for damage or liability associated with the use of this information. All reasonable efforts have been made to ensure accuracy.
CENTRAL MIDLANDS Council of Governments
0 3.5 7 14
Miles
Date Map Created: 17 May 2013
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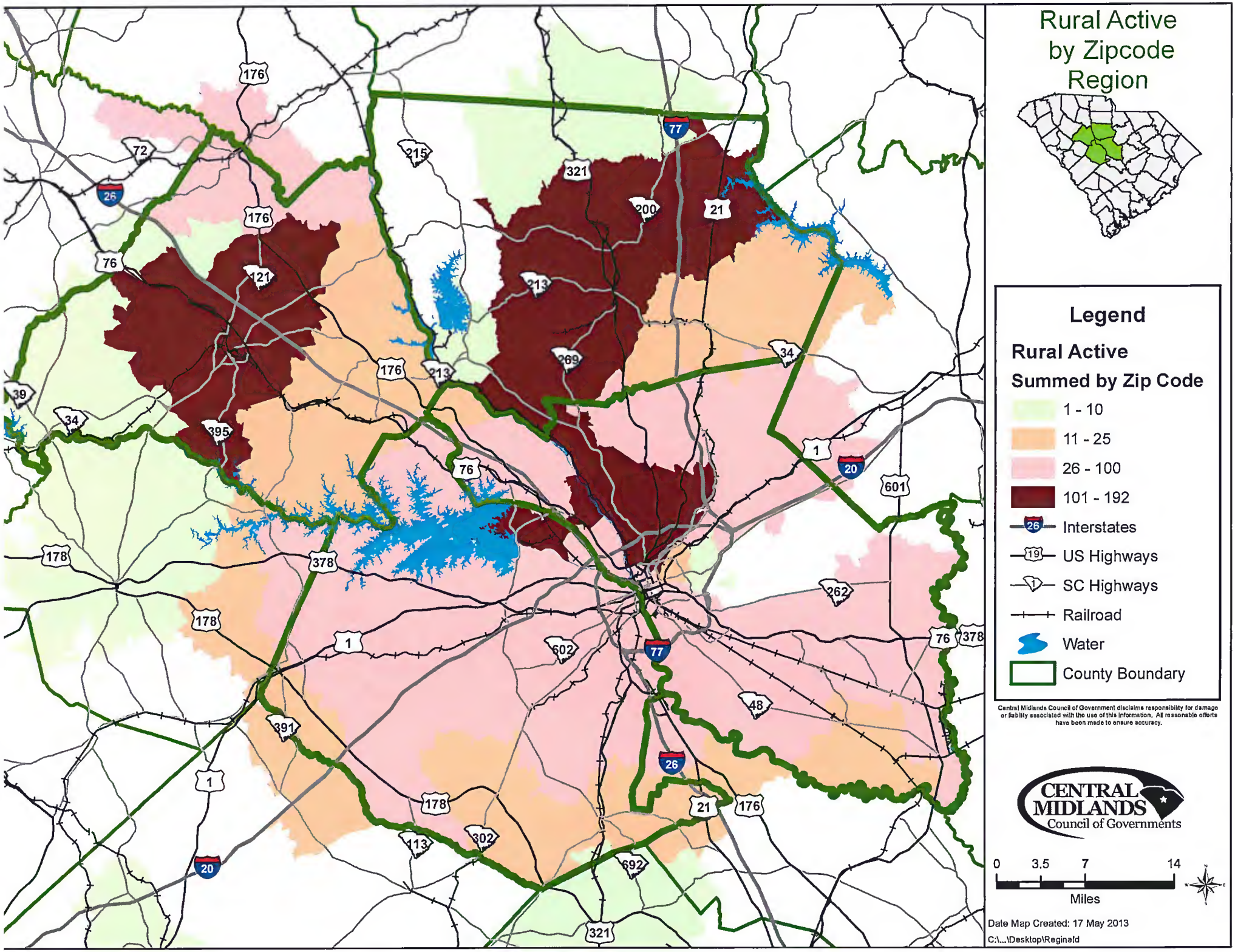
Rural Active by Zipcode Region
Legend
Rural Active
Summed by Zip Code
1 - 10
11 - 25
26 - 100
101 - 192
Interstates
US Highways
SC Highways
Railroad
Water
County Boundary
Central Midlands Council of Government disclaims responsibility for damage or liability associated with the use of this information. All reasonable efforts have been made to ensure accuracy.
CENTRAL MIDLANDS Council of Governments
0 3.5 7 14
Miles
Date Map Created: 17 May 2013
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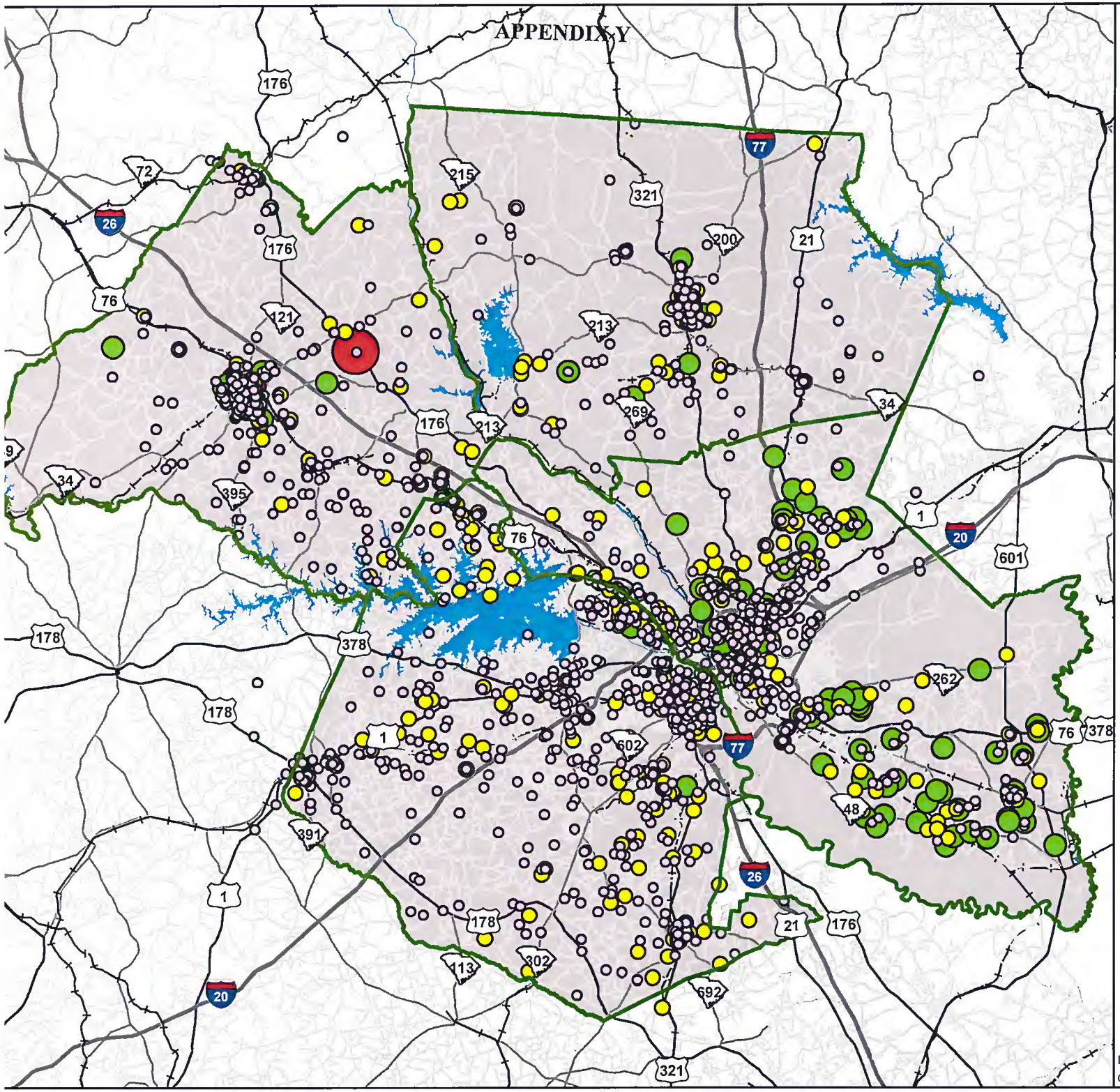
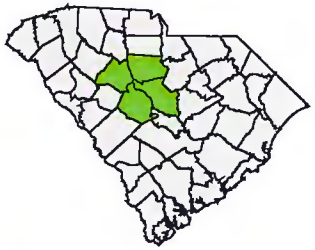


Services Provided Region



Legend

Services Provided (per person)

- 1
- 2
- 3
- 4
- Interstates
- US Highways
- SC Highways
- Local Roads
- Railroad
- Water
- County Boundary

CENTRAL MIDLANDS Council of Governments

0 3.5 7 14

Miles

Date Map Created: 17 May 2013

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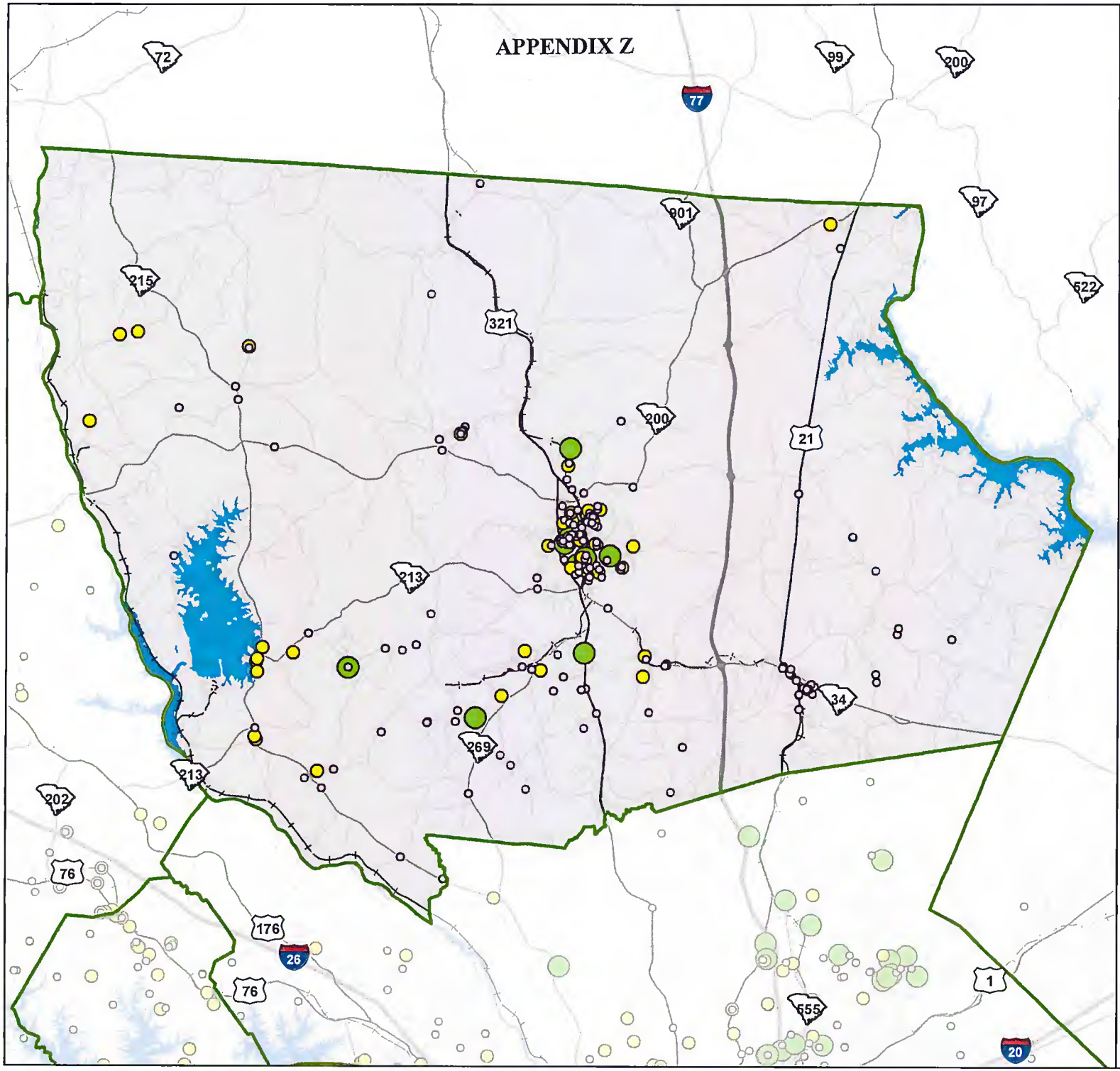
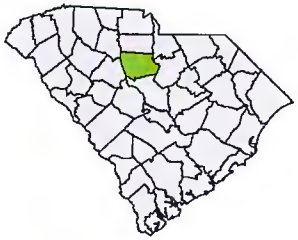
APPENDIX Z



Services Provided Fairfield County



Legend

Services Provided (per person)

- 1
- 2
- 3
- 4
- Interstates
- US Highways
- SC Highways
- Local Roads
- Railroad
- Water
- County Boundary

CENTRAL MIDLANDS Council of Governments

0 1.75 3.5 7

Miles

Date Map Created: 18 April 2013

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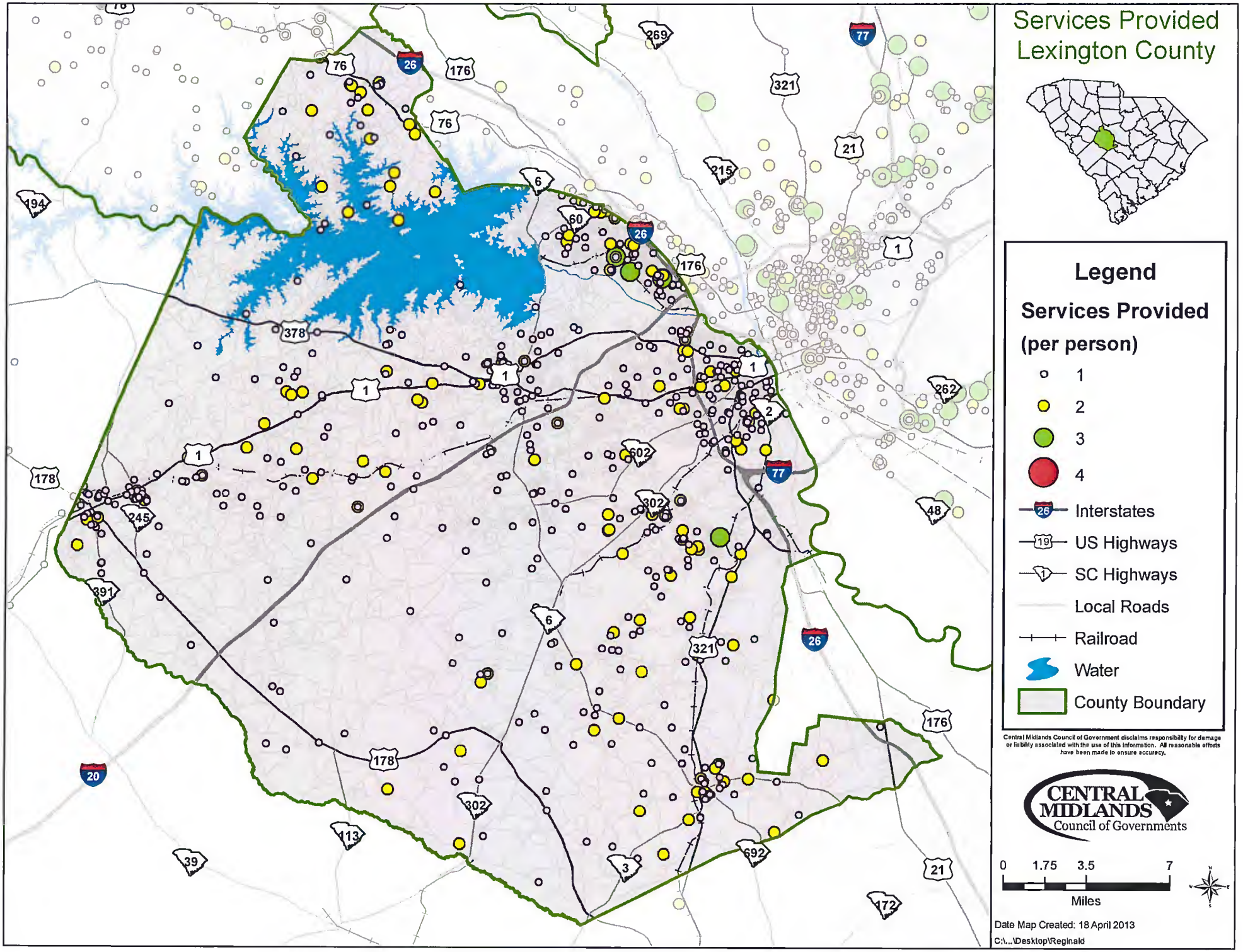
Services Provided
Lexington County
Legend
Services Provided
(per person)
1
2
3
4
Interstates
US Highways
SC Highways
Local Roads
Railroad
Water
County Boundary
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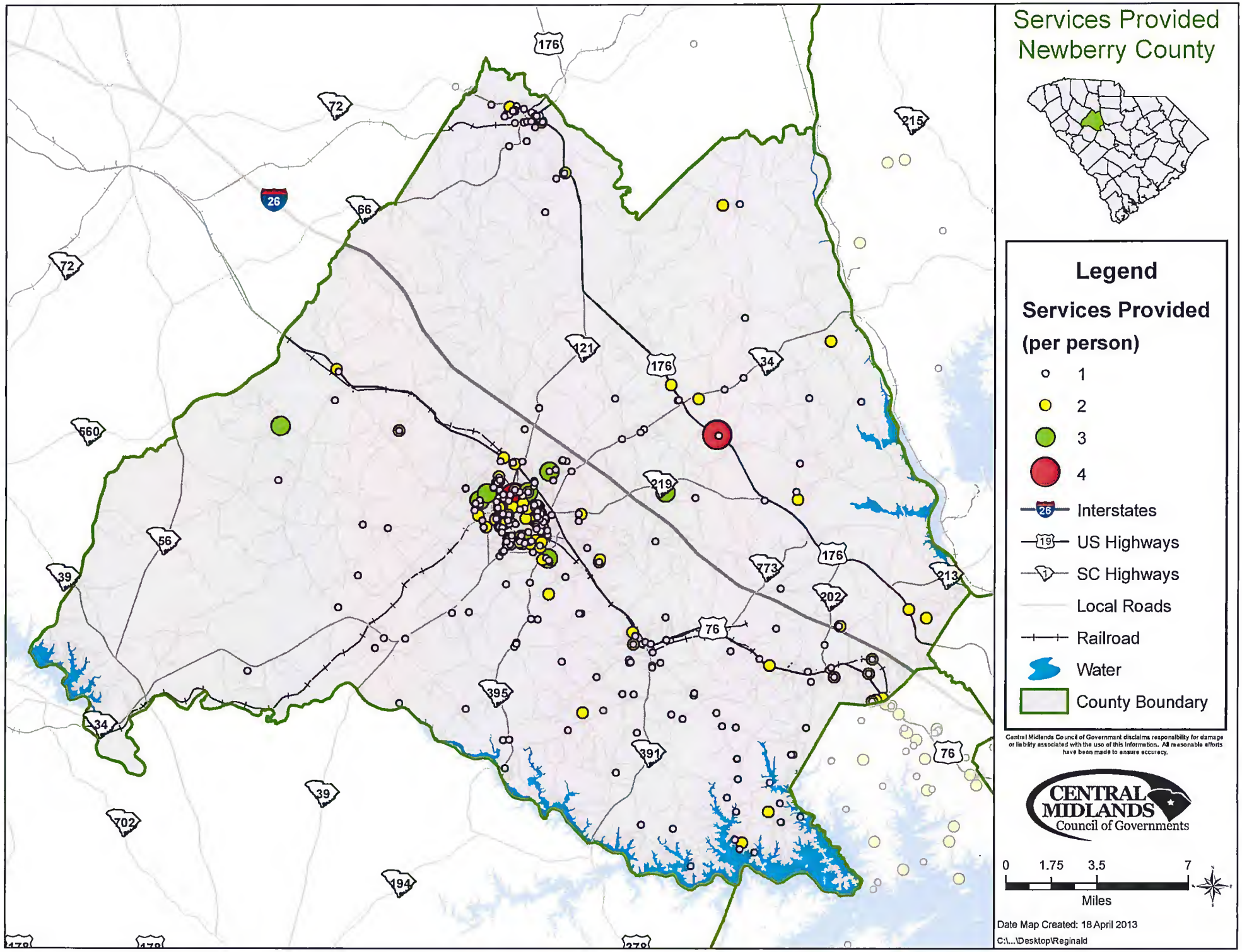
CENTRAL MIDLANDS
Council of Governments
0 1.75 3.5 7
Miles
Date Map Created: 18 April 2013
C:\...\Desktop\Reginald


Services Provided
Newberry County
Legend
Services Provided
(per person)
1
2
3
4
Interstates
US Highways
SC Highways
Local Roads
Railroad
Water
County Boundary
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CENTRAL MIDLANDS
Council of Governments
0 1.75 3.5 7
Miles
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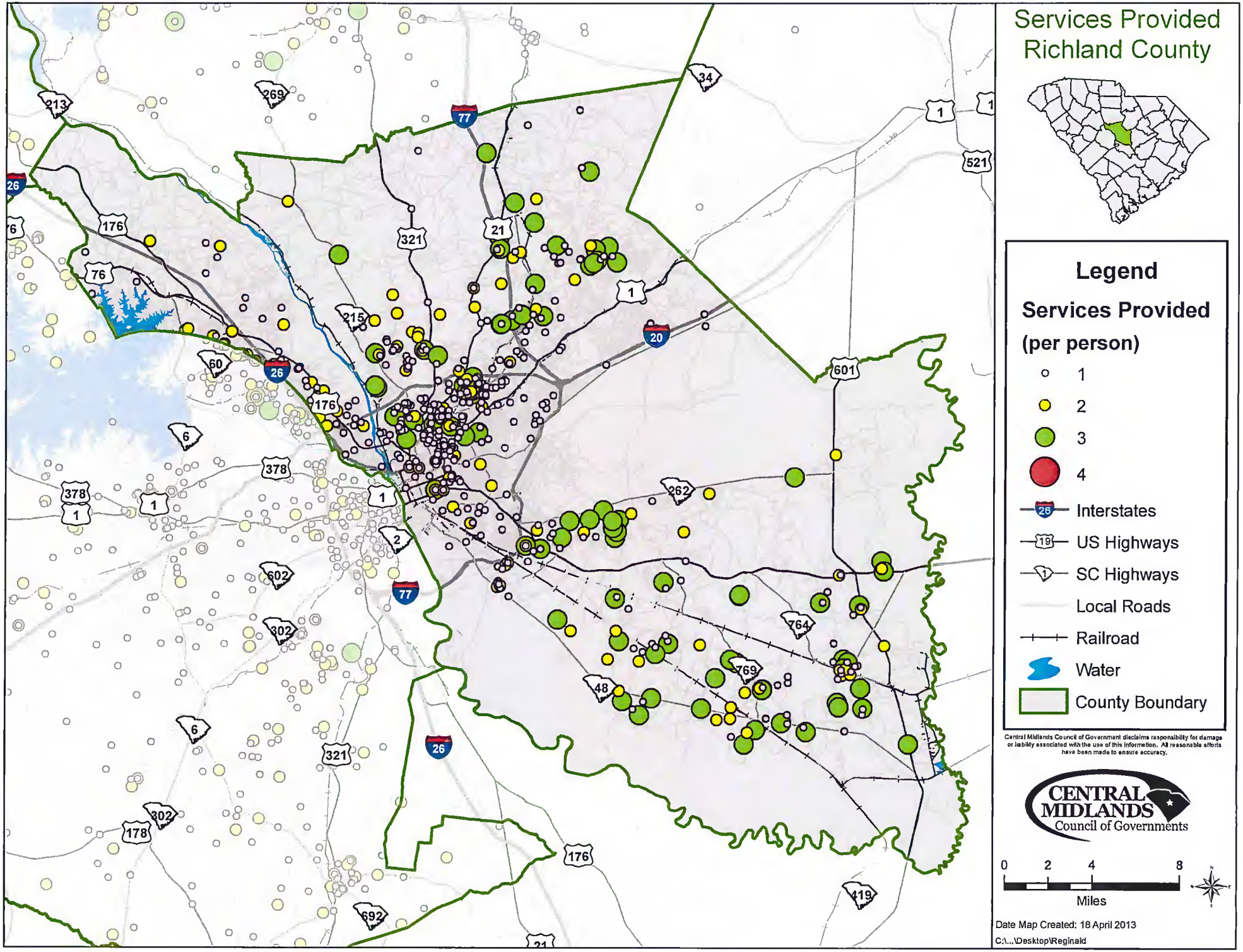
Services Provided
Richland County
Legend
Services Provided
(per person)
1
2
3
4
Interstates
US Highways
SC Highways
Local Roads
Railroad
Water
County Boundary
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CENTRAL MIDLANDS
Council of Governments
0 2 4 8
Miles
Date Map Created: 18 April 2013
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Training and Education Plan

AAA/ADRC

Director of AAA/ADRC-will attend The National Association of Area Agencies on Aging (N4A) conferences as well as the Southeastern Association of Area Agencies on Aging (SE4A) conferences. She will use these as an opportunity to learn about best practices in the nation as well as the southeast. She will attend the South Carolina Conference on Aging conferences as the budget allows.

The Family Caregiver Advocate, Information, Referral /Assistance Specialist, I-CARE Coordinator and Grants and Contracts Manager will attend local conferences. The I-CARE Coordinator and Aging Program Coordinator will pursue the Aging Certificate from the Geriatric Social Work program at the Boston University School of Social Work.

All staff attend pertinent training at Three Rivers Behavioral Health.

Regional Aging and Disability Advisory Committee

The RADAC receives training on programs the AAAA/ADRC is considering such as Assisted Rides as well as local programs in the community such as law enforcements's Project Hope. In the past RADAC members have attended Summer School of Gerontology and South Carolina Conference on Aging when funding was available.

Regional Contractors

Regionally contractors come together annually for a contractor orientation. Contractors receive training from the state periodically. In the past the region has offered training for home care workers, transportation staff and invited staff to training that AAA staff were involved in teaching such as training on Elder Abuse.

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APPENDIX XX

Date: _____

Name: _____

Address: _____

RE: _____

Dear _____:

The Central Midlands Council of Governments Aging and Disability Resource Center accepts your complaint on _____ against the _____, an acknowledges that your complaint is a "grievable concern." The complaint will be investigated by the Central Midlands Council of Governments Aging and Disability Resource Center and reviewed by the Regional Aging and Disability Advisory Committee. You will be advised of the date of the review and your participation is encouraged.

It may be necessary to contact you during the investigation. Please cooperate with us as we attempt to resolve this complaint to your satisfaction. Thank you.

Sincerely,

_____Director, Aging and Disability Resource Center

(Comp. 1)

Date:

Name:

Address:

RE:

Dear: _____

The above-named case was reviewed by the Advisory Committee Grievance Sub-Committee on _____. __The finding/recommendations of the Committee are:

_____

_____

_____

_____

_____
_____
_____
_____
_____
_____
_____
_____

If you are not satisfied with the disposition of the case as stated above, you should contact: Denise Rivers, Lt. Governor's Office on Aging, 1301 Gervais Street, Suite 350, Columbia, South Carolina 29201.

Thank you.

Sincerely,

_____

Director, Aging and Disability Resource Center

Limited English Proficiency & Home and Community Based Services

The AAA/ADRC continues to stay abreast of services and knowledge of services offered to older individuals with limited English Proficiency. The AAA/ADRC brochure was translated into Spanish for individuals who are fluent in Spanish. Staff attends the monthly Hispanic/Latino interagency meeting. Staff will coordinate our efforts to partner with this group regarding assisting the dual-English populations. A plan of action has been established with an employee at CMCOG's S.C. Works to interpret for the I,R/A and I-CARE Coordinator when needed to assist with a non-English inquiry by phone or email. For other languages staff will work with USC to assist with translation.

The AAA/ADRC continues to advocate for the state home and community based funding that will allow older individuals that may be at risk for institutional placement. The AAA/ADRC has held a session with faith community leaders in the region to explain the services of the ADRC and to request the assistance of the leaders with projects such as building ramps in the FCSP and volunteering.

APPENDIX YY

APPENDIX ZZ

ACCESS INFORMATION FOR EMERGENCY PREPAREDNESS ACTIVITIES

REGION: Central Midlands | **FISCAL YEAR 2013-2014**

ANY CHANGES TO THIS INFORMATION MUST BE REPORTED TO THE AAA, EPO, AND LGOA WITHIN TEN WORKING DAYS

COORDINATING AGENCIES (Agency Name & Street Address)	EMERGENCY CONTACT STAFF (Names and Job Titles)	CONTACT NUMBER After Business Hours
Area Agency on Aging		
State Unit on Aging	Ron Ralph	(803)-926-1647 (Home) (803) 730-3802 (Cell)
1301 Gervais St. Suite 350 Columbia, SC 29201		
Central Midlands Council of Governments AAA/ADRC		
236 Stoneridge Dr. Columbia, SC 29210	Sharon Seago	(803) 781-6215 (Home) (803) 479-1914 (Cell)
I-CARE Coordinator	Shelia Bell-Ford	(803) 727-0241 (Cell)
Manager, Contracts & Grants	Ethel Montgomery	(803) 657-5814 (Home) (803) 361-0545 (Cell)
I& R Specialist	Carol Boykin	(919)500-6361
Family Caregiver Advocate	Joe Ritchey	(803) 781-6508 (Home) (803) 260-5071 (Cell)
Long Term Care Ombudsman	Anna Harmon	(803) 407-1751(Home) (803) 463-0443 (Cell)
	Shirley Thomas	(803) 865-1220(Home)
	LaToya Buggs-Williams	(803) 446-2189(Home)
	Fretoria Williams	(803) 261-7686 (Home) (803) 269-8610 (Cell)
Area Agency Contractors		
Senior Resources, Inc. 2817 Millwood Ave. Columbia, SC 29205	Pam Dukes Shelia Stahlberger	(803) 730-3862 (Cell) (803) 791-5163 (Home) (803) 331-2464 (Cell)
Lexington County Recreation & Aging Commission 125 Parker St. Lexington, SC 29072	Lynda Christison Mary Beth Callais	(803) 271-6797 (Home) (803) 364-0783 (Home) (803) 238-5275 (Cell)
Newberry County Council on Aging 1300 Hunt St. Newberry, SC 29108	Lynn Stockman Janet Ballentine	(803) 364-2286 (Home) (803) 924-3730 (Cell) (803) 276-8838 (Home) (803) 924-0688 (Cell) (803) 924-1100 (Agency cell)
Fairfield County Council on Aging 210 East Washington St. Winnsboro, SC 29180	Angela Connor	(803) 718-3117 (Home)
Traditions Eder Day Care, LLC 1500 Woodrow St. Columbia, SC 29205	Frank Wiley	(803) 530-7359 (Home)
Corporate Care, LLC 5111 North Main St. Columbia, SC 29203	Carolyn Cooley Marcus Robinson	(864) 338-6659 (Home) (864) 350-4970 (Cell) (803) 348-2999 (Cell)
South Carolina Legal Services 2109 Bull Street Columbia, SC 29201	Andrea Loney Eddie Weinberg	(803) 252-1881 (Home) (803) 319-4505 (Cell) (803) 960-4283 (803) 744-4164

Emergency Preparedness Offices

Richland County 1410 Laurens St. Columbia, SC 29204	Michael Byrd, Director Neil Ellis, Division Manager of Plans & Mitigation	(803) 576-3417 (803) 576-3400 (803) 748-5055 (Fax)
Lexington County 212 South Lake Dr. Lexington, SC 29072	Thomas Collins, Director	(803) 785-8342 (803) 785-8343 (803) 785-8628 (Fax)
Newberry County 520 Wilson Rd. Newberry, SC 29108	Tommy Long, Director	(803) 321-2135
Fairfield County Emergency Management Dept P.O. Drawer 60 Winnsboro, SC 29180	Phyllis Watkins, Director Mike Kirkland, Coordinator	 (803) 635-4444 (803) 635-5505 (803) 635-5057 (803) 635-4299 (Fax)
S.C. Emergency Alert Systems Stations-Columbia	WCOS 97.5 FM WTCB 106.7 FM WQVA 1170 AM-Spanish	

Shelters

American Red Cross Shelter Information **Richland/Lexington** 2751 Bull St. P.O. Box 91 Columbia, SC 29202	Darlen Harsey	(803) -540-1215 1-866-getinfo
Fairfield County 117 East Washington St. Winnsboro, SC 29180		
Richland County St. Andrews Baptist Church 230 Bush River Rd. Columbia, SC 29210 **Lexington County** White Knoll High School 5643 Platt Springs Rd. Lexington, SC 29073		
Special Needs Shelters: **Fairfield County** Fairfield Memorial Hospital 102 US Highway 321 Bypass Winnsboro, SC 29180 Newberry County	Shirley Hall	(803) 635-5548 (803) 385-5002 (803) 385-1523
Newberry County Newberry Memorial Hospital 2669 Kinard St. Newberry, SC 29108	Stacy Rowlett	(803) 405-7150 (803) 276-7570
Lexington County Lexington Medical Center 2770 Sunset Blvd. West Columbia, SC 29170	Joel Huggins, Director Mark Chretian-Coordinator	(803) 791-2000 (803) 936-7682
Richland County Palmetto Richland Memorial Hospital Five Richland Medical Park Columbia, SC 29203	Administrator on duty for the day	(803) 434-7000
Palmetto Baptist Medical Center Taylor at Marion St. Columbia, SC 29220	Mary Watson Hospital Operator:	(803) 296-3294 (803) 231-8182 (803) 296-5059 (803) 296-5010

Volunteer Organizations Active in Disasters		
Salvation Army 3024 Farrow Rd. Columbia, SC 29203	Major Roger Coulson	(803) 309-6435
United Way of the Midlands 1800 Main St. Columbia, SC 29201		(803) 790-4357 or 211
Harvest Hope 2220 Shop Rd. Columbia, SC 29201		(803) 254-4432 (803) 323-6011 (Fax)
LICS-Lexington County 216 Harmon St. Lexington, SC 29072	Jenny Kennedy	(803) 356-6916
Lexington County Emergency Food Pantry 1775 12th St. Ext. Cayce, SC 29033		(803) 794-1627 (803) 794-1630 (Fax)
South Carolina DHEC 2600 Bull St. Columbia, SC		(803) 898-3432 www.scdhec.net
Social Services		
Fairfield County 1136 Kincaid Bridge Rd. Winnsboro, SC 29180		(803) 635-5502
Lexington County 541 Gibson Rd. Lexington, SC 29071		(803) 785-7333
Newberry County 2107 Wilson Rd. Newberry, SC 29108		(803) 321-2155
Richland County 3220 Two Notch Rd. Columbia, SC 29204		(803) 735-7300
DHEC 1777 St. Julian's Place Columbia, SC 29204		(803) 545-4205
Cooperative Ministries 3821 W. Beltline Blvd. Columbia, SC 29201		(803) 799-3853
Aiken/Barnwell/Lexington Community Action Commission 650 Knox Abbott Dr. Cayce, SC 29033		(803) 794-6778
Carolina Community Action 400 S. Congress St. Winnsboro, SC 29180		(803) 635-3606
Catholic Charities 1428 Oak St. P.O. Box 7245 Columbia, SC 29202		(803) 254-9776
Wateree Community Action Center 3220 Two Notch Rd. Columbia, SC 29204		(803) 786-4250
We Care Center Chapin Interfaith Outreach 1808 Chapin Rd. Chapin, SC 29036		(803) 345-3244
Gleams Human Resources Commission, Inc. (Newberry) 237 North Hospital St. Greenwood, SC 29648		(864) 223-8434
Assistance for Spanish Speaking: **S.C. Hispanic Outreach** 7900 Nell St. Columbia, SC 29224	Carmen Santiago	(803) 419-5112
Communicar 3400 Colonial St. Columbia, SC 29203	Britt Hunt	(803) 400-1178 (803) 319-8928
Public Information Phone System **Spanish interpreters available**		1-866-246-0133

Pet Information:		
S.C. Animal Care and Control		(803) 776-7387
Clemson University Cooperative Ext. Petcare		
Volunteer Organizations Active in Disasters		
Fairfield County		(803) 635-4722
Newberry County		(803) 276-1091
Lexington County		(803) 321-2185 (803) 359-8515
Richland County		(803) 865-1216
Clemson Livestock-Poultry		(803) 788-2260 ext. 268
Department of Agriculture		(803) 734-2210
SC Animal Care & Control		(803) 776-7387
Other useful information:		
National Guard		(803) 806-4200
Dept of Transportation **(Traffic Information-Road Closures)**		511 www.sctraffic.org
SC Insurance News Services		(803) 252-3455 www.scinsnews.com
Information, Referral & Assistance-Airs		www.sc211.org
SC Emergency Management Division		www.scemd.org
Road Closures		www.dot.state.sc.us
Weather		www.nhc.noaa.gov
Other Useful Sites:		
S.C. Web Site		www.myscgov.com
Center for Disease Control and Influenza Info 1600 Clifton Rd. NE Atlanta, GA 30333		1-800-232-4636 www.pademicflu.gov

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REGION: Central Midlands | **FISCAL YEAR 2013-2014**

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Lexington County 541 Gibson Rd. Lexington, SC 29071		(803) 785-7333
Newberry County 2107 Wilson Rd. Newberry, SC 29108		(803) 321-2155
Richland County 3220 Two Notch Rd. Columbia, SC 29204		(803) 735-7300
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Newberry County		(803) 276-1091
Lexington County		(803) 321-2185 (803) 359-8515
Richland County		(803) 865-1216
Clemson Livestock-Poultry		(803) 788-2260 ext. 268
Department of Agriculture		(803) 734-2210
SC Animal Care & Control		(803) 776-7387
Other useful information:		
National Guard		(803) 806-4200
Dept of Transportation **(Traffic Information-Road Closures)**		511 www.sctraffic.org
SC Insurance News Services		(803) 252-3455 www.scinsnews.com
Information, Referral & Assistance-Airs		www.sc211.org
SC Emergency Management Division		www.scemd.org
Road Closures		www.dot.state.sc.us
Weather		www.nhc.noaa.gov
Other Useful Sites:		
S.C. Web Site		www.myscgov.com
Center for Disease Control and Influenza Info 1600 Clifton Rd. NE Atlanta, GA 30333		1-800-232-4636 www.pademicflu.gov

Revised 5/22/13

2014 – 2017 VERIFICATION OF INTENT

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

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

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

1. Contract management
2. Programmatic and fiscal reporting activities
3. Oversight of contracted service delivery
4. Coordination of services and planning with the LGOA, service contractors, and other entities involved in serving and planning for the older population in the planning and service area
5. Provision of technical assistance and training to providers/contractors and other interested parties
6. Provision of public information and advocacy related to aging program activities and issues

7. Provision of all activities, programs, and services contained within the South Carolina Aging Network's Policies and Procedures Manual, and compliant with all Notice of Grant Award's (NGA's) Terms and Conditions, and assurances from the Administration on Aging (AoA) and Lieutenant Governor's Office on Aging (LGOA).

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

Date — Signature of Aging Unit Director

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

Date — Signature of Chair, Area Agency Advisory Council

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

Date — Signature of Governing Board Chair

2014 – 2017 AREA PLAN
VERIFICATION OF ADMINISTRATION ON AGING'S (AoA'S) AND LIEUTENANT GOVERNOR'S OFFICE ON AGING'S (LGOA'S) STANDARD ASSURANCES AND GENERAL CONDITIONS

ASSURANCE CATEGORIES

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

2014 – 2017 AREA PLAN ASSURANCES

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

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

2. The AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas. (**OAA 306(a)(4)(C)**)

3. The PSA, AAA/ADRC, and the AAAs'/ADRCs' providers/contractors shall comply with all applicable Federal and State laws, regulations, and guidelines.

4. The PSA and AAA/ADRC shall have a comprehensive, written policies and procedures manual for complying with all of its functions as prescribed by the OAA, the LGOA, and the South Carolina Aging Network's Policies and Procedures Manual. These written policies and procedures shall be available for inspection upon request and are subject to the South Carolina Freedom of Information Act (FOIA) requirements. The AAA/ADRC may not adopt the South Carolina Aging Network's Policies and Procedures Manual as a substitute for developing a regional manual, but may use it as a guide for what should be included in the regional manual. A summary of the written policies and procedures should be noted in the Area Plan.

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

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

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

8. The AAA/ADRC shall maintain a Regional Aging Advisory Council (RAAC) whose purpose is:
   a. to advise the AAA/ADRC on all matters related to the development of the Area Plan;
   b. to advise on the administration of the plan; and
   c. to advise on operations conducted under the plan.

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

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

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

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

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

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

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

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

16. The AAA/ADRC shall use grants made under the Older Americans Act (OAA) to pay part of the cost of the administration of the Area Plan, including preparation of plans, evaluation of activities carried out under such plans, development of a comprehensive and coordinated system for delivery of services to older adults and caregivers, development and operation of multipurpose senior centers, and the delivery of legal assistance as required under the OAA of 1965, as amended in 2006, and in accordance with the regulations, policies, and procedures established by the LGOA, the Assistant Secretary of the AoA, the Secretary of the U.S. Department of Health and Human Services and State legislation. **(OAA 303 (c) (1) and (2) and CFR 1321.11)**

17. The AAA/ADRC shall assure through the Area Plan that it has protocols in place to provide technical and programmatic assistance and training opportunities for AAA/ADRC staff and providers/contractors as required by the South Carolina Aging Network's Policies and Procedures Manual.

18. The AAA/ADRC is responsible for designing and implementing a regional training and education plan. This plan should be comprehensive in nature and reflect the training requirements identified by the AAA/ADRC, address the service priorities in the Area Plan, and complement State efforts. The training should address geographical characteristics, demographics, infrastructure, GIS Mapping, and local and community partnering resources. The annual needs assessment is the blueprint necessary to identify the types of trainings necessary in the region. Regional training shall also address all required LGOA client data tracking systems, as well as any other fiscal or programmatic requirements of the LGOA.

19. The AAA/ADRC and providers/contractors shall not means test for any service under Title III. When contributions are accepted, or cost sharing implemented, providers/contractors shall not deny services to any individual who does not contribute to the cost of the service. **(OAA 315(b)(3) and CFR 1321.61(c))**

20. The AAA/ADRC shall comply with Title VI of the Civil Rights Act of 1964 and shall require such compliance from all providers/contractors under the Area Plan. **(CFR 1321.5(c))**

21. The AAA/ADRC shall comply with all the appropriate Titles of the Americans with Disabilities Act of 1990, require such compliance from all contractors under the Area Plan, and assure that otherwise eligible older individuals shall not be subjected to discrimination under any program or activity under the Area Plan. (CFR 1327.5 and 1321.5 (c))

22. The AAA/ADRC shall assure that residency or citizenship shall not be imposed as a condition for the provision of services to otherwise qualified older individuals.

23. The AAA/ADRC shall assess the level of need for supportive services including legal assistance, transportation, nutrition services, and multipurpose senior centers within the planning and service area. (OAA 306(a)(1))

24. The AAA/ADRC shall assure that the special needs of older individuals residing in rural areas are taken into consideration and shall describe in the Area Plan how those needs have been met and how funds have been allocated to services to meet those needs. (OAA 307(a)(10))

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

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

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

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

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

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

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

32. The AAA/ADRC shall ensure that clients receive an initial assessment and then reassess service recipients no less than annually, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas, and eligible individuals, as defined in the Older Americans Act of 1965 (OAA) §518, 42 U.S.C. §3056p, as amended in 2006. Assessments must be recorded on the LGOA Assessment Form. No reimbursements will be made without proper and current assessments.
33. Based on that assessment, the AAA/ADRC shall assure that services delivered with resources under the Area Plan are provided to individuals with the highest priority scores.
34. Assessed individuals who must be terminated because of low priority scores shall be provided an opportunity to continue to receive services as a private pay recipient or as a partial-pay recipient subsidized through local resources, if available.
35. The LGOA requires that the AAA/ADRC directly provide ombudsman, information and assistance, insurance counseling, and family caregiver services. (**OAA 307(a)(8)(A)and(C)**)
36. The AAA/ADRC shall provide other direct services, only with a waiver approved by the State agency, and only when such direct provision is necessary to assure an adequate supply of such services, or where such services are directly related to the AAA's/ADRC's administrative functions, or where such services of comparable quality can be provided more economically by the AAA/ADRC. (**OAA 307(a)(8)(A)and(C)**)
37. The AAA/ADRC shall administer the nutrition programs with the advice of a dietitian (or an individual with comparable expertise). Whenever the AAA/ADRC allows providers/contractors to purchase catered meals directly, or has providers/contractors who prepare meals on site, the AAA/ADRC shall assure that such providers/contractors have agreements with a registered dietitian who provides such advice. (**OAA 339(G)**)
38. The AAA/ADRC shall conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who:
    a. reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
    b. are patients in hospitals and are at risk of prolonged institutionalization; or
    c. are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them. (**OAA 307(a)(18)**)
39. The AAAs/ADRCs are responsible for developing emergency/disaster preparedness and response plans for their planning and service area regions that are updated and reviewed annually. These plans should incorporate all requirements of the South Carolina Aging Network's Policies and Procedures Manual regarding Emergency Management and Disaster Preparedness.
40. In addition, the AAA/ADRC shall ensure that each of its providers/contractors has a disaster preparedness plan that is reviewed and updated annually.
41. AAAs/ADRCs shall meet with county emergency management directors in their regions to ensure that there is a working relationship between the counties and the

AAAs/ADRCs. AAAs/ADRCs are expected to maintain current and up-to-date emergency contact information for AAA/ADRC staff, directors of providers/contractors, and county emergency management officials in the event of a disaster or emergency, and submit this information with their Area Plans. The AAA/ADRC will designate staff to be on call throughout the duration of the declared disaster and this staff shall maintain communications with the LGOA Emergency Preparedness Coordinator.

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

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

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

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

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

Quarter One:	**Quarter Two:**
• AAA/ADRC Area Plan; • Needs assessment; • Comparison of service delivery to GIS mapping to ensure that all clients with the greatest needs within the entire county are being served; • Challenges in business operations (what is working and what isn't working); • Training requests and topics for providers/contractors;	• Career development; • Continuing education training or Continuing Education Units (CEU); • Educational workshops; and • Other issues and concerns.

• Best practices; • AAA/ADRC goals and mission for the year; and • Other issues and concerns.	
Quarter Three: • Modernizing operations; • Community resources and new partnerships; • Aging focus; • Business development; and • Other issues and concerns.	**Quarter Four:** • End of year Area Plan review; • Strategic planning and forecasting session for specific regional needs and concerns; • Analyzing end of the year data (comparing data to the GIS mapping that the AAAs/ADRCS are required to provide to the LGOA); and • Other issues and concerns.

47. The following constitutes a substantial change in the approved Area Plan and requires an amendment to the Area Plan:
    a. change or termination of a service contractor;
    b. reduction in the funding for priority services procured; and/or
    c. loss or change in the services available in any county in the region.

B. AAA/ADRC TRAINING RESOURCES ASSURANCES

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

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

3. The AAA/ADRC Training Liaison shall train new providers/contractors, field questions in the region, and provide assistance with challenges of the AIM tracking system. The

liaison shall be the only person authorized to make contact with the LGOA AIM Coordinator. On the rare occasion that the liaison cannot assist the provider/contractor, he/she may contact the LGOA AIM Coordinator for assistance. The liaison shall be responsible for forwarding the information received from the AIM Coordinator to the providers/contractors. The liaison shall be the point of contact for providers/contractors needs and shall ensure accurate, quality tracking, and monitoring for reimbursement of OAA services, prior to billing the LGOA.

4. The AAA/ADRC shall assure on-going training within its region of operation for its providers/contractors. At a minimum, the AAA/ADRC shall do the following:
   - assure that a minimum one monthly e-mail is disseminated to their providers/contractors regarding a variety of aging issues, including but not limited to outreach opportunities, outreach events, national initiatives, activity development, resources, etc.
   - host an aging orientation meeting within the first thirty (30) days of a new contract agreement for all new providers/contractors in their region. Materials provided in the orientation shall include, but are not limited to, the following:
     - a general overview of the LGOA and ADRC network operations and roles;
     - a LGOA two-sided flyer;
     - a LGOA benefits guide;
     - a SC Access flyer;
     - a copy of the AAA/ADRC Area Plan;
     - a copy of the SC Aging Network's Policies and Procedures Manual;
     - a summary of structure of the aging network in South Carolina;
     - a copy of general AAA/ADRC goals for that operating year;
     - an AAA/ADRC staffing contact sheet; and
     - a copy of the AAA/ADRC Strategic Plan.
5. The AAAs/ADRCs shall assure that an Advanced Information Manager (AIM) training session is provided by the AAA/ADRC Training Liaison and an operation manual shall be given to the new provider/contractor within the first thirty (30) days of a new contract agreement.

C. CLIENT DATA COLLECTION ASSURANCES

1. The AAA/ADRC and its providers/contractors will utilize the Advanced Information Management (AIM) system to document and track units of services delivered. Reimbursements for service funds will be supported by client data correctly entered into AIM. The AAA/ADRC will assure that service providers/contractors are trained properly and monitored accordingly, and that AIM data is inputted monthly by the tenth (10th).
2. The AAA/ADRC shall ensure that each group dining site uses the LGOA approved LG-94 sign-in sheet and that each client sign his/her name or make a mark on the sign-in sheet daily. In addition, home-delivered meal drivers must sign and date a document daily listing their clients and certifying that the meals were delivered. The provider/contractor dining manager will sign and date that document after the driver has returned to the operational site.

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

D. **FISCAL ASSURANCES**

1. The PSAs and AAAs/ADRCs shall be good stewards of OAA and LGOA funding and be accountable for programmatic budgeting, monitoring, and operation. The AAA/ADRC shall assure in writing, through its Area Plan, that I&R/A funding is not being used to fund other programs outside of the I&R/A program area. Should the LGOA determine the AAA/ADRC is in violation of using I&R/A funds for other activities, then funding for I&R/A services may be withheld in the future.
2. The PSA and AAA/ADRC shall provide satisfactory assurance that such fiscal control and accounting procedures shall be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal and State funds paid under the Area Plan to the AAA/ADRC, including funds paid to the recipients of grants or contracts. (OAA 307(a)(7)(A))
3. The AAA/ADRC shall assure that funds received under the OAA shall supplement and not supplant any Federal, State, or local funds expended to provide services allowable under Title III. (OAA 321(d))
4. Each funding source shall have a distinct client population for the duration of the contract period or until the client's service is terminated. A new client, who is in need of the service and meets the eligibility criteria of that funding source, will be added when such vacancies occur.
5. The PSAs and AAAs/ADRCs shall include as part of their Area Plans, a breakdown of the components of the unit cost for each different unit of service and the methodology showing how the unit cost is determined. The cost justification shall include the assessment costs, activities costs, product costs, administrative costs, and any other relevant variable that contributes to the overall rate.
6. The AAA/ADRC shall ensure that it has a process in place to verify how the provider's/contractor's unit costs are determined and that the units are being earned.
7. All invoices and financial and program reports must be submitted in the format provided by the LGOA and on the schedule(s) set by the LGOA. Invoices and financial reports shall be submitted to the Accounting and Finance Division, while program reports will be submitted to the appropriate program manager as stipulated by the LGOA.
8. The AAA/ADRC shall submit a total aging budget, disclose all sources and expenditures of funds that the AAA/ADRC receives or expends to provide services to older

individuals, and the cost allocation plan, or approval of the indirect cost rate from the funding agency, used to prepare such budget. (OAA 306(a)(13)(E))

9. The AAA/ADRC shall expend all prior year's funds first, before expending any new funds.

10. Planning and Administration funds for Titles III-B, III-C, III-C-2, and III-E must be expended before any program development of III-E service funds are expended for subgrantee staff activities or internal operations.

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

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

13. Any AAA/ADRC that expends a total of $500,000 or more in Federal awards must monitor delivery and have an audit that complies with OMB Circular A-133. The audit shall be submitted to the LGOA within nine (9) months after the close of the organization's fiscal year.

14. The AAA/ADRC shall consult with relevant service providers/contractors and older individuals to determine the best method for accepting voluntary contributions that comply with the Cost Sharing policies of the LGOA and the OAA, as amended in 2006. (OAA 315(b)(2))

15. The AAA/ADRC shall assure that any revenue generated from voluntary contributions or cost sharing shall be used to expand the services for which such contributions or co-pays were given. (OAA 315(a)and(b))

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

update.

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

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

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

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

21. A final financial report for the grant period shall be submitted to the LGOA, within forty-five (45) days of the close of each State fiscal year in the grant period (August 14) or within forty-five (45) days of the last payment made, whichever occurs first.

22. The AAA/ADRC shall assure that funds received for Nutrition Services Incentive Program (NSIP) shall be used only for the purchase of United States agricultural commodities or commercially prepared meals served in the Title III-C services and that NSIP funds shall be distributed throughout the region based on the percentage of eligible meals served by each provider/contractor. (OAA 311(d)(2))

23. The AAA/ADRC shall not use funds received under the OAA to pay any part of a cost, including an administrative cost, incurred to carry out a contract or commercial relationship that is not carried out to implement the OAA. (OAA 306(a)(14))

E. MONITORING AND COMPLIANCE ASSURANCES

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

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

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

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

older. (OAA 336)

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

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

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

F. PROCUREMENT AND CONTRACTUAL ASSURANCES

1. Service procurement contracts must incorporate all components of the South Carolina Aging Network's Policies and Procedures Manual. Through the direction of the South Carolina Aging Network's Policies and Procedures Manual, each of the PSA's procurement contracts for aging services shall be based on meeting the unique regional needs of each planning and service area.

2. The PSA and AAA/ADRC shall require all programs funded under the Area Plan to be operated fully in conformance with the LGOA and all applicable Federal, State and local fire, safety, health and sanitation standards or licensing prescribed by law or regulation. (CFR1321.75(a))

3. The PSA and AAA/ADRC shall contract only with service delivery agencies that shall provide to the AAA/ADRC all program information and reports required by the Lieutenant Governor's Office on Aging. Provision of timely and correct data shall be in a format and contain such information as the LGOA may require the AAA/ADRC to submit. (OAA 307(a)(6))

4. All PSA and AAA/ADRC Requests for Proposal (RFP) shall provide direction, coordination, and planning in the fulfillment of contractual agreements with providers/contractors.

5. All contractual agreements must include a procedure for the resolution of grievances or concerns between the Planning Service Area (PSA), AAA/ADRC, and provider/contractor.
6. When there is grievance between the AAA/ADRC and a provider/contractor, all efforts shall be made by the AAA/ADRC to resolve the issue. Minimal contact should be made at the State level and only after all attempts have failed to resolve the issues locally. The Lieutenant Governor's Office on Aging (LGOA) shall serve only as a source of information to the AAA/ADRC regarding the resolution process. All grievances shall be handled by the AAA/ADRC and provider/contractor unless the grievance includes illegal, immoral, and/or unethical behavior, at which time the LGOA and proper authorities shall be notified. If the AAA/ADRC wants to include the LGOA, or cannot work out the issue, then the LGOA may be contacted to assist with the resolution process through guidance only.
7. The PSA and AAA/ADRC must advertise the Request for Proposal (RFP) in legal ads in newspapers throughout the region and post information in a prominent spot on its website at least thirty (30) days before the release of the RFP. The AAA/ADRC shall notify the LGOA Policy Manager so that the RFP can be posted on the LGOA web site.
8. The PSA and AAA/ADRC shall include in each solicitation for providers/contractors of any service under the OAA, a requirement that the applicant will:
    a. Specify how the organization intends to satisfy the service needs of low income minority individuals and older individuals residing in rural areas;
    b. Provide services to low income minority individuals in accordance with their need for such services;
    c. Meet specific objectives set by the AAA/ADRC, for providing services to low income minority individuals; (OAA 306(a)(4)(A))
    d. Make a good faith effort to obtain a client consent form from all service recipients to allow their information to be included in AIM for research and advocacy purposes.
9. All contracts for the procurement of services or goods which are supported with financial assistance through the LGOA, must adhere to applicable Federal and State procurement codes (COG: OMB Circulars A102 and A-87) (PN-P: OMB Circulars A110 and A-122).
10. The AAA/ADRC and providers/contractors shall have the Knowledge, Skills and Abilities (KSA) to use professional practices of performing, reporting, tracking, and administering their Older American Act (OAA) and State funding, and this should be reflected in all procurement contracts and RFPs.
11. The PSA and AAA/ADRC shall have legal representation on their RFP (Request for Proposal) Board.
12. The PSA and AAA/ADRC shall host a pre-RFP application informational meeting for potential providers/contractors three weeks following the public release of the RFP to explain the RFP process and aging network policies/procedures and to answer

questions about the RFP. The date, time, and location of the meeting shall be included in the RFP packet. This shall assure fairness in the bid process. Opportunities for submitting written questions shall be provided by the AAA/ADRC before the pre-application meeting.

13. Prior to engaging in a contract, the PSA and AAA/ADRC shall assure through the RFP bid and contract that the provider/contractor has the necessary equipment, technology, software, and trained staff to operate in a professional manner and to execute or administer the duties.

14. An AIM Operational Manual shall be provided at the start of the bid process so that providers/contractors know what is expected in advance if the provider/contractor gets the contract.

15. The PSA and AAA/ADRC shall provide all potential providers/contractors with an overview of the LGOA organization and procurement process before submitting a bid for contract in order that they understand the proper procedures and policies.

16. The AAA/ADRC shall encourage each group dining provider to be a member of the National Council on Aging (NCOA) / National Institute of Senior Centers (NISC) or to operate according to NISC's national standards for senior centers and group dining sites.

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

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

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

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

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

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

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

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

25. The AAA/ADRC shall assure that a facility purchased for use as a multi-purpose senior center with OAA or State Permanent Improvement funds, shall continue to be used for the same purpose for not less than ten (10) years after acquisition, or twenty (20) years after construction.

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

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

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

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

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

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

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

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

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

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

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

37. The AAA/ADRC shall enter into contract only with providers/contractors of legal assistance who can:
    a. demonstrate the experience or capacity to deliver legal assistance;
    b. assure that any recipient of funding for legal assistance shall be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act;
    c. require providers/contractors of legal assistance to give priority to cases related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect and age discrimination; and
    d. attempt to involve the private bar in legal assistance activities. (OAA 307(a)(11)(A) through (E))

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

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

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

during periods of crisis, hazardous weather, emergencies, and unscheduled closings.

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

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

G. COORDINATION, OUTREACH, AND INFORMATION AND REFERRAL ASSURANCES

1. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual.

2. The AAA/ADRC shall have a visible focal point of contact where anyone can visit or call for assistance, information, or referrals on any aging and/or adults with disability issue.

3. The AAA/ADRC shall require providers/contractors to use outreach efforts that shall identify individuals eligible for assistance under the OAA, with special emphasis on
   a. Older individuals residing in rural areas
   b. Older individuals with greatest economic need
   c. Older individuals with greatest social need
   d. Older individuals with severe disabilities
   e. Older individuals with limited English speaking ability
   f. Older individuals with Alzheimer's disease or related disorders and caregivers
   g. Low income minority individuals in each of the above populations. **(OAA 306(a)(4)(B))**

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

5. The AAA/ADRC shall provide for the identification of public and private resources in or serving persons in, the planning and service area as part of their overall outreach and coordination efforts. Local aging partners should be brought into the AAA's/ADRC's planning process in order to better serve the region's older population. The

AAA/ADRC shall work to coordinate the programs funded under the Area Plan with such resources to increase older persons' access to quality services. Coordination and outreach efforts should be detailed in the Area Plan, with particular emphasis on coordination with entities conducting Federal programs as outlined in Section 403 B-10 of the South Carolina Aging Network's Policies and Procedures Manual. Where appropriate, the AAA/ADRC shall consider joint funding and programming to better serve older persons.

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

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

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

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

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

(2) Each AAA/ADRC shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area shall be expended for the delivery of each of the following categories of services
(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance; and assurances that the AAA/ADRC shall report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the AAA/ADRC shall—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub clause (I);
(ii) provide assurances that the AAA/ADRC shall include in each agreement made with a provider/contractor of any service under this title, a requirement that such provider/contractor shall—

(I) specify how the provider/contractor intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider/contractor;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the AAA/ADRC, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each AAA/ADRC shall
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the AAA/ADRC met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall use outreach efforts that shall identify individuals eligible for assistance under this Act, with special emphasis on
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each AAA/ADRC shall provide assurance that the AAA/ADRC shall ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, shall include a focus on the needs of low income minority older individuals and older individuals residing in rural areas.

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

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

(9) Each AAA/ADRC shall provide assurances that the AAA/ADRC, in carrying out the State Long Term Care Ombudsman program under section 307(a)(9), shall expend not less than the

total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

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

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

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

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

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

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

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

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

(13)(C) Each AAA/ADRC shall provide assurances that the AAA/ADRC shall demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and shall not result from such non-governmental contracts or such commercial relationships.

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

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

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

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

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

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

The AAA/ADRC certifies compliance with all of these assurances and requirements of the OAA, as amended, the Federal regulations pertaining to such Act, and the policies of the LGOA

throughout the effective period of this Area Plan. Should any barriers to compliance exist, the AAA/ADRC shall develop procedures to remove such barriers. Some assurances may be modified by Federal regulations issued or the OAA reauthorization during the plan period. In such event, a revised list of assurances shall be issued.

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

Date

Signature of Executive Director
Planning Service Area (PSA)

Date

Signature of Aging Unit Director

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

Date

Signature of Chair, Area Agency
Advisory Council

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

Date

Signature of Chair, PSA Governing Board

The director of the multi-purpose agency must certify that the aging unit functions only as the area agency on aging for the purpose of carrying out the nine area agency functions specified in the Older Americans Act.

Benjamin J Mandel

Interim Executive Director

Region IV – Requested Waivers - Area Plan Period July 1, 2013 to June 30, 2017

Before the Area Agency on Aging requests waivers allowable under the OAA, the Agency shall conduct a timely public hearing. Area Agencies requesting a waivers shall notify all interested parties in the PSA of the hearing and invite such parties to testify. (OAA 306(b)(2)(A)

The Area Agency on Aging shall prepare a record of the public hearing and shall furnish such record to the LGOA with the request for the waiver. (OAA 306(b)(2)(B)

Any individual or any provider of services from the area who will be affected by the waiver is entitled to request a hearing before the LGOA on the request to grant such a waiver. (OAA 306(b)(C)

State the Current Federal or State Requirement	Describe the Proposed Change	Expected Outcomes with Change	Impact on Current Services	Method to Evaluate the Impact of the Change
State Policies & Procedures Section 210:B	Fairfield County does not average twenty-five participants at the Winnsboro Community Center.	Allowing fewer than twenty-five participants will serve this rural community	Decline in federal funds may not allow as many OAA participants.	ZMUSRS will be reviewed.
State Policies & Procedures Section 210:B	Newberry County does not average twenty-five participants at the Whitmire Community Center.	Allowing fewer than twenty-five participants will serve this rural community	Decline in federal funds may not allow as many OAA participants.	ZMUSRS will be reviewed.
State Policies & Procedures Section 210:B	Richland County does not average twenty-five participants at the Eastover and Hopkins Community Centers.	Allowing fewer than twenty-five participants will serve this rural community	Decline in federal funds may not allow as many OAA participants.	ZMUSRS will be reviewed.
Older Americans Act Section 331(c)(1)	Blythewood will be open four days a week.	Allowing this senior center to open four days a week will serve this rural community.	Decline in federal funds may not allow as many OAA participants.	ZMUSRS will be reviewed.