DEPARTMENT OF ELDER AFFAIRS
STATE OF FLORIDA

Area Plan on Aging Program Module

TEMPLATE AND INSTRUCTIONS

For the Period
January 1, 2009 - December 31, 2011

Revised December ___, 2008

About This Program Module Template

The format of this program module file differs from years past. This file was designed to be a template that when completed will become your final area plan. Since formatting is already a part of the document, you will have features such as page numbering automatically updating as you work. You may paste text from other sources into this template.

General instructions are included within each section and detailed instructions have been consolidated into one section located at the end of this file. Links to section-specific instructions are included throughout the document to ensure instructions are easily accessible. Links from the instructions back to the sections they relate to have also been included. By including the detailed instructions as a separately numbered section, they can easily be removed once they are no longer needed, i.e., when you finalize your area plan file.

Steps for Creating Your Area Plan File

Read the entire document first, including the instructions located at the back of the document. It is recommended that you make and re-name a copy of this electronic file before you begin editing to ensure the original set of instructions and forms remain available. Any instructions included throughout the body of the document can be removed as well when finalizing your plan, or left in as additional clarification for the reader. Be sure to change the footer to remove the word “Instruction” in the final area plan prior to submission.

Enter your planning and service area number in the header of the document that will become your area plan program module, along with the program module completion date.

Information specific to your planning and service area needs to be put in the body of the document as well as in Appendices 1 – 6. The Appendices will contain your needs assessment detail along with a list of community focal points, senior centers, lead agencies and access points.

This document includes hyperlinks between the template and the instructions. Along with the hyperlink, the page number to which you are being linked is listed, to make it easier for those who are using a printed copy. Once you start adding your text to the template, the template page numbers referenced in the instructions will no longer be correct.

If you are pasting text from another document, to ensure formatting consistency, make sure to use a normal or body text style selection. The heading 1 style is reserved for selections you want listed in the Table of Contents.

After you have edited the file, you will need to update the Table of Contents. This is done by clicking to the left of the Table of Contents and selecting the F9 key on your keyboard. You will be asked if you want to update page numbers or the entire Table of Contents. If new sections have been added, you should select the second radio button. New sections will show in the Table of Contents if the section title has been formatted with the Heading 1 style.

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Overview

The area plan describes in detail the specific services to be provided to the older population of the PSA. The plan is developed from an assessment of the needs of the area determined by public input that involves public hearings and the solicited input of those affected, their caregivers and service providers. The plan also states the goals and objectives that the area agency and its staff and volunteers plan to accomplish during the planning period.

The area plan is divided into two parts, the Program Module and the Contract Module. The program module includes a description of the PSA, the needs assessment, the service plan including goals and objectives, and other elements relating to services. The Contract Module includes the elements of the plan relating to funding sources and allocations, and other administrative/contractual requirements.

This document provides the detail for the Area Plan Program Module. involved

Program Module Certification

(For instructions, click here to go to page I.)

Program Module Certification

1. AREA AGENCY ON AGING INFORMATION:

Executive Director:

Legal Name of Agency:

Mailing Address:

Telephone: []

FEDERAL ID NUMBER:

2. GOVERNING BOARD CHAIR: (Name/Address/Phone)

3. ADVISORY COUNCIL CHAIR: (Name/Address/Phone)

4. FUNDS ADMINISTERED: Check all that apply

[ ] OAA Title IIIB	[ ] CCE	[ ] USDA	[ ] NSIP
[ ] OAA Title IIIC	[ ] HCE	[ ] ADA Waiver	[ ] Contracted Services
[ ] OAA Title IIID	[ ] ADI	[ ] ALE Waiver	[ ] ARC/ADRC
[ ] OAA Title IIIE	[ ] LSP	[ ] SHINE	[ ] Others (List)
[ ] OAA Title VII	[ ] RELIEF	[ ] EHEAP	

5. CERTIFICATION BY BOARD PRESIDENT, ADVISORY COUNCIL CHAIR, AAA DIRECTOR:

I hereby certify that the attached document:

[ ] Reflects input from a cross section of service providers, consumers, and caregivers that are representative of all areas and culturally diverse populations of the PSA.

[ ] Incorporates the comments and recommendations of the Area Agency's Advisory Council.

[ ] Has been reviewed and approved by the Area Agency's Board of Directors.

I further certify that the contents are true, accurate and complete statements. I acknowledge that intentional misrepresentation or falsification may result in the termination of financial assistance. I have reviewed and approved the 2009-2011 area plan.

Name: _____ Signature: _____ Date: _____
(President, Board of Directors)

Name: _____ Signature: _____ Date: _____
(Advisory Council Chair)

Name: _____ Signature: _____ Date: _____
(Area Agency on Aging Director)

Signing this form verifies that the Board of Directors and the Advisory Council understand that they are responsible for the development and implementation of the plan and ensuring compliance with Older Americans Act Section 306.

P.I. Executive Summary

This section describes the major highlights of the area plan, such as how the agency is addressing significant needs, key initiatives and your role as an ARC/ADRC. (This section should not be longer than three pages in length.)

Enter text here

P.II. Profile of the Planning and Service Area (PSA)

This section contains an overview of the social, economic and demographic characteristics of the planning and service area (PSA). Focus should be given to geographic areas and population groups within the PSA with large percentages of persons with low-income, minority, limited English speaking proficiency, older individuals at risk of institutional placement and rural factors. (For additional instructions, click here to go to page III.)

Enter text here

P.III. Needs Assessment and Implementation Plan

This section defines the significant needs for services and how those needs will be addressed.

Detailed Needs Assessment Findings and Implementation Plan

Enter the full detail of the needs assessment, including the methodology in Appendix 1. *(For additional instructions, click here to go to page IV.)*

Key Needs Assessment Findings and Implementation Plan

This section includes a general overview of the identified needs and the planned solutions. How the findings relate to goals and objectives should also be explained. The information for the needs assessment findings is organized under the Department's goal areas and their objectives (except for Goal E). The goals and objectives must be supported by the needs findings and fully document the AAA's priorities. Strategies or action steps detailing how the AAA will address the needs findings must be measurable and clearly state what the AAA plans to do to achieve the objective and outcome. (For additional instructions, click here to go to page V.)

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

Goal Narrative: (For detailed instructions, click here to go to page VI.)

Enter text here

(To skip to Targeting Report, click here to go to page 41.)

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

GOAL A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 1: Decrease demand for institutional long-term care services through infrastructure modernization and increased emphasis on prevention.

NEED(S) BEING ADDRESSED: (For instructions, click here to go to page VI.)

Enter text here

STRATEGIES/ACTION STEPS: (For instructions, click here to go to page VI.)

Enter text here

OUTCOMES: [2009] (For instructions, click here to go to page VII.)

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

- *Percent of elders CARES determined to be eligible for nursing home placement who were diverted (Standard: 30%)*
- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home (Standard: 97%)*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable consumer groups (Standard: $2,384)*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved* (Standard: 65%)
- *Percent of new service recipients whose IADL assessment score has been maintained or improved* (Standard: 62.3%)

OUTPUT: [2009]
Total number of CARES assessments (Standard: 96,000)

P.III. 2009 GOALS, OBJECTIVES ANDG PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 2: Develop a more sensitive and less formal system to more quickly identify and refer individuals who need a service plan or a change in an existing plan.

NEED(S) BEING ADDRESSED
Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 3: Increase provider network capacity.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

- *Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers (Standard: 2.8 months)*
- Percent of customers who are at imminent risk of nursing home placement who are served with community-based services (Standard: 90%)

OUTPUT: [2009]

- *Number of people served with registered long-term care services*

DOEA Internal Measure:

- Percent of co-pay goal achieved

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 4: Improve support of caregivers by providing services that are more timely and specifically targeted to individual caregiver needs.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:
(Include strategies to address the inclusion of services for caregivers age 55 and older as required by the National Family Caregiver Support Program)

Enter text here

OUTCOME: [2009]

- Percent of family and family-assisted caregivers who self-report they are very likely to provide care (Standard: 89%)
- Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor)(Standard: 90%)

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 5: Ensure collection and maintenance of a database of resources that provide health and/or human services in the planning and service area.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measure:

The area agency will administer information and referral services under the AIRS Standards for Professional Information and Referral, which are included as an attachment to the Older Americans Act (OAA) contract, and will do the following:

1. Maintain resources in the statewide online database.
2. Ensure the accuracy of data entered in the resource database and adherence to the inclusion/exclusion criteria.
3. Ensure the timely entry of accurate data in the online database.

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 6: Ensure a system is in place for collecting and organizing inquirer data to facilitate appropriate referrals and identify gaps in service.

NEED(S) BEING ADDRESSED
Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measure:

The area agency will ensure the inquiry data collected will identify:

1. The number of calls received by Elder Helplines.
2. The type/level of services requested.
3. Quarterly reports from the Elder Helplines are submitted to the Department with regard to information and referral activity.

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 7: Prioritize services to the most frail elders.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measures:

- Percent of high-risk consumers (APS, Imminent Risk, and/ or priority levels 4 and 5) out of all referrals who are served.
- Average time for applicants who are APS or imminent risk referrals or assessed as priority levels 4 and 5 to start services (other than case management) is less than the average time for applicants assessed as priority levels 1, 2 or 3 to start services.

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 8: Ensure services provided to consumers are meeting consumer needs.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measure:

- The AAA must assess consumer satisfaction with services provided

(Tools developed under contract with the Administration on Aging and technical assistance are available from the Department.)

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 9: Ensure that Medicaid Waiver funds are appropriately managed to ensure as many consumers are served as possible.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measures:

- The AAA must detail procedures to manage Medicaid Waiver expenditures
- The AAA must incorporate care plan review protocols and surplus/deficit management.

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options.

OBJECTIVE 10: To maximize resources

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measures

The AAA must:

1. Detail procedures to identify funding alternatives to be used prior to relying on Community Care for the Elderly funds.
2. Identify volunteer and other community resources to be accessed prior to relying on Department-funded services.
3. Detail service coordination efforts to prevent duplication of effort.
4. Provide technical assistance to providers on appropriate Medicaid expenditures for Medicaid enrollment.
5. Monitor providers for appropriate Medicaid expenditures for Medicaid enrollment.

OUTPUT: [2009]

Goal B: Promote communities statewide that value and meet the needs of elders.

Goal Narrative: *Enter text here*

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 1: Help communities better support people age 60 and older to age in place, function independently, and live safely and affordably in their community.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

Percent of elders assessed with high or moderate risk environments who improved their environment score (Standard: 79.3%).

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 2: Promote recognition of the impact of elders on the economy by updating the Area Agencies on Aging websites to include an area on the importance of the role of elders in the state's economic health and well-being.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 3: Identify additional training and employment opportunities for elders.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 4: Ensure elder consumers information needs for health insurance and pre-planning for long-term care needs (including long-term care insurance) are provided.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measures:

- Improve access to SHINE program activities (health insurance counseling, long-term care counseling, outreach and SHINE program volunteer recruitment)
- Conduct outreach activities to underserved populations and consumers from targeted groups;
- Increase recruitment of volunteers from underserved groups.

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 5: Strengthen RELIEF program operations through annual monitoring of provider agencies and communicate areas of need, barriers, and monitoring findings and follow-up issues with DOEA's RELIEF Program Coordinator.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 6: Continue to promote volunteerism and civic engagement to improve the quality of life for elders.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal B: Promote communities statewide that value and meet the needs of elders.

OBJECTIVE 7: Continue to strengthen the disaster preparedness plans to address the specific needs of elders.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

Goal C: Empower older persons to stay active and healthy.

Goal Narrative: *Enter text here*

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal C: Empower older persons to stay active and healthy.

OBJECTIVE 1: Encourage elder lifestyles that incorporate routine physical activity in all aspects of their lives.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal C: Empower older persons to stay active and healthy.

OBJECTIVE 2: Help people better prepare for aging through education about the aging experience.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal C: Empower older persons to stay active and healthy.

OBJECTIVE 3: Address health needs of people 60 and older by focusing on a holistic approach to their physical and mental health.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal C: Empower older persons to stay active and healthy.

OBJECTIVE 4: Promote healthy lifestyles for elders through improved nutrition.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

Percent of new service recipients with high-risk nutrition scores whose nutritional status improved (Standard: 66%).

DOEA Internal Measure:

Percent of increase in providers participating in the Adult Care Food Program (Standard: 10%).

OUTPUT: [2009]

Number of congregate meals provided (Standard: 5,105,950).

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Goal Narrative: *Enter text here*

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 1: Protect elder Floridians through education, enforcement and intervention.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours (Standard: 97%).

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 2: Support multidisciplinary elder rights activities and ensure the coordination of services provided through the Area Agency on Aging (AAA) with services instituted under Adult Protective Services (APS), state and local law enforcement systems, and the courts.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 3: Work to form collaborative relationships with community organizations in order to augment abuse prevention activities and strengthen ties among community groups, including the Long Term Care Ombudsman Program (LTCOP).

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 4: Support public education and training approaches for professionals, identified/developed by the Department, on elder abuse, neglect and exploitation prevention.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 5: Support statewide efforts to measure status and success of outreach activities and use available data to identify unmet service, enforcement or intervention needs.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

OBJECTIVE 6: Support statewide efforts to improve the quality and quantity of legal and advocacy assistance as a means for ensuring a comprehensive elder rights system.

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal E: Maintain effective and responsive management.

OBJECTIVE 1: Effectively manage state and federal funds awarded in AAA contracts for consumer services.

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]
DOEA Internal Measure:
Percent of state and federal funds expended for consumer services (Standard: 100%).

OUTPUT: [2009]

P.III. 2009 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

Goal E: Maintain effective and responsive management.

OBJECTIVE 2: The Client Information and Registration Tracking System (CIRTS) data will be accurately maintained.

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2009]

DOEA Internal Measure:

Percent of CIRTS data entry error rate (Standard: 1%).

OUTPUT: [2009]

P.III. 2008 GOALS, OBJECTIVES AND PERFORMANCE MEASURES

(This blank is inserted for any goals/objectives/measures added by the AAA.)

GOAL:

OBJECTIVE:

NEED(S) BEING ADDRESSED

Enter text here

STRATEGIES/ACTION STEPS:

Enter text here

OUTCOME: [2008]

OUTPUT: [2008]

P.IV. Targeting

(To return to Key Needs Assessment findings, click here to go to page 6.)

Targeting Goals for 2009-2011
The purpose of the targeting goal is for the AAA to demonstrate incremental improvements in reaching the targeted populations. (For instructions, click here to go to page XII.)

Insert targeting goals here

Targeting Report
The purpose of the targeting report is to show how effective the targeting efforts were through the report of services provided to the specific population groups. Complete all cells in the table below. (For instructions, click here. to go to page XII.)

2007 Targeting Report
(embedded Excel worksheet)

Characteristic	PSA 60+ Population Count[1)]	%	Number of Registered* Service Recipients in PSA[2)]	%
All 60+		*#DIV/0!*		*#DIV/0!*
Below Poverty Level		*#DIV/0!*		*#DIV/0!*
Living Alone		*#DIV/0!*		*#DIV/0!*
Minority		*#DIV/0!*		*#DIV/0!*
Minority Below Poverty Level (low-income minority)		*#DIV/0!*		*#DIV/0!*
Rural areas		*#DIV/0!*		*#DIV/0!*
Low-Income Minority Older Individuals with Limited English Proficiency[3)]		*#DIV/0!*		*#DIV/0!*

* Registered services include personal care, homemaker, chore, home delivered meals, adult day care, adult day health care, case management, escort, congregate meals, and nutrition counseling.

Data Sources:
1) The PSA 60+ population count data source is the 2007 County Profiles.
2) The PSA registered services recipients count is provided by the Department from the NAPIS report data.
3) The low-income minority older individuals with limited English proficiency data is projected based on: (1) the AoA census 2000 Special Tabulation on Aging (Table P96), and (2) the 2007 total population in the 2007 County Profiles. Because specific data is not available for the low-income *minority* older individuals with limited English proficiency, the closest approximation is using select data from Table P96 to obtain low-income older individuals with limited English proficiency.

Targeting Plan Summary

The purpose of the targeting plan summary is to document the AAA's plan to provide outreach to the targeted populations. *(For instructions, click here to go to page* XII.*)*

Enter text here

P.V. Partnerships and Resource Development

The Partnerships and Resource Development section is for the AAA to detail efforts to enhance services and quality of life for people age 60 and older in the planning and service area. This section has three components: Communities for a Lifetime, other local initiatives and fee-for-service approaches. (For instructions, click here to go to page XIII.)

Enter text here

P.VI. Special DOEA Initiatives

This area plan section is to address specific initiatives of the Governor or the Department's Secretary. Currently, bringing attention of the value of elders to communities and the value of the aging network services is a key initiative. (For instructions, click here to go to page XIV.)

Enter text here

P.VII. Special AAA Initiatives

A key value of Area Agencies is the ability to address local needs with local partnerships and facilitate efficient and effective service programs by capitalizing on unique opportunities in the community. This section provides the AAA an opportunity to discuss innovations and creative programs and to showcase best practices. This section, since the content is more exploratory in nature, will enable the AAA to discuss the approaches without having concerns about being monitored on achieving the goals. (For instructions, click here to go to page XIV.)

Enter text here

Appendices

The appendices include elements of the plan that do not need to be part of the core of the plan and can be omitted when a more condensed document is desired, such as for advocacy or educational efforts.

Appendix 1. Needs Assessment Detail

This version of the needs assessment includes the more detailed findings and the methodology for the needs assessment activities. (For instructions, click here to go to page IV.)

Enter text here

Appendix 2: Community Focal Points

The listing of the community focal points is included in the area plan as an appendix. (For instructions, click here to go to page XVIII.)

Insert copy of report from Web DB here

Appendix 3: Senior Centers

The listing of the senior centers including multipurpose senior centers is included in the area plan as an appendix. (For instructions, click here to go to page XXV.)

Insert copy of report from Web DB here

Appendix 4: Lead Agencies

The listing of the lead agencies is included as an appendix. (For instructions, click here to go to page XXV.)

Insert copy of report from Web DB here

Appendix 5: Aging and Disability Resource Center/Aging Resource Center Access Points

The listing of the Aging and Disability Resource Center/Aging Resource Center Access Points is included as an appendix in the area plan. (For instructions, click here to go to page XXV.)

Insert copy of aging and disability resource center/aging resource center report from Web DB here

Appendix 6: Direct Service Waiver Requests

DIRECT SERVICE WAIVER REQUEST FORM #__

Insert completed forms for each direct service waiver request. It is not necessary to submit waivers requests for outreach, information and assistance and referral, as the state has a statewide waiver for these services. (For instructions, click here to go to page XXVI.)

OAA Title: **[ ]** III-B **[ ]** III-C1 **[ ]** III-C2 **[ ]** III-D **[ ]** III-E
Service: _____

Section 307(a)(8) of the Older Americans Act provides that services will not be provided directly by the State Agency or an Area Agency on Aging unless, in the judgment of the State agency, it is necessary due to one or more of the three provisions listed below.

I. Please select the basis for which the waiver is requested (more than one may be selected).
   - **[ ]** *(i) provision of such services by the State agency or the Area Agency on Aging is necessary to assure an **adequate supply** of such services*;
   - **[ ]** *(ii) such services are directly related to such State agency's or Area Agency on Aging's **administrative functions**; or*
   - **[ ]** *(iii) such services can be provided **more economically, and with comparable quality**, by such State agency or Area Agency on Aging.*

II. Provide a detailed justification for the waiver request. The justification should include such factors as a cost analysis or needs assessment, the Area Agency's efforts to secure services through a competitive solicitation process such as a Request for Proposal (RFP), Request for Information (RFI) or Invitation to Bid (ITB); etc., or if the service is considered part of the administrative activity, describe the rationale for considering it part of the administrative activity and the authority for that rationale.

III. Provide documentation of the public hearing held to gather public input on the proposal to directly provide service(s). This documentation should include identification of when and where the public hearing was held, information on the sources used to advertise the public hearing, a description of the number and types of participants (number of private citizens, number of service provider representatives, number of public officials, etc.), and a summary of the public comments specific to the services proposed for direct service provision. An actual participant list must be kept in the administrative files and be available for review by the Department upon request.

Appendix 7: Program Module Review Checklist

Please complete the form provided by indicating whether each item is included in the area plan (Yes/No/Not Applicable) and identifying the area plan page number(s) where the items can be found. ((For instructions, click here to go to page XXVI.)

P.XII. PROGRAM MODULE REVIEW CHECKLIST

Program Module	*YES*	*NO*	*N/A*	*PAGE*
Table of Contents				
The location of each section of the program module is accurately reflected.				
Program Module Certification Page				
The form is properly completed.				
The form is signed by Board President (or Designee) and dated.				
The form is signed by Advisory Council Chair and dated.				
The form is signed by Executive Director and dated.				
Section P.I. Executive Summary				
This section describes major highlights.				
This section is limited to 3 pages or less.				
Section P.II. Profile of the Planning and Service Area (PSA)				
This section includes the following:				
Mission and vision statement				
Identification of counties and/or major communities within PSA				
Statistical overview with narrative and graphics				
The statistical overview includes the following:				
Maps identifying the PSA				
Map identifying rural areas				
Discussion of economic and social resources available in your PSA				
Discussion of the conditions of older persons				

Program Module	*YES*	*NO*	*N/A*	*PAGE*
Discussion of the AAA's role collaborative efforts and interagency coordination				
Discussion of system changes resulting from the transition to ARC				
Discussion of the socio-demographic and economic factors most relevant to the AAA				
Section P.III. Needs Assessment Detail				
Included are the following elements as appropriate:				
Services currently being provided				
Information to demonstrate unmet need				
Comparison of areas with high and very high needs to the rest of the PSA and the state				
Analysis of service implications of identified unmet needs				
Discuss how the supportive services funded by OAA address the needs of and conditions of elders in the PSA and include:				
Description of service needs and targeted area(s)				
Detail targeting activities				
Section P. III. Key Needs Assessment Findings and Implementation Plan				
Goal A: *Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports and long-term care options*				
Goal Narrative:				
Focus is on the highest ranked needs identified in the needs assessment				
The goals narrative is supported by the needs findings				
The goals narrative fully documents the AAA's priorities				
Emphasis is placed on those with the greatest economic and social need, including elders with limited English speaking proficiency, low-income minorities, older individuals at risk of institutional placement and elders residing in rural areas				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Goal narrative addresses following topics:				
Why goal is important to elders				
What is status of achieving the goal and what are the trends				
SWOT analysis				
Consequences of not addressing the goal				
Services which currently address the goal				
Identified needs of elders				
Prioritization of funded services is explained and is based on identified needs				
How will projected expenditures address the needs and support the goal				
Includes a summary of all programs and how they coordinate with OAA programs				
Listed the specific needs being addressed by specific objective				
Objective 1: *Decrease demand for institutional long-term care services through infrastructure modernization and increased emphasis on prevention*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 2: *Develop a more sensitive and less formal system to more quickly identify and refer individuals who need a service plan or a change in an existing plan*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 3*: Increase provider network capacity*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 4: *Improve support of caregivers by providing services that are more timely and specifically targeted to individual caregiver needs*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Objective 5: *Ensure collection and maintenance of a database of resources that provide health and/or human services in the planning and service area*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 6: *Ensure a system is in place for collecting and organizing inquirer data to facilitate appropriate referrals and identify gaps in service*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 7: *Prioritize services to the most frail elders*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 8: *Ensure services provided to consumers are meeting consumer needs*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 9: *Ensure that Medicaid Waiver funds are appropriately managed to ensure as many consumers are served as possible*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Objective 10: *Maximize resources*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Goal B: *Promote communities statewide that value and meet the needs of elders*				
Goal Narrative:				
Focus is on the highest ranked needs identified in the needs assessment				
The goals narrative is supported by the needs findings				
The goals narrative fully documents the AAA's priorities				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Goal narrative addresses following topics:				
Why goal is important to elders				
What is status of achieving the goal and what are the trends				
SWOT analysis				
Consequences of not addressing the goal				
Services which currently address the goal				
Identified needs of elders				
Prioritization of funded services is explained and is based on identified needs				
How will projected expenditures address the needs and support the goal				
Specific needs being addressed by specific objective				
Objective 1: *Help communities better support people age 60 and older to age in place, function independently and live safely and affordably in their community*				
Implementation strategies are logical steps toward assuring that the objective and performance measure are met				
Objective 2: *Promote recognition of the impact of elders on the economy by updating the Area Agencies and aging websites to include an area on the importance of the role of elders in the state's economic health and well-being*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 3: *Identify additional training and employment opportunities for elders*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 4: *Ensure elder consumers information needs for health insurance and pre-planning for long-term care needs are provided*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Objective 5: *Strengthen RELIEF program operations through annual monitoring of provider agencies and communicate areas of need, barriers and monitoring findings and follow-up issues with DOEA's RELIEF Program Coordinator*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 6: *Continue to promote volunteerism and civic engagement to improve the quality of life for elders*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 7: *Continue to strengthen the disaster preparedness plans to address specific needs of elders.*				
Implementation strategies are logical steps toward assuring that the objective is met				
Goal C*: Empower older persons to stay active and healthy*				
Goal Narrative:				
Focus is on the highest ranked needs identified in the needs assessment				
The goals narrative is supported by the needs findings				
The goals narrative fully documents the AAA's priorities				
Goal narrative addresses following topics:				
Why goal is important to elders				
What is status of achieving the goal and what are the trends				
SWOT analysis				
Consequences of not addressing the goal				
Services which currently address the goal				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Identified needs of elders				
Prioritization of funded services is explained and is based on identified needs				
How will projected expenditures address the needs and support the goal				
Specific needs being addressed by specific objective				
Objective 1: *Encourage elder lifestyles that incorporate routine physical activity in all aspects of their lives*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 2: *Help people better prepare for aging through education about the aging experience*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 3: *Address health needs of people 60 and older by focusing on a holistic approach to their physical and mental health*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 4: *Promote healthy lifestyles for elders through improved nutrition*				
Implementation strategies are logical steps toward assuring that the objective and performance measures are met				
Goal D: *Ensure the rights of older people and prevent their abuse, neglect and exploitation*				
Goal Narrative:				
Focus is on the highest ranked needs identified in the needs assessment				
The goals narrative is supported by the needs findings				
The goals narrative fully documents the AAA's priorities				

Program Module	***YES***	***NO***	***N/A***	***PAGE***
Goal narrative addresses following topics:				
Why goal is important to elders				
What is status of achieving the goal and what are the trends				
SWOT analysis				
Consequences of not addressing the goal				
Services which currently address the goal				
Identified needs of elders				
Prioritization of funded services is explained and is based on identified needs				
How will projected expenditures address the needs and support the goal				
Specific needs being addressed by specific objective				
Objective 1: *Protect elder Floridians through education, enforcement and intervention*				
Implementation strategies are logical steps toward assuring that the objective and performance measure are met				
Objective 2: *Support multidisciplinary elder rights activities and ensure the coordination of services provided through the Area Agency on Aging (AAA) with services instituted under Adult Protective Services (APS), state & local law enforcement systems, and the courts*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 3*: Work to form collaborative relationships with community organizations in order to augment abuse prevention activities and strengthen ties among community groups, including the Long-Term Care Ombudsman Program (LTCOP)*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 4: *Support public education and training approaches for professionals, identified/developed by the Department, on elder abuse, neglect and exploitation prevention*				
Implementation strategies are logical steps toward assuring that the objective is met				

Program Module	*YES*	*NO*	*N/A*	*PAGE*
Objective 5*: Support statewide efforts to measure status and success of outreach activities and use available data to identify unmet service, enforcement or intervention needs.*				
Implementation strategies are logical steps toward assuring that the objective is met				
Objective 6: *Support statewide efforts to improve the quality and quantity of legal and advocacy assistance as a means for ensuring a comprehensive elder rights system*				
Implementation strategies are logical steps toward assuring that the objective is met				
Goal E: *Maintain effective and responsive management*				
Objective 1: *Effectively manage state and federal funds awarded in AAA contracts for consumer services*				
Implementation strategies are logical steps toward assuring that the objective and performance measure are met				
Objective 2: *The client information and Registration Tracking System (CIRTS) data will be accurately maintained*				
Implementation strategies are logical steps toward assuring that the objective and performance measure are met				
If the AAA added any goals and/or objectives, implementation strategies are logical steps toward assuring that the objective and performance measure(s) are met.				
Section P.IV. Targeting Report Instructions				
*Included **targeting goals**: projected the number and percentage to be served in each county during each year of the three-year plan*				
Used table provided, properly completing the cells of the table.				
*Included **targeting report:** extent to which objectives have been met*				
*Included **targeting plan summary** addressing the following populations:*				
Older individuals residing in rural areas				
Older individuals with greatest economic need				
Older individuals with greatest social need				
Older individuals with severe disabilities				
Older individuals with limited English-speaking ability				
Older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of these individuals				

Program Module	*YES*	*NO*	*N/A*	*PAGE*
Older individuals at risk for institutional placement				
Caregivers:				
Caregivers of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction				
Grandparents or older individuals who are relative caregivers who provide care for children with severe disabilities				
Caregivers who are older individuals with greatest social need				
Caregivers who are older individuals with greatest economic need				
Caregivers who are older individuals who provide care to individuals with severe disabilities, including children with severe disabilities				
Section P. V. Partnerships and Resource Development				
Communities for a Lifetime summary details efforts to enhance services and quality of life for people age 60 and older				
Other Local Initiatives summary details efforts to enhance services and quality of life for people age 60 and older				
Fee-For-Service Approaches summary details efforts to enhance services and quality of life for people age 60 and older				
Section P. VI. Special DOEA Initiatives				
Included a description of activities the AAA will undertake to educate legislators and staff about what elders offer communities, how communities in the PSA can be better prepared for an aging population and issues of particular interest to elders in the PSA.				
Included narrative about how AAA and providers serve as a resource for state and community leaders on the value of elders to the community and specific service needs of elders.				

Program Module	*YES*	*NO*	*N/A*	*PAGE*
Section P. VII. Special AAA Initiatives				
Discussed innovations and creative programs				
Best practices				
Section P.VIII. Program Module Review Checklist				
The form indicates if each item is included.				
The form identifies the page location(s) of the items.				
Appendix 1 Needs Assessment Detail				
Includes detailed needs assessment including the methodology used to gather the needs assessment information.				
Appendix 2 Community Focal Points				
Inserted a copy of the report.				
Appendix 3 Senior Centers				
Inserted a copy of the report.				
Appendix 4 Lead Agencies				
Inserted a copy of the report.				
Appendix 5 Aging Resource Center/Aging and Disability Resource Center Access Points				
Inserted a copy of the report.				

Other comments (identify relevant sections):

Program Module Comments and Recommendations:
(to be completed by DOEA staff)

Table of Contents:
Certification Page:
Section P.I.: Executive Summary
Section P.II.: Profile of the PSA
Mission and vision statement of the AAA
Identification of counties and/or major communities within the PSA
Statistical overview
Section P.III.: Needs Assessment Findings and Implementation Plan
Needs assessment key findings
Goals and objectives
Section P.IV: Targeting
Section P.V.: Partnerships and Resource Development
Section P.VI.: Special DOEA Initiatives
Section P.VII.: Special AAA Initiatives
Appendix 1.: Needs Assessment Detail
Appendix 2.: Community Focal Points
Appendix 3.: Senior Centers
Appendix 4.: Lead Agencies
Appendix 5.: Aging and Disability Resource Centers/Aging Resource Centers Access Points
Appendix 6.: Direct Service Waiver Requests
Appendix 7.: Program Module Review Checklist

Other changes: Identify section and provide comments or recommendations.

Instructions

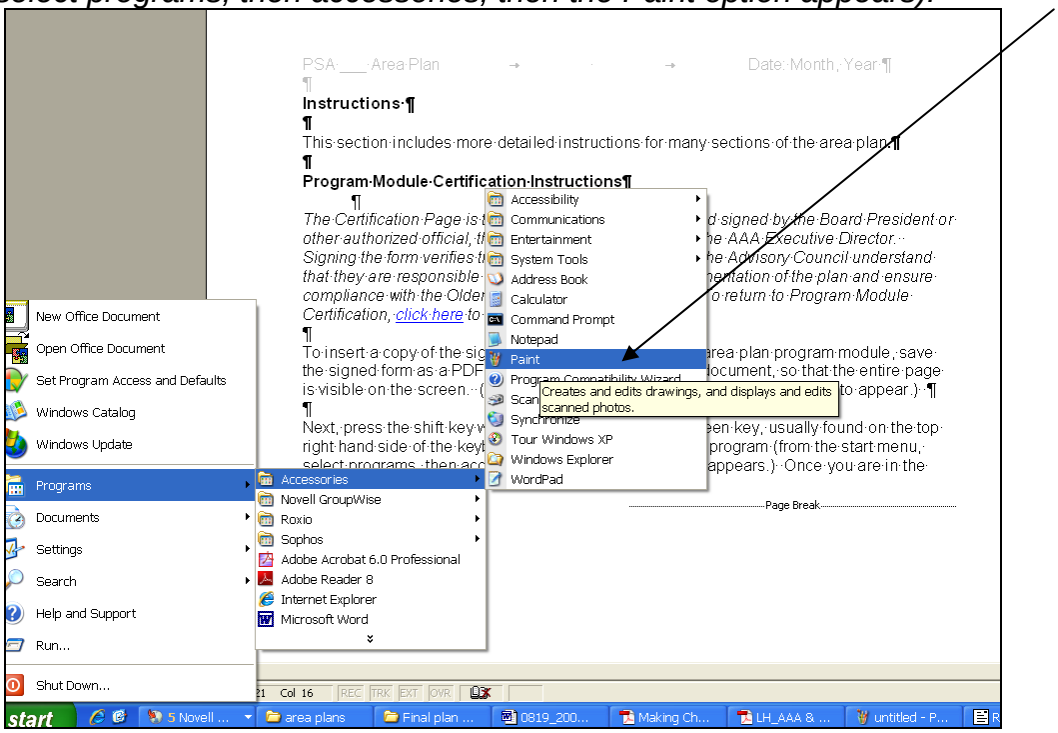
This section includes more detailed instructions for many sections of the area plan**.**

Program Module Certification Instructions

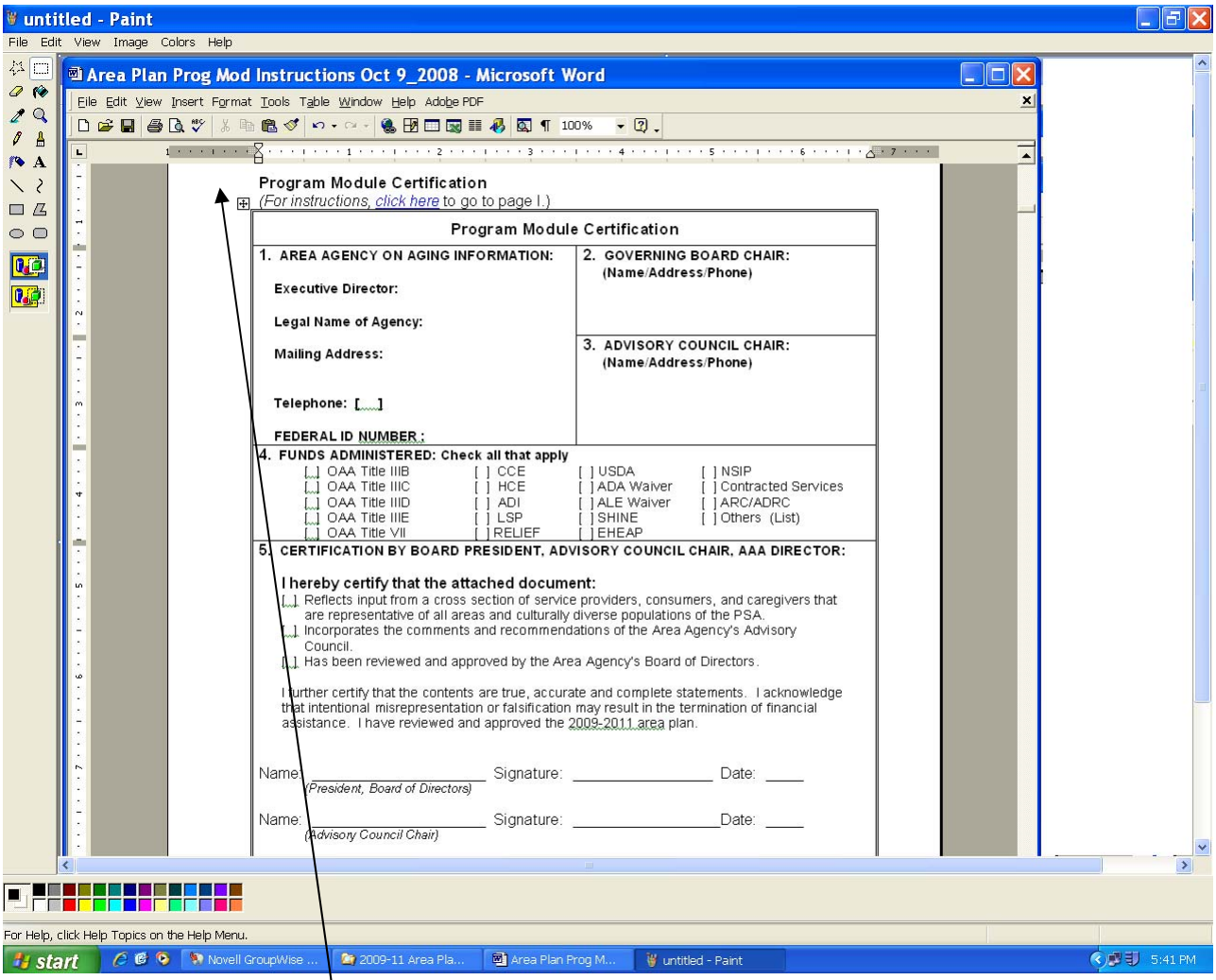
The Certification Page is to be completed as indicated and signed by the Board President or other authorized official, the Advisory Council chair, and the AAA Executive Director. Signing the form verifies that the Board of Directors and the Advisory Council understand that they are responsible for the development and implementation of the plan and ensure compliance with the Older Americans Act Section 306. (To return to Program Module Certification, click here to go to page 5.)

To insert a copy of the signed certification page into the area plan program module, save the signed form as a PDF document. Open up the PDF document, so that the entire page is visible on the screen. (You may need to reduce the size in order for it all to appear.)

Next, press the shift key while also pressing the print screen key, usually found on the top right hand side of the keyboard. Next, open up the Paint program (from the start menu, select programs, then accessories, then the Paint option appears).



Once you are in the Paint program, paste the picture of the form.



To eliminate the other details and just show the copy of the form, place your cursor on the top left corner of the form and highlight the entire form. Select edit, copy. Insert the copy in your area plan document by placing your cursor in the document where you would like the form, select edit, and paste. You can reduce the size of the picture from any corner. You may need to practice the procedure a couple of times to get the best results.

Table of Contents Instructions

Each page must be sequentially numbered and the location of each section must be listed in the Table of Contents. The Table of Contents is already set up to hyperlink to the relevant sections. As the AAA inserts the relevant information, the correct pages should appear when the Table of Contents is updated.

** REMEMBER, to update the TOC, position the cursor in the left margin and click on F9.*
(To return to the template, click here to go to page 3.)

P.II. Profile of the Planning and Service Area Instructions
(To return to the template, click here to go to page 6.)

This section must include the following:

1. *Mission and vision statement of the Area Agency on Aging*
2. *Identification of counties and/or major communities within the planning and service area.*
3. *The statistical overview is to accurately describe the PSA using both narrative and graphics. Include relevant information from the DOEA's County Profiles (available on the DOEA internet website). Include the number of registered services provided and the number of clients served in each county as well as a discussion of socio-demographic and economic factors. Attention must be paid to rural factors, where applicable.*

   The information below will be included in your statistical overview:
   - *One or more maps showing the PSA in relation to the entire state*
   - *A map identifying the rural areas in your PSA*
   - *A discussion of economic and social resources available in your PSA*
   - *A discussion of the conditions of older persons, focusing on conditions that are significantly better or worse in comparison to the state as a whole or national averages/estimates (e.g., greater number of old-old, greater isolation, higher costs for essential services, fewer family supports, poorer housing)*
   - *A discussion of the AAA's role in coordinating and/or participating in interagency collaborative efforts, such as coordination with community mental health providers*
   - *A discussion of the systems change resulting from transition to ARC/ADRC*

   The following items are examples of socio-demographic and economic factors. Use those that are most relevant to your PSA.
   - *Population characteristics of the PSA, including the number of clients served in each county and also the numbers served of low-income elders, minority elders, and elders residing in rural areas*
   - *Estimate the average units of service provided per client*
   - *Increases in the 85+ age group*
   - *Geographic concentrations of elders with low incomes*
   - *Geographic concentration of minority and culturally diverse elders*
   - *Locations of socially isolated elders*

- *Urban/rural areas*
- *Counties or communities with limited access to transportation, significant supportive services or social service agencies*
- *Housing conditions and availability of affordable housing*
- *Availability of medical/health care, including mental health counseling*
- *Trends for in or out migration affecting elders*
- *Number of elder caregivers, including the number of grandparents raising grandchildren*
- *Condition of elder caregivers*
- *Discuss resources beyond traditional services that are available from government entities and the private sector that enhance quality of life for elders*
- *Describe significant differences between counties in the planning and service area*
- *Identification of new or declining retirement communities*

Needs Assessment Detail Instructions

The full needs assessment detail, including a description of the method(s) employed to assess the needs, must be included in the area plan as Appendix 1. Document how elders and caregivers were included in the needs assessment process. *(To go to Appendix 1, click here to go to page 43. To go to the template, click here to go to page 6.)*

These are elements to consider for inclusion in the detailed findings:

- *Services Currently Being Provided*
  - *Number of people being served*
  - *Frequencies of types of services offered*

- *Types of Information to Demonstrate Unmet Need:*
  - *Number of people 60+ with ADL limitations not receiving services*
  - *Number of people 60+ with IADL limitations not receiving services*
  - *Number of people 60+ with mobility limitations not receiving services*
  - *Caregiver unmet needs*
  - *Access service needs*
    - *Information about services*
    - *Transportation*
  - *Health care needs*
    - *Preventive health*
    - *Medical care needs*
    - *Ancillary health care needs (such as hearing aids and eyeglasses)*
  - *Number of people 60+ who qualify for Food Stamps, but are not receiving them*
  - *Elders with limited access to senior centers*
  - *People living in communities they feel are not elder friendly*
  - *Elders with housing and safety needs*
  - *Elders who would like employment training or related assistance*
  - *People on wait list not yet receiving any services*
  - *Existing clients waiting for more services*

- *Comparison of areas with high and very high needs to the rest of the PSA and the state*
- *Analysis of service implications of identified unmet needs*
- *Discuss how the supportive services funded by the Older Americans Act address the needs and conditions of elders in the PSA*
- *Description of service needs and targeted area(s) – Describe the communities or targeted areas and identify service needs that will be the focus of targeting efforts*
- *Targeting activities – List all service providers to be directly involved in targeting and describe the services and activities to be conducted. Outreach and information should be included. For a multiple county PSA, information should be provided for each county.*

Key Needs Assessment Findings and Implementation Plan Instructions

(How the findings relate to goals and objectives.)

(To return to the template, click here to go to page 6.)

The key needs assessment findings section is to focus on the highest ranked needs (such as the top 10 needs) identified in the needs assessment. The difference between this section and the Needs Assessment Detail section is that the Needs Assessment Detail includes all the information about the needs assessment and the methodology for identifying needs. This section focuses on the highest ranked needs and includes how the AAA addresses those highest ranked needs. The information for the needs assessment findings is organized under the Department's goal areas (except for Goal E) and their objectives. The goals and objectives must be supported by the needs findings and fully document the AAA's priorities. Strategies or action steps detailing how the AAA will address the needs findings must be measurable and clearly state what the AAA plans to do to achieve the objective and outcome.

In preparing this section of the area plan, include particular emphasis on assessing the needs of those with the greatest economic and social need, including elders with limited English speaking proficiency, low-income minorities, older individuals at risk of institutional placement and elders residing in rural areas. Include a summary analysis of the priority needs of elders and caregivers in high and very high need index areas. If you don't have more recent information, you may use the Department's needs assessment, "Assessing the Needs of Elder Floridians, 2004" located on the DOEA website.

Goals and Objectives

The five goals (A through E) and their objectives, as documented in the Florida State Plan on Aging 2009-2011, have been listed. Additional goals and objectives particular to your AAA may also be added.

Goal Narratives (To return to template, click here to go to page 6.)

The goal narrative section of the area plan will include a discussion of the significant needs for services in the PSA in combination with how those needs will be addressed. (The AAA's needs assessment with more detailed findings and methodology is to be included in Appendix 1.) The goal narratives and strategies must be supported by the needs findings you identify and fully document the AAA priorities. Charts, tables, graphs, or other exhibits should be incorporated in the narrative to illustrate data relative to service needs, service availability, and funding priorities in each county.

The narrative preceding each goal should incorporate findings from needs assessment activities and address the following questions/topics:

- *Why is this goal of particular importance to elders?*
- *What is the current status of achieving the goal and what are the trends?*
- *Strengths/Weaknesses/Opportunities/Threats (SWOT) analysis*
- *What would be the consequences of not addressing the goal?*
- *Summary description of services currently addressing the goal*
- *Identified needs of elders relating to this issue*
- *Explain how funded services are prioritized based on identified needs*
- *Explain how the projected expenditures will address the objectives and strategies developed by the AAA to support the goal*
- *Since Older Americans Act funds help provide the administrative infrastructure for most activities performed, the area plan should include a summary of all the other programs and how they coordinate with Older Americans Act programs.* ***(This requirement applies to Goal A only.)***

Goals, Objectives and Performance Measures

The Goals, Objectives and Performance Measures forms relating to each specific goal follow each goal narrative. A form is included for every objective with the goal and objective already filled in. Complete the needs being addressed and strategies/action steps sections for each form. If the objective has associated performance measures, they are listed in the outcomes and outputs sections at the bottom of the form.

Needs Being Addressed (To return to template, click here to go to page 7.)

List the specific needs being addressed by the specific objective. The purpose of listing the needs here is to ensure that the most significant needs identified in the needs assessment are being addressed through the strategies.

Strategies/action steps (To return to template, click here to go to page 7.)

Strategies or action steps detailing how the AAA will address the needs findings must be measurable and clearly state what the AAA plans to do to achieve the objective and outcomes. Words such as "work with" do not provide specific strategies and are to be avoided.

Outcomes/Outputs (To return to template, click here to go to page 7.)

Department performance-based program budgeting and Department-specified performance measures are included with relevant objectives. The AAAs will not be monitored on the

measures listed in italics, though the AAA must still include strategies to address them in this section. Note: The Department must report on all outcomes statewide, including those in italics. Outcome reports are available to the AAAs that choose to monitor their performance, which is encouraged.

List of Goals and Objectives

Goal A: Enable elders, their families and caregivers to experience a high quality of life through easy service access, home- and community-based supports, and long-term care options

Goal A Objectives

1. Decrease demand for institutional long-term care services through infrastructure modernization and increased emphasis on prevention
   Outcome Measures:
   - *Percent of elders CARES determined to be eligible for nursing home placement who were diverted (Standard: 30%) Applies to CARES*
   - *Percent of most frail elders who remain at home or in the community instead of going into a nursing home (Standard: 97%)*
   - *Average monthly savings per consumer for home- and community-based care versus nursing home care for comparable consumer groups (Standard: $2,384)*
   - *Percent of new service recipients whose ADL assessment score has been maintained or improved (Standard: 65%)*
   - *Percent of new service recipients whose IADL assessment score has been maintained or improved (Standard: 62.3%*)

     Output Measure:
     - *Total number of CARES assessments (Standard: 96,000)*

2. Develop a more sensitive and less formal system to more quickly identify and refer individuals who need a service plan or a change in an existing plan (for example, if someone visiting the home reports a concern about a client's health or behavior, a case manager would conduct a reassessment to determine if adjustments in the care plan are needed.)

3. Increase provider network capacity
   Outcome Measures:
   - *Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers (Standard: 2.8 months)*
   - Percent of customers who are at imminent risk of nursing home placement who are served with community-based services (Standard: 90%)

   Output Measure:
   - *Number of people served with registered long-term care services*

   DOEA Internal Measure:
   - Percent of co-pay goal achieved

4. Improve support of caregivers by providing services that are more timely and specifically targeted to individual caregiver needs
   Outcome Measures:
   - Percent of family and family-assisted caregivers who self-report they are very likely to provide care (Standard: 89%)

- Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor)(Standard: 90%)

5. Ensure collection and maintenance of a database of resources that provide health and/or human services in the planning and service area.

   DOEA Internal Measure:

   The Area Agency will administer information and referral services under the AIRS Standards for Professional Information and Referral, which are included as an attachment to the Older Americans Act (OAA) contract, and will:
   1. Maintain resources in the statewide online database.
   2. Ensure the accuracy of data entered in the resource database and adherence to the inclusion/exclusion criteria.
   3. Ensure the timely entry of accurate data in the online database.

6. Ensure a system is in place for collecting and organizing inquirer data to facilitate appropriate referrals and identify gaps in service.

   DOEA Internal Measure:

   The Area Agency will ensure the inquiry data collected will identify:
   1. The number of calls received by Elder Helplines.
   2. The type/level of services requested.
   3. Quarterly reports from the Elder Helplines are submitted to the Department with regard to information and referral activity.

7. Prioritize services to the most frail elders

   DOEA Internal Measures:
   1. Percent of high-risk consumers (APS, Imminent Risk, and/ or priority levels 4 and 5) out of all referrals who are served.
   2. Average time for applicants who are APS or imminent risk referrals or assessed as priority levels 4 and 5 to start services (other than case management) is less than the average time for applicants assessed as priority levels 1, 2 or 3 to start services

8. Ensure services provided to consumers are meeting consumer needs

   DOEA Internal Measure:
   - The AAA must assess consumer satisfaction with services provided

   (Tools developed under contract with the Administration on Aging and technical assistance are available from the Department.)

9. Ensure that Medicaid Waiver funds are appropriately managed to ensure as many consumers are served as possible

   DOEA Internal Measures:
   - The AAA must detail procedures to manage Medicaid Waiver expenditures

- The AAA must incorporate care plan review protocols and surplus/deficit management.

10. To maximize resources
    DOEA Internal Measures
    The AAA must do the following:
    6.1. Detail procedures to identify funding alternatives to be used prior to relying on Community Care for the Elderly funds.
    7.2. Identify volunteer and other community resources to be accessed prior to relying on Department-funded services.
    8.3. Detail service coordination efforts to prevent duplication of effort.
    9.4. Provide technical assistance to providers on appropriate Medicaid expenditures for Medicaid enrollment.
    10.5. Monitor providers for appropriate Medicaid expenditures for Medicaid enrollment.

Goal B: Promote communities statewide that value and meet the needs of elders.

1. Help communities better support people age 60 and older to age in place, function independently, and live safely and affordably in their community
   Outcome Measure:
   - *Percent of elders with high or moderate risk environments who improved their environment score (Standard: 79.3%)*

2. Promote recognition of the impact of elders on the economy by updating the Area Agencies on Aging websites to include an area on the importance of the role of elders in the state's economic health and well-being

3. Identify additional training and employment opportunities for elders

4. Ensure elder consumers information needs for health insurance and pre-planning for long-term care needs (including long-term care insurance) are provided
   DOEA Internal Measures:
   - Improve access to SHINE program activities (health insurance counseling, long-term care counseling, outreach and SHINE program volunteer recruitment)
   - Conduct outreach activities to underserved populations and consumers from targeted groups
   - Increase recruitment of volunteers from underserved groups.

5. Strengthen RELIEF program operations through annual monitoring of provider agencies and communicate areas of need, barriers, and monitoring findings and follow-up issues with DOEA's RELIEF Program Coordinator.

6. Continue to promote volunteerism and civic engagement to improve the quality of life for elders.

7. Continue to strengthen the disaster preparedness plans to address specific needs of elders.

Goal C: Empower older persons to stay active and healthy

Goal C Objectives

1. Encourage elder lifestyles that incorporate routine physical activity in all aspects of their life

2. Help people better prepare for aging through education about the aging experience

3. Address health needs of people 60 and older by focusing on a holistic approach to their physical and mental health

4. Promote healthy lifestyles for elders through improved nutrition
   Outcome Measure:
   - *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved (Standard: 66%)*

   DOEA Internal Measure:
   - Percent of increase in providers participating in the Adult Care Food Program (Standard: 10%)

   Output Measure:
   - *Number of congregate meals provided (Standard: 5,105,950)*

Goal D: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Goal D Objectives

1. Protect elder Floridians through education, enforcement and intervention
   Outcome Measure:
   - Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours (Standard: 97%)

2. Support multidisciplinary elder rights activities and ensure the coordination of services provided through the Area Agency on Aging (AAA) with services instituted under Adult Protective Services (APS), state & local law enforcement systems, and the courts.

3. Work to form collaborative relationships with community organizations in order to augment abuse prevention activities and strengthen ties among community groups, including the Long-Term Care Ombudsman Program (LTCOP).

4. Support public education and training approaches for professionals, identified/developed by the Department, on elder abuse, neglect and exploitation prevention.

6.5. Support statewide efforts to measure status and success of outreach activities and use available data to identify unmet service, enforcement or intervention needs.

6. Support statewide efforts to improve the quality and quantity of legal and advocacy assistance as a means for ensuring a comprehensive elder rights system.

Goal E: Maintain effective and responsive management

1. Effectively manage state and federal funds awarded in AAA contracts for consumer services
   DOEA Internal Measure:
   Percent of state and federal funds expended for consumer services (Standard: 100%)

2. The Client Information and Registration Tracking System (CIRTS) data will be accurately maintained
   DOEA Internal Measure:
   Percent of CIRTS data entry error rate (Standard: 1%)

(To return to the template, click here to go to page 6.)

P.IV. Targeting Instructions
(To return to the template, click here to go to page 41.)

Targeting goal(s) – Based on the identified service needs of targeted areas and population groups as determined through needs assessment and other data, project the number and percentage to be served in each county during each year of the three-year plan. (To return to the template, click here to go to page 41.)

Targeting report – The purpose of the targeting report is to show how effective the targeting efforts were through the report of services provided to the specific population groups.

Report on the extent to which the targeting objectives established for 2007 have been met. The NAPIS report data will be provided. The table is an embedded Excel worksheet and includes formulas in the columns identified for displaying percentages.

Targeting Plan Summary -- Summarize the Area Agency's methods for providing outreach to populations most in need of services and for directing services to:
(To return to the template, click here to go to page 41.)

1. *Older individuals residing in rural areas*
2. *Older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas)*
3. *Older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas)*

4. *Older individuals with severe disabilities*
5. *Older individuals with limited English-speaking ability*
6. *Older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals)*
7. *Older individuals at risk for institutional placement*
8. *Caregivers*
   - *Caregivers of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction;*
   - *Grandparents* or older individuals who are relative caregivers who provide care for children with severe disabilities;*
   - *Caregivers who are older individuals with greatest social need;*
   - *Caregivers who are older individuals with greatest economic need (with particular attention to low-income older individuals); and*
   - *Caregivers who are older individuals who provide care to individuals with severe disabilities, including children with severe disabilities.*

** The term ''grandparent or older individual who is a relative caregiver'' means a grandparent or step-grandparent of a child**, or a relative of a child by blood, marriage, or adoption who is* ***age*** *55 or older and—*

(A) lives with the child;

(B) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and

(C) has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally.

*** The term ''child'' means an individual who is not more than 18 years of age or who is an individual with a disability.*

P.V. Partnerships and Resource Development Instructions

(To return to the template, click here to go to page 42.)

The Partnerships and Resource Development section is for the AAA to detail efforts to enhance services and quality of life for people age 60 and older in their planning and service areas. This section has three components: Communities for a Lifetime, other local initiatives and fee-for-service approaches.

1. Communities for a Lifetime

Include a summary of the Area Agency's involvement in the Communities for a Lifetime initiative. Include issues such as the following items in the discussion:

- *Increasing awareness of the initiative in communities that have not submitted proclamations of commitment*
- *Making initial contact with city and county elected officials and notifying DOEA for appropriate follow-up*
- *Supporting communities that have submitted proclamations of commitment by participating on local task forces whenever possible*
- *Serving as a source of information and referral*

- *Keeping contact with communities and making recommendations as needed*
- *Promoting community mentoring opportunities*
- *Keeping DOEA staff apprised of Communities for a Lifetime activities or issues in their PSA*
- *Assist DOEA with coordination and promotion of state agency facilitated Communities for a Lifetime activities in communities (i.e., workshops)*

2. *Other Local Initiatives -- Include a summary of any other local initiatives that strengthen the community and help increase service access (for example, faith-based initiatives, Front Porch communities and volunteer initiatives such as the SHINE program).*

3. *Fee-For-Service Approaches -- Include a summary of fee-for-service or other resource development approaches.*

P.VI. Special DOEA Initiatives Instructions
(To return to the template, click here to go to page 42.)

This area plan section is to address specific Department initiatives. A key initiative is bringing visibility of the value of elders to communities and the value of the aging network services.

Include a description of activities the AAA will undertake to educate legislators and staff about what elders offer communities, how communities in the PSA can be better prepared for an aging population and issues of particular interest to elders in the PSA.

Include narrative about how the AAA and providers serve as a resource for state and community leaders on elder issues and specific service needs of elders.

P.VII. Special AAA Initiatives Instructions
(To return to the template, click here to go to page 42.)

A key value of area agencies is the ability to address local needs with local partnerships and facilitate efficient and effective service programs by capitalizing on unique opportunities in the community. This section provides the AAA an opportunity to discuss innovations and creative programs and to showcase best practices. This section, since the content is more exploratory in nature, will enable the AAA to discuss the approaches without having concerns about being monitored on achieving the goals.

1. *Innovations/Creative programs*
   This section is reserved for innovations that the AAA is pursuing. The field of potential topics includes managerial and programmatic changes to improve quality of life for elders. It is recognized that because the efforts are exploratory and optional, the AAA will not be monitored on actions planned that are specific to these projects.

2. *Best Practices*

Discuss programs or efforts that show evidence of particular effectiveness and that result in program efficiencies, improved services, quality of life improvements, etc.

Performance Measures Listing

Note: The AAAs will not be monitored on the measures listed in italics, though the AAA must still include strategies to address them in this section.

This section includes a listing of the performance measures required by the Department. This serves as a quick reference to the measures and standards.

Outcome Measures:

- *Percent of elders CARES determined to be eligible for nursing home placement who were diverted (Standard: 30%) Applies to CARES*
- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home (Standard: 97%)*
- *Average monthly savings per consumer for home- and community-based care versus nursing home care for comparable consumer groups (Standard: $2,384)*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved (Standard: 63%)*
- *Percent of new service recipients whose IADL assessment score has been maintained or improved (Standard: 62.3%)*
- *Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers (Standard: 2.8 months)*
- Percent of customers who are at imminent risk of nursing home placement who are served with community-based services (Standard: 90%)
- Percent of family and family-assisted caregivers who self-report they are very likely to provide care (Standard: 89%)
- Percent of caregivers whose ability to provide care is maintained or improved after one year of service intervention (as determined by the caregiver and the assessor)(Standard: 90%)
- *Percent of elders with high or moderate risk environments who improved their environment score (Standard: 79.3%)*
- *Percent of new service recipients with high-risk nutrition scores who nutritional status improved (Standard: 66%)*
- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours (Standard: 97%)
- *Percent of elders with high or moderate risk environments who improved their environment score (Standard: 79.3%)*

Output Measures:

- *Total number of CARES assessments (Standard: 96,000)*
- *Number of people served with registered long-term care services*
- *Number of congregate meals provided (Standard: 5,105,950)*

DOEA Internal Performance Measures:

- Percent of co-pay goal achieved
- Percent of increase in providers participating in the Adult Care Food Program
- Percent of high-risk consumers (APS, Imminent Risk, and/ or priority levels 4 and 5) out of all referrals who are served.

- Average time for applicants who are APS or imminent risk referrals or assessed as priority levels 4 and 5 to start services (other than case management) is less than the average time for applicants assessed as priority levels 1, 2 or 3 to start services
- Maintain resources in the statewide online database
- Ensure the accuracy of data entered in the resource database and adherence to the inclusion/exclusion criteria
- Ensure the timely entry of accurate data in the online database
- The Area Agency will ensure the inquiry data collected will identify:
  - The number of calls received by Elder Helplines.
  - The type/level of services requested
  - Quarterly reports from the Elder Helplines are submitted to the Department with regard to information and referral activity.
- The AAA must assess consumer satisfaction with services provided
- The AAA must detail procedures to manage Medicaid Waiver expenditures
- The AAA must incorporate care plan review protocols and surplus/deficit management
- Detail procedures to identify funding alternatives to be used prior to relying on Community Care for the Elderly funds
- Identify volunteer and other community resources to be accessed prior to relying on Department-funded services
- Detail service coordination efforts to prevent duplication of effort
- Provide technical assistance to providers on appropriate Medicaid expenditures for Medicaid enrollment
- Monitor providers for appropriate Medicaid expenditures for Medicaid enrollment
- Promote recognition of the impact of elders on the economy by updating the Area Agencies on Aging websites to include an area on the importance of the role of elders in the state's economic health and well-being
- Identify additional training and employment opportunities for elders
- Ensure elder consumers information needs for health insurance and pre-planning for long-term care needs (including long-term care insurance) are provided
- Improve access to SHINE program activities (health insurance counseling, long-term care counseling, outreach and SHINE program volunteer recruitment)
- Conduct outreach activities to underserved populations and consumers from targeted groups
- Increase recruitment of volunteers from underserved groups
- Percent of state and federal funds expended for consumer services (Standard: 100%)
- Percent of CIRTS data entry error rate (Standard: 1%)

Appendix 1: Needs Assessment Detail

Instructions are located in section P.III. (For instructions, click here to go to page III.)

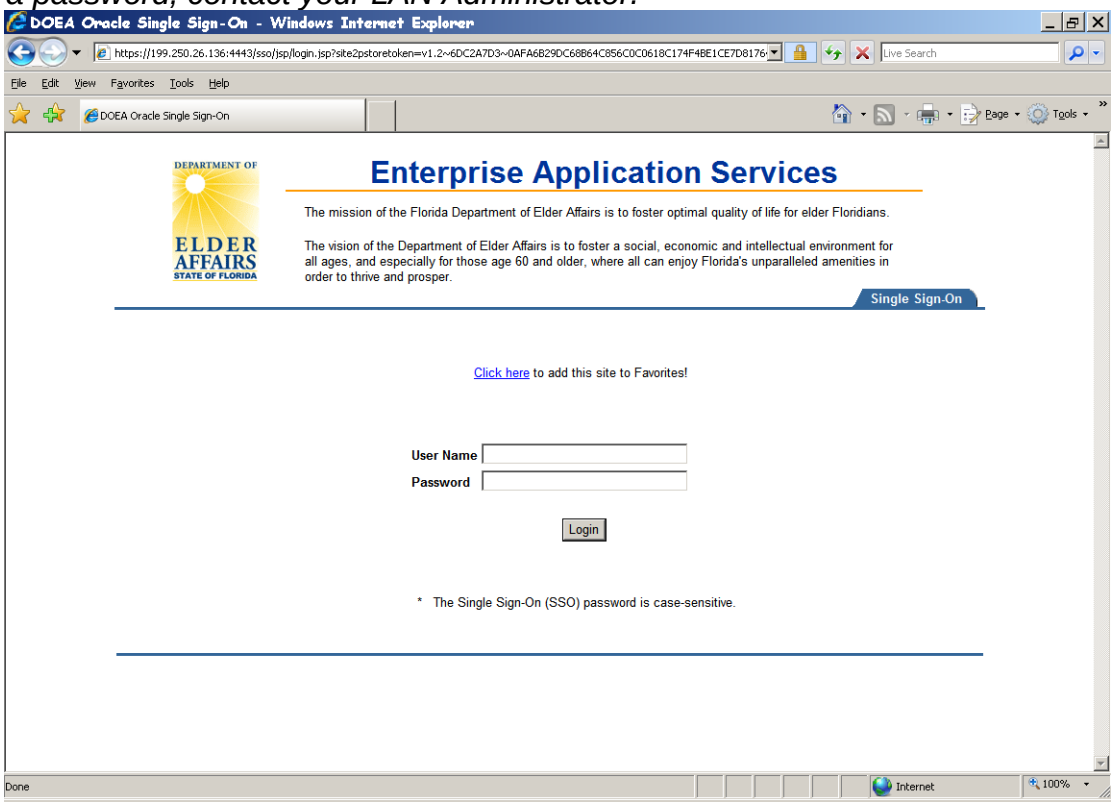
Appendix 2: Community Focal Points Instructions

The community focal point list that was in WebDB is now in a new application that has greater utility. The data was imported from WebDB to the new application. The screen shots below show how you access the new application to edit the information in the listing and run the report. Check the Community Focal Point information to ensure its accuracy and include a copy in the area plan.

Step 1: Access the initial portal to the applications from the intranet.

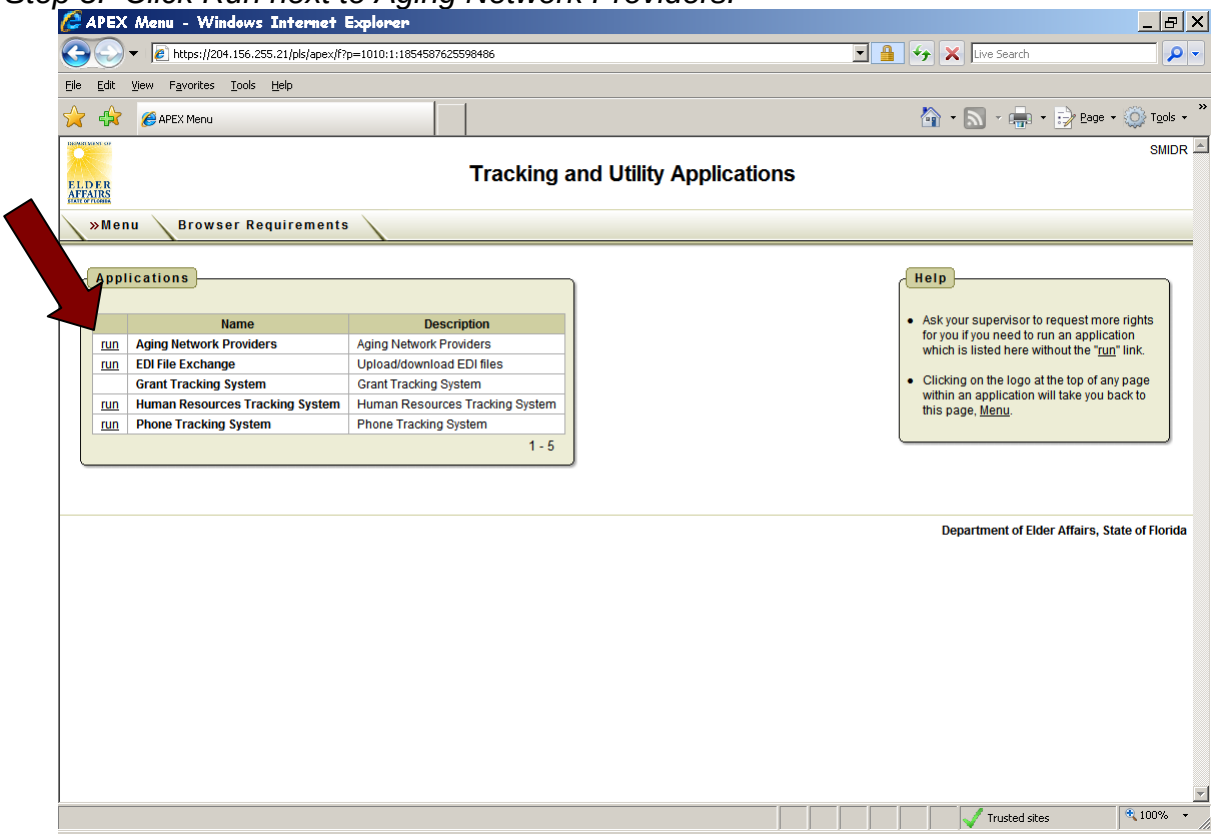
Step 2: Select the Aging Network Providers option from the list as pictured below.

Step 3: Enter your user name and password. If you do not know your user name or have a password, contact your LAN Administrator.

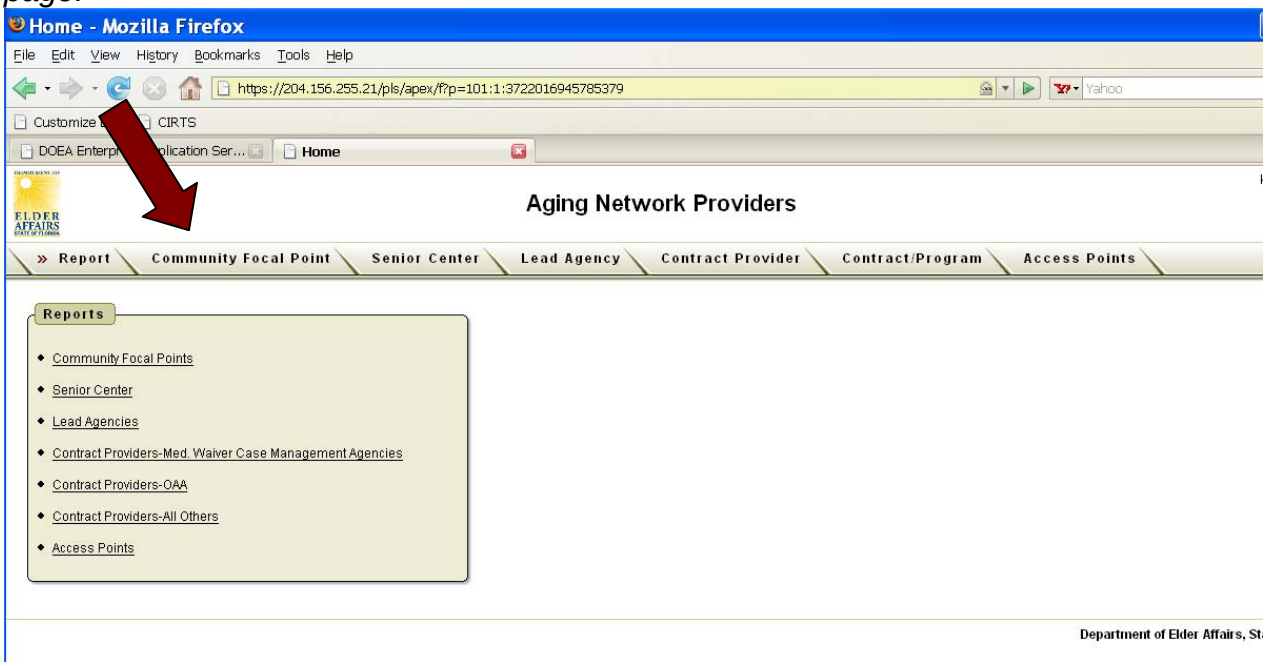


Step 4: Select Tracking and Utility Applications from the list of options.

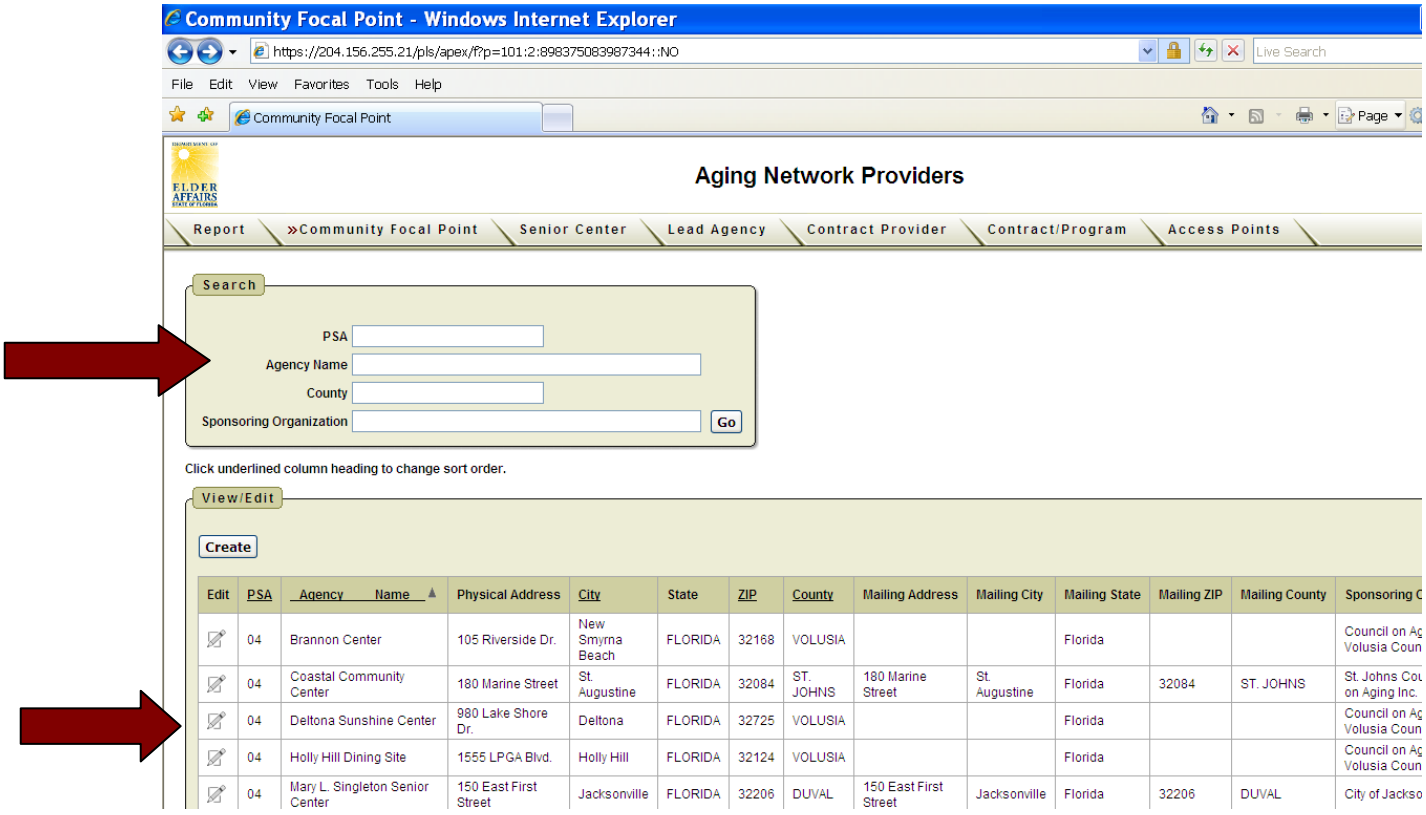
Step 5: Click Run next to Aging Network Providers.



Step 6: Select the Community Focal Point tab from the horizontal menu at the top of the page.

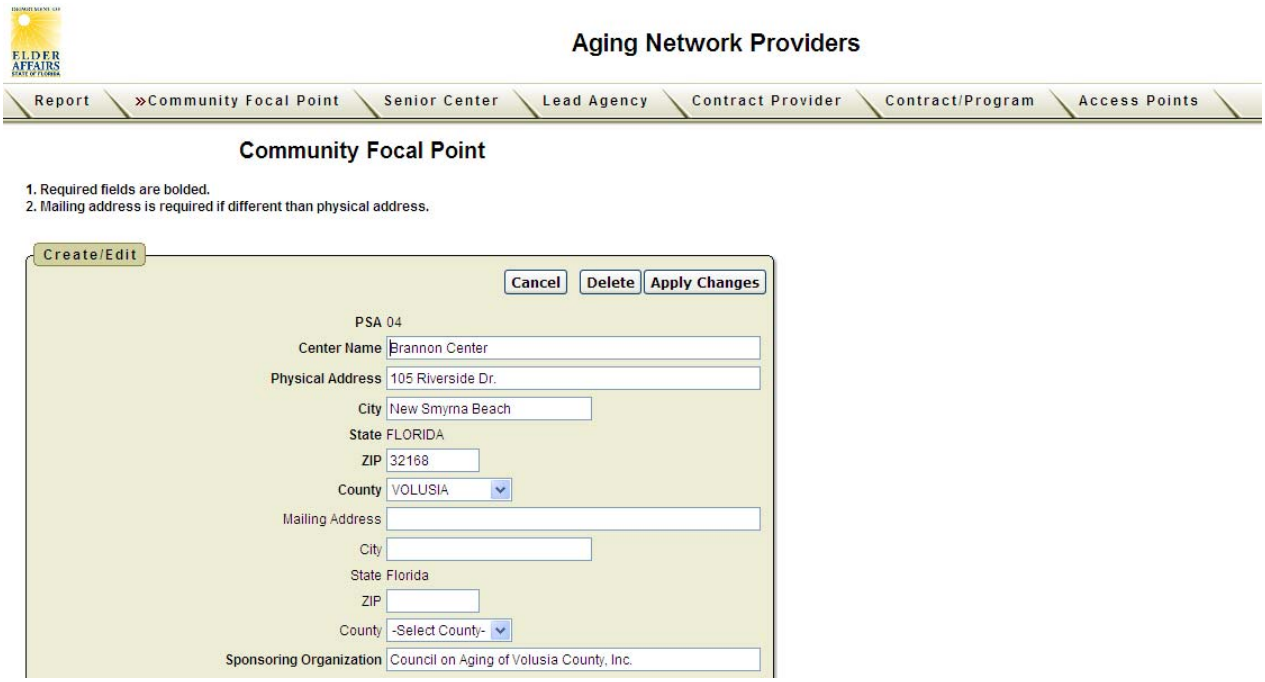


Step 7: To find a particular focal point, you can use the search function or you can scroll through the list. To search for a particular focal point, enter the information in the search screen and select Go.

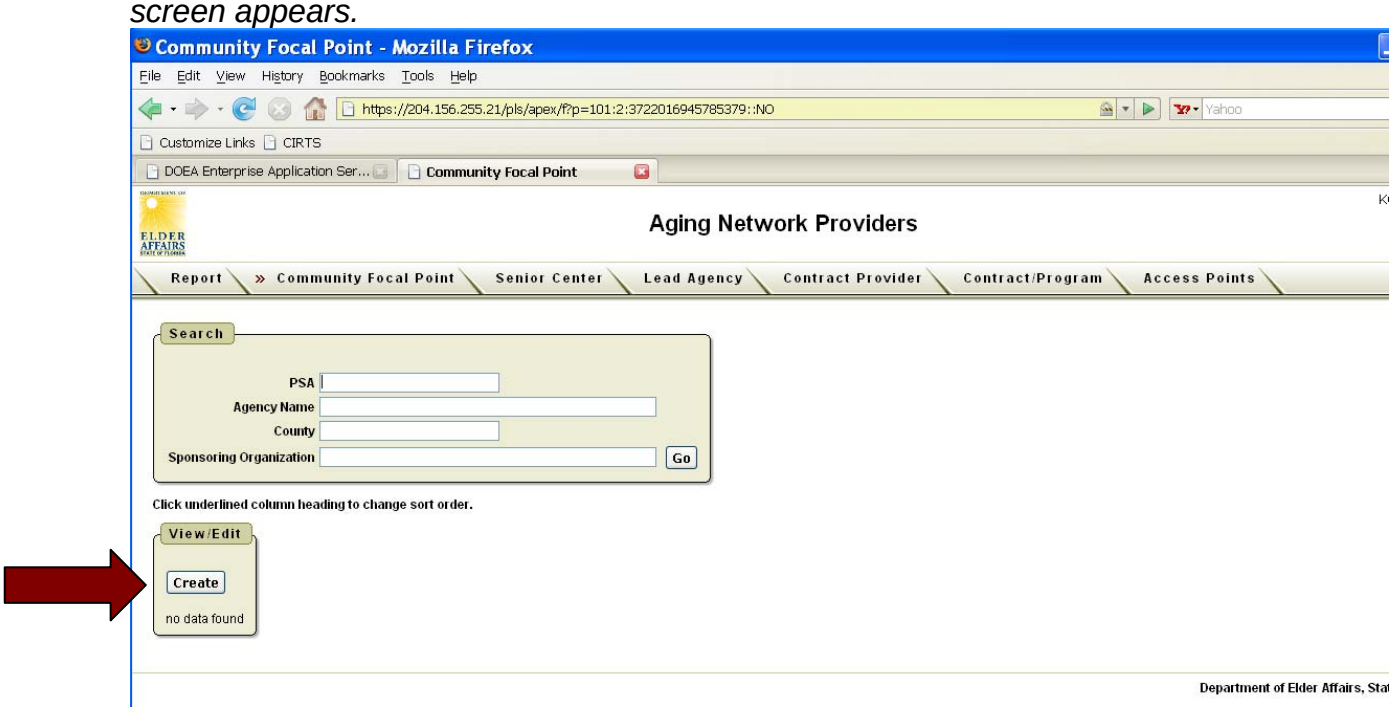


Step 8: To edit an entry, select the pad and pencil icon on the far left on the appropriate row.

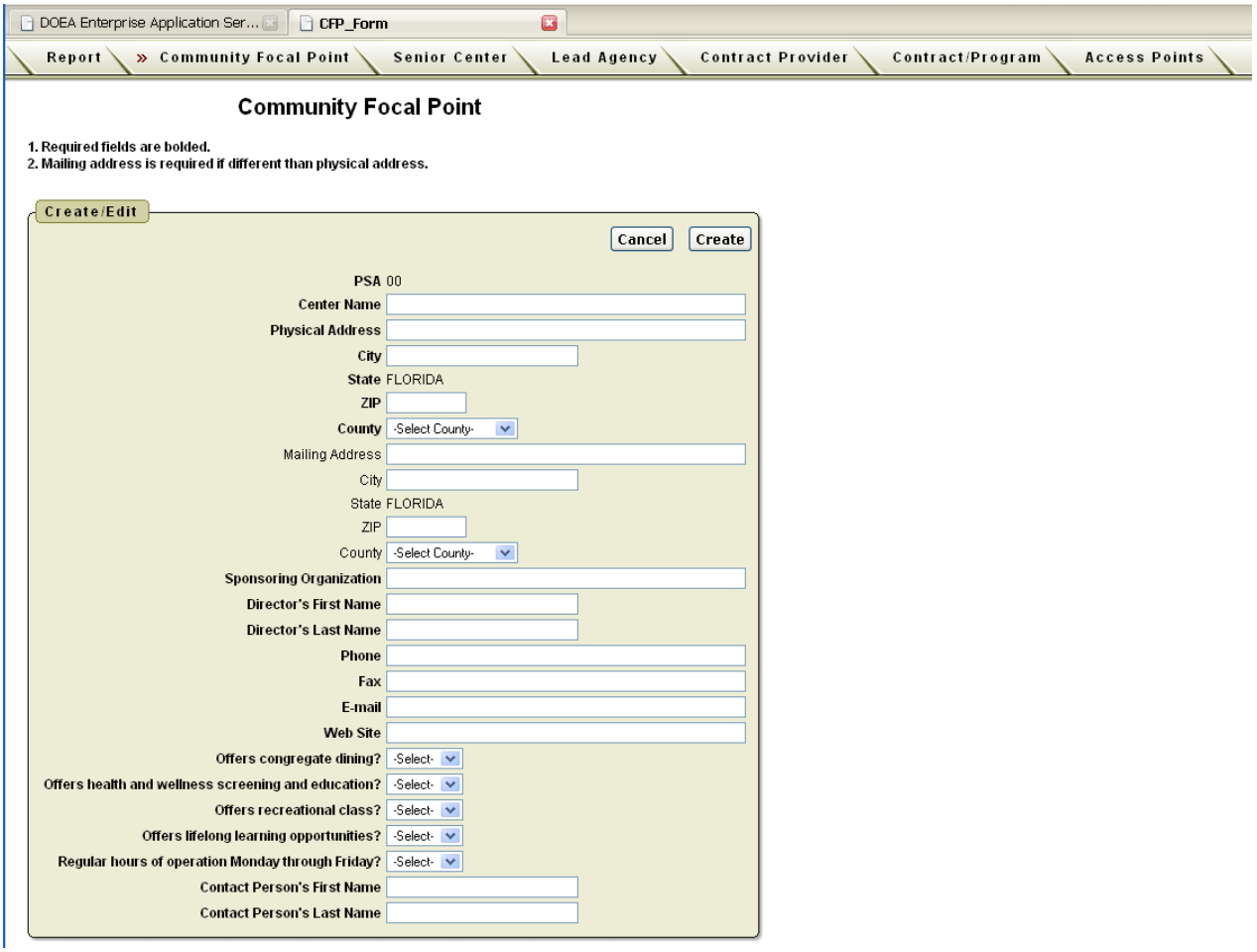
Step 9: Make the corrections to fields you would like to edit and select Apply Changes to save the changes.



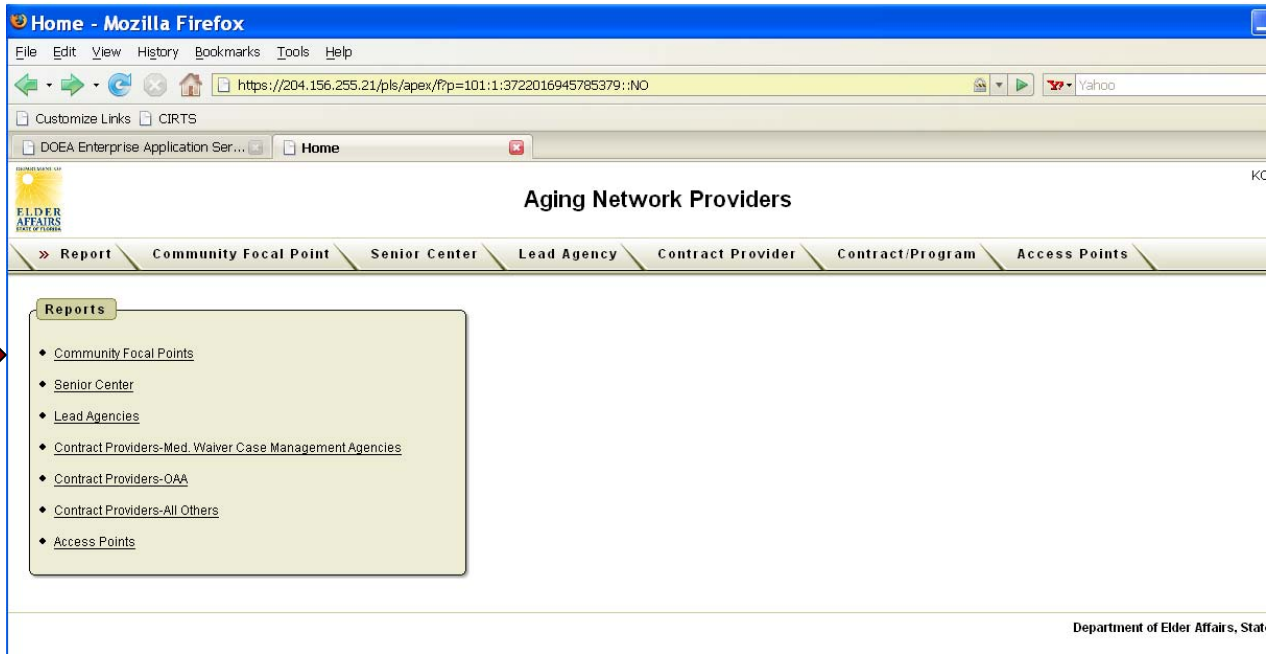
Step 10: If you are creating a new record, follow Steps 1-6, then select Create when the screen appears.



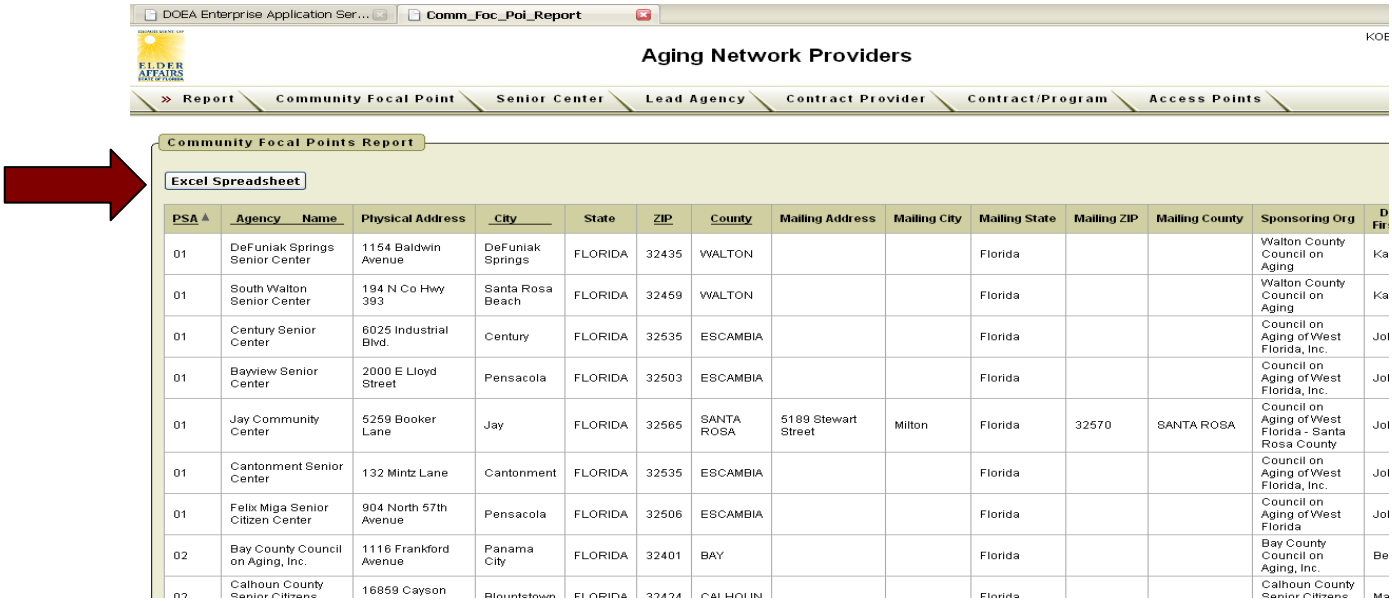
Step 11: Enter the data, then select Create. Repeat this step, as needed, to add qualifying sites not previously included.



Step 12: When ready to run a report, select Community Focal Points from the reports list.



Step 13: The report output appears. To more easily use the output, select the Excel Spreadsheet button. From Excel file, you can save the file as it is or select only the fields needed for inclusion in the area plan (facility name, address, city, state, zip code, contact person and telephone number) and eliminate the other fields. It can then be copied and pasted into the Area Plan document.



PSA	Agency Name	Physical Address	City	State	ZIP	County	Mailing Address	Mailing City	Mailing State	Mailing ZIP	Mailing County	Sponsoring Org	D Fir
01	DeFuniak Springs Senior Center	1154 Baldwin Avenue	DeFuniak Springs	FLORIDA	32435	WALTON			Florida			Walton County Council on Aging	Ka
01	South Walton Senior Center	194 N Co Hwy 393	Santa Rosa Beach	FLORIDA	32459	WALTON			Florida			Walton County Council on Aging	Ka
01	Century Senior Center	6025 Industrial Blvd.	Century	FLORIDA	32535	ESCAMBIA			Florida			Council on Aging of West Florida, Inc.	Jol
01	Bayview Senior Center	2000 E Lloyd Street	Pensacola	FLORIDA	32503	ESCAMBIA			Florida			Council on Aging of West Florida, Inc.	Jol
01	Jay Community Center	5259 Booker Lane	Jay	FLORIDA	32565	SANTA ROSA	5189 Stewart Street	Milton	Florida	32570	SANTA ROSA	Council on Aging of West Florida - Santa Rosa County	Jol
01	Cantonment Senior Center	132 Mintz Lane	Cantonment	FLORIDA	32535	ESCAMBIA			Florida			Council on Aging of West Florida, Inc.	Jol
01	Felix Miga Senior Citizen Center	904 North 57th Avenue	Pensacola	FLORIDA	32506	ESCAMBIA			Florida			Council on Aging of West Florida	Jol
02	Bay County Council on Aging, Inc.	1116 Frankford Avenue	Panama City	FLORIDA	32401	BAY			Florida			Bay County Council on Aging, Inc.	Be
02	Calhoun County Senior Citizens	16859 Cayson	Blountstown	FLORIDA	32424	CALHOUN			Florida			Calhoun County Senior Citizens	Ma

(To return to the template, click here to go to page 43.)

Appendix 3: Senior Centers Instructions

Update the information requested in the senior center database, including multipurpose senior centers, following the instructions in Appendix 2 for community focal points, substituting senior centers for each mention of focal points. (Click here to go to community focal point instructions on page XVII.) Multipurpose senior center is defined in the Older Americans Act as a community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals. Please include community focal points that are also senior centers. (Duplication is appropriate when an organization is both a community focal point and a senior center.) Include in the area plan a listing that includes the facility name, address, city, state, zip code, contact person and telephone number for each senior center. (To return to the template, click here to go to page 43.)

Appendix 4: Lead Agencies Instructions

Update the information requested in the Lead Agency database for the lead agencies in the planning and service area, following the instructions in Appendix 2 for community focal points, substituting lead agencies for each mention of focal points. (Click here to go to community focal point instructions on page XVII.) Include in the area plan a listing that includes the facility name, address, city, state, zip code, contact person and telephone number for each senior center. (To return to the template, click here to go to page 43.)

Appendix 5: Aging and Disability Resource Center/Aging Resource Center Access Points Instructions

Complete the information requested in the database for the aging and disability resource center/aging resource center access points in the planning and service area. Since this is a new report available on the intranet, information that was in the tables for senior centers and lead agencies pre-populates this table, to make data entry less cumbersome. Edit the entries as needed for accuracy following the instructions in Appendix 2 for community focal points, substituting aging and disability resource center/aging resource center access points for each mention of focal points. (Click here to go to community focal point instructions on page XVII.) Include in the area plan a listing that includes the facility name, address, city, state, zip code, contact person and telephone number for each senior center. (To return to the template, click here to go to page 43.)

Appendix 6: Direct Service Waiver Requests Instructions

A completed direct service waiver request form must be included in the area plan program module for any service the AAA plans to provide directly with Older Americans Act services funds, except for outreach, information and assistance and referral. It is not necessary to submit waiver requests for outreach, information and assistance and referral, as the state has a statewide waiver for these services. If the AAA has already been directly providing a service, a public hearing addressing the direct service issue is not required. For any service that is new for the AAA to provide directly, the AAA must hold a public hearing.

The purpose of the public hearing is to ensure that the community is informed of the services the AAA is proposing to provide directly and is offered the opportunity to comment on the AAA's intention to provide these services directly. To adequately document the public hearing, the following information must be submitted on the Direct Service Waiver Request form:

1. *Identification of when and where the public hearing was held;*
2. *Information on the sources used to advertise the public hearing;*
3. *A description of the number and types of participants (number of private citizens, number of service provider representatives, number of public officials, etc.) An actual participant list must be kept in the administrative files and be available for review by the Department; and*
4. *A summary of the public comments specific to the services proposed for direct service provision.*

Since the Direct Service Waiver Request form is to be included in the area plan, approval of the area plan includes approval of the waiver request.

The AAA must update WebDB forms C.I.C. and C.I.E for each service the AAA plans to provide directly showing the AAA provided units of service and costs.

(To return to the template, click here to go to page 44.)

Appendix 7: Program Module Review Checklist

Complete the included checklist and indicate the page numbers of the requested information. (To return to the template, click here to go to page 45.)