AREA PLAN ON AGING
PROGRAM MODULE
TEMPLATE and INSTRUCTIONS

PSA: _____

For the Period
January 1, 2013 - December 31, 2015

_____, 2012
(*Insert month*)

Table of Contents

P. I. INTRODUCTION to the PROGRAM MODULE TEMPLATE

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.

Steps for Creating Your Area Plan File

Read the entire document first, including the instructions located in Appendix 1. 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.

Enter your Planning and Service Area (PSA) 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 PSA needs to be put in the body of the document as well as in Appendices 2 and 3. The Appendices will contain instructions to complete the Program Module, Direct Service Waivers, and the Program Module Checklist.

After you have edited the file, you will need to update the Table of Contents.

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 and their caregivers and service providers. The plan also states the goals and objectives that the Area Agency on Aging (AAA) 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.

P. II. PROGRAM AND CONTRACT MODULE CERTIFICATION (For Instructions, click here)

Program and Contract 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	[ ] ARC/ADRC
[ ] OAA Title IIID	[ ] ADI	[ ] ALE Waiver	[ ] AoA Grant(s)
[ ] OAA Title IIIE	[ ] LSP	[ ] SHINE	(_____) Identify
[ ] 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 who 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.

[ ] Signatures below indicate that both the Program Module and the Contract Module have been reviewed.

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 2013-2015 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 for ensuring compliance with Older Americans Act Section 306.

P.III (A) 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 ADRC. This section should not be longer than three pages.)
(For instructions, click here)

Enter text here

P.III (B) MISSION AND VISION STATEMENT

The Mission Statement should define the purpose and primary objectives of the Area Agency on Aging. The Vision Statement should include a description of what the Area Agency on Aging would like to accomplish or achieve in the future. (For instructions, click here)

Enter text here

P.IV. NEEDS ASSESSMENT

This section defines the significant needs for services and how those needs will be addressed. (For instructions, click here)

P.IV (A) Profile

This section contains an overview of the social, economic, and demographic characteristics of the 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 instructions, click here)

A. Identification of Counties and/or Major Communities
(For instructions, click here)

Enter text here

B. Description of Service System
(For instructions, click here)

Enter text here

C. Economic and Social Resources
(For instructions, click here)

Enter text here

D. Role in Interagency Collaborative Efforts
(For instructions, click here)

Enter text here

E. Socio-Demographic and Economic Factors
(For instructions, click here)

Enter text here

P.IV (B) Unmet Needs/Gaps
This section defines the significant unmet needs for services and how the gaps in service will be addressed. (For instructions, click here)

A. Types of Information to Demonstrate Unmet Need

1. Home and Community-Based Services (HCBS)
   (a) Analysis of service implications of identified HCBS unmet needs.
   (For instructions, click here)

   Enter text here

2. Caregiver
   (a) Analysis of service implications of identified Caregiver unmet needs.
   (For instructions, click here)

   Enter text here

3. Access to Services
   (a) Analysis of service implications of identified Access to Services unmet needs.
   (For instructions, click here)

   Enter text here

4. Health Care
   (a) Analysis of service implication of identified Health Care unmet needs.
   (For instructions, click here)

   Enter text here

5. Communities

(a) Analysis of service implications of identified Communities unmet needs.
(For instructions, click here)

Enter text here

(b) Significant Differences Among Counties
Provide county level analysis for unmet needs/gaps in service.
(For instructions, click here)

Enter text here

P.V. TARGETING AND OUTREACH

The purpose of the targeting goal is for the AAA to demonstrate incremental improvements in reaching the targeted populations and to show how effective the targeting efforts were through the report of services provided to the specific population groups. 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)

A. Targeting Goals for 2013-15

The purpose of the targeting goals is for the AAA to demonstrate incremental improvements in reaching the targeted populations. (For instructions, click here)

Insert targeting plan with goals here

B. 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. (For instructions, click here)

Insert completed Targeting Table Here

C. 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)

Enter text here

P.VI. GOALS AND OBJECTIVES

The Department has aligned the Area Plan goals with the Administration on Aging's goals, which are indicated by this symbol: ▲. Additional goals and objectives particular to each AAA may be added. (For instructions, click here)

Explanations have also been added for each goal and objective. The explanation is being used to provide guidance in the creation of strategies/action steps. (For instructions, click here)

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.1: ▲ Provide streamlined access to health and long-term care options through the Aging and Disability Resource Centers

EXPLANATION: The primary intent of this objective is to address ways you link people to information and services. Strategies should address ways to improve connecting people to information and services through the ADRC. Examples include building new relationships and/or partnerships~~,~~ and the effective use of technology.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.2: ▲Encourage individuals, including people under 60, to plan for future long-term care needs by providing access to information

EXPLANATION: The primary intent of this objective is to get the message to people who are not yet 60 that planning for long-term care is needed. Strategies should address ways to increase public awareness of the costs of long-term care (LTC), the likelihood of the need for LTC services and the LTC options available. They should also dispel the myth that Medicare will meet all long-term care needs.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.3: Ensure that complete and accurate information about resources is available and accessible

EXPLANATION: The intention of this objective is to keep ReferNET current and to continue to enhance how people can connect to the information, such as through additional access points. Strategies should ensure that information in ReferNET is kept accurate and up-to-date. ReferNET should include services identified through the creation of new partnerships.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.4: Ensure that elders have access to free, unbiased, and comprehensive health insurance counseling

EXPLANATION: The primary intent of this objective is to show how the AAA is supporting the SHINE program. Ways to show the support might be through establishing additional counseling sites. Strategies may include activities that expand the SHINE program and access more consumers. Example: increase the number of SHINE service sites.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.5: Increase public awareness of existing mental and physical health and long-term care options

EXPLANATION: The primary intent of this objective to help people become aware that they might benefit from mental and physical health services and that the services are available in the community. Strategies for this objective should include how to inform the public of available long-term care services. Examples: using websites, publications, or mailings.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.6: Identify and serve target populations in need of information and referral services

EXPLANATION: The primary intent of this objective is for the AAA to detail how they plan to reach populations in need of information or referral services that might require more challenging outreach efforts. Strategies may include how to reach and serve individuals in need of I&R who have limited English proficiency, low-literacy, low-income in rural populations, disabled persons who receive Medicare but are under the age of 65, grandparents caring for grandchildren, individuals with disabilities, and dual eligibles across any Special Needs Population.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care

OBJECTIVE 1.7: Provide streamlined access to Medicaid Managed Care and address grievance issues

EXPLANATION: The primary intent of this objective is for the AAA to provide detail on the role the AAA will assume as Medicaid Managed Care is implemented in the PSA. Strategies may include actions that will be taken to provide consumers with access to Medicaid Managed Care information and enrollment services. Strategies to address grievance issues in relation to Medicaid Managed Care should also be included.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.1: Identify and serve target populations in need of home and community-based services

EXPLANATION: The primary intent of this objective is twofold: 1) to address how the AAA will identify the target populations in the PSA and 2) to address how the AAA will provide services to the targeted populations who may be in hard-to-reach areas. Strategies should include how the PSA will identify and serve individuals who are in need of HCBS with limited English proficiency, low-literacy, low-income in rural populations, disabled persons who receive Medicare but are under the age of 65, grandparents caring for grandchildren, people with developmental disabilities, and dual eligibles across any Special Needs Population. Best practice should also include the PSA serving clients according the to the Department's prioritization criteria.

STRATEGIES/ACTION STEPS:

OUTCOMES:

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 most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved*
- *Percent of new service recipients whose IADL assessment score has been maintained or improved*
- Percent of customers who are at imminent risk of nursing home placement who are served with community-based services
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- Percent of new service recipients with high-risk nutrition scores whose nutritional status improved

DOEA Internal Performance Measures:

- Percent of high-risk consumers (APS, Imminent Risk, and/or priority levels 4 and 5) out of all referrals who are served

OUTPUTS:

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.2: Ensure efforts are in place to fulfill unmet needs and serve as many clients as possible

EXPLANATION: The primary intent of this objective is to address how the AAA oversees the service delivery system in the PSA. Strategies to address unmet needs/gaps can include partnerships and collaborations with other entities which have expertise in meeting the identified needs/gap.

STRATEGIES/ACTION STEPS:

OUTCOMES:

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 most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved*
- *Percent of new service recipients whose IADL assessment score has been maintained or improved*
- Percent of customers who are at imminent risk of nursing home placement who are served with community based services
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- Percent of new service recipients with high-risk nutrition scores whose nutritional status improved

OUTPUTS:

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

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.3: Provide high quality services

EXPLANATION: The primary intent of this objective is for the AAA to detail quality assurance efforts in the PSA. Strategies can include evaluating service effectiveness using reliable and valid assessment instruments.

STRATEGIES/ACTION STEPS:

OUTCOMES:

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 most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved*
- *Percent of new service recipients whose IADL assessment score has been maintained or improved*
- Percent of customers who are at imminent risk of nursing home placement who are served with community-based services
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- Percent of new service recipients with high-risk nutrition scores whose nutritional status improved.

OUTPUTS:

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.4: Provide services, education, and referrals to meet specific needs of individuals with dementia

EXPLANATION: This objective focuses on individuals with dementia to ensure that the specific needs of these individuals are not overshadowed by serving populations without dementia. Strategies should include the implementation of caregiver programs that adopt or expand state and federal volunteer respite program models and innovative projects that address caregiver needs and reduce their stress. Strategies should also include effective partnerships with organizations and providers who have dementia expertise, training Information & Referral Specialists and other staff to recognize possible cognitive impairment and person-centered services planning.

STRATEGIES/ACTION STEPS:

OUTCOMES:

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 most frail elders who remain at home or in the community instead of going into a nursing home*
- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Percent of new service recipients whose ADL assessment score has been maintained or improved*
- *Percent of new service recipients whose IADL assessment score has been maintained or improved*
- Percent of customers who are at imminent risk of nursing home placement who are served with community based services
- *Percent of elders assessed with high or moderate risk environments who improved their environment score*
- Percent of new service recipients with high-risk nutrition scores whose nutritional status improved

OUTPUTS:

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.5: Improve caregiver supports

EXPLANATION: The primary intent of this objective is to strengthen caregiver services to meet individual needs as much as possible. For example, existing caregiver support groups may not sufficiently address the differing challenges of spouse caregivers compared to adult child caregivers. Strategies may include providing education, training, and options to help caregivers make better decisions and deal with current and prepare for possible future needs. Caregiver supports can include the following: home-delivered meals, older adult companionship, socialization, transportation, homemaking, home maintenance and repair, in-home care training, and daily calls to check on an isolated older adult. Consideration should also be given to volunteer companions (retired seniors helping seniors) and older caregivers providing care for grandchildren or other relatives.

STRATEGIES/ACTION STEPS:

OUTCOMES:

- 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%)

OUTPUTS:

GOAL 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers

OBJECTIVE 2.6: Facilitate the voluntary transition of identified nursing home residents to a safe community setting

EXPLANATION: The primary intent of this objective is for the AAA to detail how the PSA will accommodate clients who are transitioning out of nursing homes. Strategies can include individualized transition planning, overcoming barriers to the transition and support for a safe return to the community with services and available community support.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status

OBJECTIVE 3.1: ▲Continue to increase the use of Evidence-Based (EB) programs at the community level

EXPLANATION: The primary intent of this objective is for the AAA to detail how Evidenced-Based programs will be incorporated into the PSA. Strategies should include the management and coordination of programs that empower older people to control their own health through community level interventions, as well as sustaining continued funding. Consideration should be given to programs that build self confidence and reduce disease progression for people with chronic conditions. Examples include the advocacy for sustaining EB health promotion, including fall prevention, and Medication Management.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status

OBJECTIVE 3.2: Promote good nutrition and physical activity to maintain healthy lifestyles

EXPLANATION: The primary intent of this objective is to focus on nutrition and physical activity specifically, since they are two key components to maintaining health. Many elders are not aware of the long-term implications of a less than adequate diet and how it may exacerbate chronic health conditions. Likewise, they may be unaware of the positive impact physical activity might have on their overall health and/or chronic conditions. Strategies might include the establishment of: 1) a coordinated, comprehensive nutrition and physical activity program by engaging stakeholders and partners and 2) community programs that help build social supports, for example, by increasing the use of congregate meal sites. Another approach may be the encouragement of community programs that help build social support for physical activity by improving access to places that people can be active, such as walking or bike trails, classes at gyms or senior centers, athletic fields, etc.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status

OBJECTIVE 3.3: Promote the adoption of healthy behaviors

EXPLANATION: The primary intent of this objective is to focus on lifestyle choices beyond nutrition and physical activity as in objective 3.2. Lifestyle choices include such activities as smoking, alcohol, and/or drug consumption, average nightly hours of sleep, amount of stress, amount of socialization, engaging in enjoyable pursuits, etc. Strategies could include conducting community-wide campaigns that combine highly visible messages to the public, community events, and support groups that encourage older people to become or remain active. Recruit older adults to participate in the promotion of healthy behaviors through advertising and marketing to community partners.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status

OBJECTIVE 3.4: Promote social connectivity, community service, and lifelong learning to maintain positive mental health

EXPLANATION: The primary intent of this objective is to address the benefits to the individual and the community when elders are active and engaged in the community. Strategies could include ways to increase the use of congregate meal sites, develop comprehensive programs that include an intergenerational component, provide volunteer opportunities within aging network and external partners, and provide community service training opportunities that could lead to sustainable employment.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status

OBJECTIVE 3.5: Advocate for prevention and early intervention of mental health and substance abuse services for elders

EXPLANATION: The primary intent of this objective is to enable the AAA to focus on advocacy specific to the need for mental health and substance abuse services. Strategies for this objective could include public awareness activities to increase the understanding of mental and substance use disorders. Improve or develop partnerships with advocates in the community. Encourage group-based activities composed of older adults accessible to the participant like those at a senior center. Attention to physical health issues such as nutrition, sleep habits, medication, and pain should be considered.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation (ANE)

OBJECTIVE 4.1: Collaborate and coordinate within the community and aging network to increase accessible legal services

EXPLANATION: The primary intent of this objective is to enable the AAA to detail efforts to make legal services more accessible to seniors in greatest economic or social need, as well as to improve the quality of legal services. Strategies should include ongoing joint planning between the aging network and legal assistance providers to identify target groups, establish priority legal issue areas, and develop outreach mechanisms to ensure limited legal assistance resources are allocated in such a way as to reach those seniors who are most vulnerable and have the most critical legal needs.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

OBJECTIVE 4.2: ▲Facilitate the integration of Older Americans Act elder rights programs into Aging Services

EXPLANATION: The primary intent of this objective is to make legal services a more visible and mainstream part of the aging network package of services. Ensure capacity to assist vulnerable and at-risk older people in understanding their rights, exercising choices, and benefiting from services and opportunities authorized by law. Strategies may include in-person and/or online cross training and the use of available technology and media outlets to inform older adults, the general public, and professionals.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

OBJECTIVE 4.3: ▲Improve the identification and utilization of measurable consumer outcomes for elder rights programs

EXPLANATION: The primary intent of this objective is to enable the AAA to document efforts to ensure targeting of elder rights programs in the PSA and to demonstrate the value and impact of those services. Strategies should include participating in statewide efforts to develop a uniform statewide reporting system for legal services, as well as establishing mechanisms for utilizing data available to improve awareness of the importance of legal assistance, increase access to legal assistance, and address the quality of legal assistance provided.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

OBJECTIVE 4.4: Promote primary prevention of elder abuse, neglect, and exploitation

EXPLANATION: The primary intent of this objective is for the AAA to expand existing education/outreach/awareness efforts such as websites, newsletters, presentations, etc., to include prevention of abuse, neglect, and exploitation. Primary prevention focuses on preventing elder abuse, neglect, and exploitation from happening at all. Strategies should be developed to educate the public about the special needs of elders and about the risk factors for abuse in vulnerable adults.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

OBJECTIVE 4.5: Reduce the rate of abuse, neglect, and exploitation recidivism through education, outreach, and the provision of services.

EXPLANATION: The intent of this objective is to expand existing efforts supporting ANE interventions. Strategies to reduce the rate of recidivism should include education and outreach for caregivers and clients to help them with coping skills and services to alleviate caregiver stress and possible family strife. Establish and maintain collaborative relationships with other entities that endeavor to prevent elder abuse, neglect, and exploitation.

STRATEGIES/ACTION STEPS:

OUTCOMES:

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours

OUTPUTS:

GOAL 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

OBJECTIVE 4.6: Increase the awareness of health care fraud and other elder rights issues

EXPLANATION: The intent of this objective is for the AAA to use existing mechanisms to increase public awareness. Strategies can involve the use of websites, newspapers, other media outlets, etc.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 5: Promote planning and collaboration at the community level that recognize the benefits and needs of its aging population.

OBJECTIVE 5.1: Foster opportunities for elders to be an active part of the community

EXPLANATION: The intent of this objective is to collaborate with communities to identify opportunities for elders that benefit them and their community. Strategies can include methods of promoting volunteer services by and for older persons including the use of intergenerational activities that allow elders to "give back" while educating younger generations about the value elders bring.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 5: Promote planning and collaboration at the community level that recognize the benefits and needs of its aging population.

OBJECTIVE 5.2: Promote safe and affordable communities for elders that will benefit people of all ages

EXPLANATION: The intent of this objective is to encourage communities to incorporate elements of universal design into new construction and renovations of streets, sidewalks, and other common areas that will support an elder's ability to age in place. Strategies should include the development of comprehensive health and support service systems; provide input regarding land use and transportation planning; the expansion of educational, employment, cultural, and recreational resources; and the promotion of active, caring, and inclusive communities that respect autonomy, informed decision-making, and empowerment of older adults.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 6: Maintain effective and responsive management

OBJECTIVE 6.1: Promote and incorporate management practices that encourage greater efficiency

EXPLANATION: Best practice strategies may include internal monitoring, quality assurance, and performance-based standards and outcomes.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 6: Maintain effective and responsive management

OBJECTIVE 6.2: Effectively manage state and federal funds to ensure consumers' needs are met and funds are appropriately spent

EXPLANATION: The intent of this objective is for all state and federal funds to be spent, as well as to identify alternate resources for funding. In addition, the intent is for the funds to be spent on those populations for which the funds were intended.

STRATEGIES/ACTION STEPS:

OUTCOMES:

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.

- *Average monthly savings per consumer for home and community-based care versus nursing home care for comparable client groups*
- *Average time in the Community Care for the Elderly program for Medicaid Waiver probable customers*

DOEA Internal Performance Measures:

- Percent of co-pay goal achieved
- Percent of increase in providers participating in the Adult Care Food Program
- Percent of state and federal funds expended for consumer services (Standard: 100%)

OUTPUTS:

GOAL 6: Maintain effective and responsive management

OBJECTIVE 6.3: Ensure that providers continue to strengthen the disaster preparedness plans to address specific needs of elders

EXPLANATION: Strategies may include the development of formal agreements with local, state, and federal entities that provide disaster relief and recovery. Consideration should also be given to the planning and identification of consumer needs and the availability of special needs shelters in times of disaster.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 6: Maintain effective and responsive management

OBJECTIVE 6.4: Accurately maintain the Client Information and Registration Tracking System (CIRTS) data

EXPLANATION: The intent of this objective is to ensure that data is entered accurately in CIRTS and that data is updated in a timely manner as to reflect changes. Strategies may include comparisons of CIRTS data to information in client files to verify the accuracy of CIRTS data and the provision of training and ongoing technical assistance to ensure employees understand how to use CIRTS.

STRATEGIES/ACTION STEPS:

OUTCOMES:

OUTPUTS:

GOAL 6: Maintain effective and responsive management

OBJECTIVE 6.5: Promote volunteerism by and for older people when possible

EXPLANATION: The intent of this objective is twofold: 1) detail how incorporating volunteers might extend the AAA's capacity to provide services and 2) promote the benefit of elder volunteers to other entities who also provide services. Strategies may include the collection and use of "Best Practices" volunteer programs that enhance local services. Activities to recruit elders as volunteers should also be discussed.

STRATEGIES/ACTION STEPS:

OUTCOMES:

DOEA Internal Performance Measures:

- Develop strategies for the recruitment and retention of volunteers

OUTPUTS:

APPENDIX 1: INSTRUCTIONS

General instructions are included within each section.

PROGRAM MODULE and CONTRACT MODULE CERTIFICATION

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 to ensure compliance with the Older Americans Act Section 306. (Click here to return to template)

TABLE OF CONTENTS

Each page must be sequentially numbered and the location of each section must be listed in the Table of Contents. As the AAA inserts the relevant information, the correct pages should appear when the Table of Contents is updated. The Table of Contents can be updated by using the Reference Tab and following the instructions provided.

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 ADRC. (Click here to return to template)

MISSION AND VISION STATEMENT

This section includes the Mission and Vision of the agency. (Click here to return to template)

NEEDS ASSESSMENT

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. In the Needs Assessment, use questions that will elicit discussion for suggestions of services that may not currently be provided in addition to suggestions about how the current services are provided and quantity of services are provided. Use a variety of methods to evaluate the current system and the gaps in services. Partnerships with other entities to conduct the Needs Assessment may enhance the final report. (Click here to return to template)

PROFILE

This section contains an overview of the social, economic, and demographic characteristics of the Planning and Service Area as well as the conditions of older persons in the Planning and Service Area. (Click here to return to template)

A. Identification of Counties and/or Major Communities

Identify the counties and/or major communities within the Planning and Service Area. Use at least one map to visually display the Planning and Service Area in relation to the entire state and one map to identify rural areas of the Planning and Service Area. (Click here to return to template)

B. Description of Service System

Describe the services that are in place to meet the needs of elders and individuals with disabilitie, including AAA- funded services and other public and private sector services. This section should also include the number of people being served, the category of population, such as individuals with severe and persistent mental illness, physical or developmental disabilities and Alzheimer's disease, as well as the types of services and their frequency. Discuss how the supportive services funded by the Older Americans Act address the needs and conditions of elders in the PSA. This should be an overall snapshot of the PSA, including the number of registered services provided and the number of clients served in each county. (Click here to return to template)

C. Economic and Social Resources

Describe the economic and social resources available in the PSA. Include any partnerships, additional funding, in-kind resources, and resource development undertaken by the AAA that enhance the services and quality of life for people age 60 and older. Also describe the economic and social resources of the PSA as a whole, to provide context in which the services are being provided. For example, the PSA or areas within the PSA have attractions such as Disney, a university, a vibrant arts community, or other significant amenities. If the economic and social resources vary significantly across counties of the PSA, the differences should be included in the narrative. (Click here to return to template)

D. Role in Interagency Collaborative Efforts

Describe the AAA's role in coordinating and/or participating in interagency collaborative efforts, such as coordination with community mental health providers or disability organizations. Include a discussion regarding any special initiatives by the Department or the AAA that show evidence of particular effectiveness and that

result in program efficiencies, improved services, quality of life improvements, etc. (Click here to return to template)

E. Socio-Demographic and Economic Factors

Describe the socio-demographic and economic factors of the population in the Planning and Service Area. Include a discussion of the conditions and circumstances of older persons in the PSA by describing what life is like for them. Consider the overall quality of life of individuals, such as the addition or existence of recreational programs and other elements that enhance quality of life. (Click here to return to template)

Describe the population characteristics including the number of low-income minority elders, elders residing in rural areas and increases in the 85+ age group. Also indicate the location and concentration of the following characteristics within the PSA:

- elders with low incomes
- socially isolated elders
- minority and culturally diverse elders
- urban and rural areas

Use maps and charts to illustrate data provided.

UNMET NEEDS/GAPS

This section defines the significant unmet needs of elders and/or gaps in service to elders within the PSA. The analysis for each topic may be conducted at the county level if helpful. (Click here to return to template)

The needs assessment survey results provided a major source for many of the following data elements which are indicated below with an asterisk (*).

A. Types of Information to Demonstrate Unmet Need

1. Home and Community-Based Services (HCBS)
    - 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
    - Number of people 60+ who qualify for Food Stamps, but are not receiving them*
    - People on wait list not yet receiving any services
    - Existing clients needing additional services

Analysis of service implications of identified HCBS unmet needs. Incorporate a discussion of actions that have been pursued and what actions will be taken to address the need. Describe the expected outcome of all actions to be taken. (Click here to return to template)

2. Caregiver
    - Caregiver unmet needs*
    - Number of elder caregivers,* including the number of grandparents raising grandchildren
    - Condition of elder caregivers

    Analysis of service implications of identified Caregiver unmet needs. Incorporate a discussion of actions that have been pursued and what actions will be taken to address the need. Describe the expected outcome of all actions to be taken. (Click here to return to template)

3. Access to Services
    - Information about services*
    - Counties or communities with limited access to transportation
    - Counties or communities with limited access to significant supportive services
    - Counties or communities with limited access to social services agencies

    Analysis of service implications of identified unmet Access needs. Incorporate a discussion of actions that have been pursued and what actions will be taken to address the need. Describe the expected outcome of all actions to be taken. (Click here to return to template)

4. Health Care
    - Preventative health
    - Medical care needs*
    - Ancillary health care needs (such as hearing aids and eyeglasses)*
    - Availability of medical/health care, including mental health counseling*

    Analysis of service implications of identified unmet Health Care needs. Incorporate a discussion of actions that have been pursued and what actions will be taken to address the need. Describe the expected outcome of all actions to be taken. (Click here to return to template)

5. Communities
    - Transportation*
    - Elders with limited access to senior centers*
    - Elders with housing and safety needs*

- Elders who would like employment training or related assistance*
- Housing conditions and availability of affordable housing*

Analysis of service implications of identified unmet Community needs. Incorporate a discussion of actions that have been pursued and what actions will be taken to address the need. Describe the expected outcome of all actions to be taken. (Click here to return to template)

Significant Differences Among Counties
Provide county level analysis for unmet needs/gaps in service. If desired, this information may be displayed in a chart or other graphic, accompanied by some narrative. (Click here to return to template)

TARGETING AND OUTREACH INSTRUCTIONS

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. (Assist each county in establishing goals and determine the total planning and service area (PSA) projections through collaboration with each county.)

Targeting goals are documented in the "Goal" columns on the Targeting Plan. The goals are projected numbers of service recipients in the PSA to be provided registered services, (i.e., personal care, homemaker, chore, home delivered meals, adult day/healthcare, case management, escort; congregate meals; and Nutrition Services Incentive Program) during each year of the plan.

(Click here to return to template)

2013 - 2015 Targeting Plan (embedded Excel worksheet)								
Characteristic	**2012 PSA 60+ Population Count[(1)]**	**%**	**Goal: # of Service* Recipients in PSA[(2)] to serve in 2013**	**%**	**Goal: # of Service* Recipients in PSA[(2)] to serve in 2014**	**%**	**Goal: # of Service* Recipients in PSA[(2)] to serve in 2015**	**%**
All 60+	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Below Poverty Level	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Living Alone	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Minority	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Minority Below Poverty Level (low-income minority)	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Rural areas	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*
Low-Income Minority Older Individuals with Limited English Proficiency	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	*#DIV/0!*

* Registered Services include personal care, homemaker, chore, home delivered meals, Nutrition Services Incentive Program (NSIP), adult day/health care, case management, escort, and congregate meals.

Data Sources:

(1) The PSA 60+ population count data source is the 2013 County Profiles (projected). Cite in the Area Plan the date the data was extracted from the County Profiles.

(2) The projection for the PSA registered services recipients count is based on data from CIRTS and reported the NAPIS report in the year prior to the plans completion.

Targeting Plan Summary -- The purpose of the targeting plan summary is to document the AAA's and providers' planned activities to address the identified service needs of targeted populations, such as identifying ZIP codes with targeted populations. The targeting plan summary includes a narrative section to address outreach. The outreach section of the targeting plan summary will consists of the Area Agency's planned outreach activities for the PSA. In developing the outreach section the AAA must collaborate with each county to summarize the types of community events/activities, dates and locations, and numbers of anticipated participants. The targeting plan will discuss the AAA's methods for ensuring the provision of outreach and education to populations most in need of services and for directing services to:

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.

Outreach is an access service and is a required service or function in Title IIIB and Title IIIC. Outreach is defined as a face-to-face, one-to-one intervention with clients initiated by the agency for the purpose of identifying potential clients or caregivers and encouraging their use of existing and available resources.

Education/Training is defined as:

1. Speaking to groups or distributing materials to individuals at public gatherings about services and opportunities available to them within their communities;
2. Providing formal or informal opportunities for individuals or groups to acquire knowledge, experience or skills; to increase awareness in such areas as crime or accident prevention; promoting personal enrichment; and to increase or gain skills in a specific craft, trade, job or occupation.
3. Training individuals or groups in guardianship proceedings of older individuals if other adequate representation is unavailable can also be done; and
4. Training conducted by memory disorder clinics funded under the Alzheimer's Disease Initiative designed to increase understanding of the disease and facilitate management of persons with Alzheimer's disease by their caregivers and health professionals

The targeting plan summary update is submitted annually when the area plan is updated. The summary update consists of the AAA's and providers' progress in addressing the identified service needs of targeted populations, i.e., barriers or obstacles to reaching targeted individuals in identified ZIP codes, and achievement of targeting goals. The outreach section of the targeting plan summary update includes discussion of the AAA's participation in community events and status of oversight of the providers' activities. Oversight includes the AAA's monitoring and tracking of providers' outreach efforts. The AAA will require providers to submit status reports at least semi-annually in a uniform format for the PSA, that include type of community events or activities; dates and locations of event; numbers of participants; identified services needed; and information or referrals provided. (Click here to return to template)

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. The targeting report is submitted annually when the area plan is updated. The report consists of the following information (provided initially in the Targeting plan):

1) Characteristics and targeted populations - all individuals in the PSA age 60+; older individuals below poverty level (low income/greatest economic need); older individuals living alone (greatest social need); older minority individuals; older minority individuals below poverty level (low income); older individuals in residing rural areas; older individuals with limited English proficiency;
2) PSA 60+ Population Count which indicates the number of older individuals in the PSA and the number of older individuals in each targeted population category;
3) Percent to all 60+ which indicates the percent of older individuals in each targeted population category to the number in each targeted population category;
4) Number of Registered Service Recipients in the PSA which indicates the number or older individuals in each targeted population category that received

a registered service;

5) Percent to all 60+ which indicates the percent of older individuals in each targeted population category to the number in each targeted population category that received a registered service; and
6) 6) Goals for 2013 indicates the number of projected older individuals to be served based upon identified service needs; Percent of Goal Met indicates the percent of projected older individuals served to the goal established.

(Click here to return to template)

Include a report on the extent to which the targeting goals established for 2011 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.

2011 Targeting Report						
Characteristic	**PSA 60+ Population Count(1)**	**%**	**Number of Registered* Service Recipients in PSA(2)**	**%**	**Goals for 2010**	**% of Goal Met**
All 60+	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Below Poverty Level	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Living Alone	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Minority	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Minority Below Poverty Level (low-income minority)	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Rural areas	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!
Low-Income Minority Older Individuals with Limited English Proficiency	*0*	*#DIV/0!*	*0*	*#DIV/0!*	*0*	#DIV/0!

*Registered Services include personal care, homemaker, chore, home delivered meals, Nutrition Services Incentive Program (NSIP), adult day/health care, case management, escort, and congregate meals.

Data Sources:
(1) The PSA 60+ population count data source is the 2011 County Profiles.
(2) The PSA registered services recipients count is provided by the Department from the NAPIS report data.

GOALS AND OBJECTIVES

The six goals and their objectives have been listed in a table format. Additional goals and objectives particular to your AAA may be added. The Department has spent a considerable amount of time in thoughtful discussions and the decision was made to align the goals with the Administration on Aging's (AoA) goals (they are indicated by this symbol -▲). (Click here to return to template)

A. Goals, Objectives and Performance Measures

The Goals, Objectives, Strategies/Action Steps, and Performance Measures are included in table format in the template. A table is included for every objective with the goal and objective already filled in. If the objective has associated performance measures, they are listed in the outcomes and outputs sections at the bottom of the form.

B. Explanations

The explanations are intended to be used as guidance and to assist AAAs in the creation of strategies/action steps.

C. Strategies/action steps

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. Complete Strategies/Action Steps sections for each table.

D. Outcomes/Outputs

Department performance-based program budgeting and Department-specified performance measures are included with relevant objectives. 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.

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:

- *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
- Percent of state and federal funds expended for consumer services (Standard: 100%)
- Develop strategies for the recruitment and retention of volunteers

APPENDIX 2: DIRECT SERVICE WAIVER REQUESTS

Instructions for Completing the Form

Direct Service Waiver (DSW): A direct service waiver allows the Area Agency on Aging to provide a service directly to clients without having to subcontract the services.

Section I:

The Area Agency on Aging (AAA) must select the basis for which the waiver is being requested. In accordance with Section 307(a)(8) of the Older Americans Act, 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 conditions listed below:

(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 and/or 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).

Section II:

The detailed justification should include the following elements, if applicable.

If (i) is checked in Section 1, demonstrate that there is an inadequate supply. For example, current provider is not able to serve all counties, all types of clients, provide needed services, etc.

If (ii) is checked in Section 1, show how the service is considered part of the administrative activity and the rationale for categorizing it as such. Note: There are no administrative costs in III-D.

If (iii) is checked in Section 1, include such factors as a cost analysis or needs assessment and/or 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).

Note: Applying for a Direct Service Waiver does not mean that the AAA has to cover the entire Planning and Service Area as long as there are providers to cover those areas.

The AAA can apply for a Direct Service Waiver even though there is another provider delivering the same service as long as there is justification for having the service being delivered by another organization.

Section III:

As part of its area plan development, the AAA must include in its public hearing(s) a discussion of each service that the AAA proposes to provide directly. The hearing notice must list each service for which a waiver will be requested and a copy of the notice must be included in the Area Plan documentation.

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 with the Direct Service Waiver Request Form:

a) a copy of the public hearing notice;
b) identification of when and where the public hearing was held;
c) information on the sources used to advertise the public hearing;
d) a description of the number and types of participants (number of private citizens, number of service provider representatives, number of public officials, etc.); and,
e) a summary of the public comments specific to the services proposed for direct service provision.

Note: An actual participant list must be kept in the administrative files and be available for review by the Department upon request.

A completed Direct Service Waiver Request Form must be included in the Area Plan program module for each 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.

Since the Direct Service Waiver Request Form is to be included with the Area Plan submission, approval of the Area Plan indicates approval of the waiver request.

The AAA must include in CIRTS contract budget information about each service the AAA plans to provide directly.

DIRECT SERVICE WAIVER REQUEST FORM #__

Insert completed forms for each direct service waiver request. 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.

OAA Title: [ ] III-B [ ] III-C1 [ ] III-C2 [ ] III-D1 [ ] III-D2 [ ] 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.

Enter text here

III. Provide documentation of the public hearing held to gather public input on the proposal to directly provide service(s).

Enter text here

APPENDIX 3: 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.

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.				
P. I. INTRODUCTION to the PROGRAM MODULE TEMPLATE				
Overview				
Describe the specific services to be provided.				
P. II. PROGRAM AND CONTRACT MODULE CERTIFICATION				
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.				
P.III (a) Executive Summary				
This section describes major highlights.				
This section is limited to three pages or fewer.				
P.III (b) Mission and Vision Statement				
This section includes the mission and vision of the agency.				
P.IV. Needs Assessment				
Section P.IV (a) Profile				
A. Identification of Counties and/or Major Communities				
This section identifies the counties and/or major communities within the PSA. Include at least one map to visually display the PSA.				

Program Module	YES	NO	N/A	PAGE
B. Description of Service System				
This section describes the current services that are in place to meet the needs of elders. Includes private and public funding sources.				
C. Economic and Social Resources				
This section describes the economic and social resources available to elders in the PSA.				
D. Role in Interagency Collaborative Efforts				
This section describes collaborative efforts, partnerships, special initiatives by the PSA and/or DOEA.				
E. Socio-Demographic and Economic Factors				
This section includes a description of the social and economic climate in the PSA, including how this impacts elders.				
Highlight the following characteristics:				
1. Elders with low incomes				
2. Socially isolated elders				
3. Minority and culturally diverse elders				
4. Urban and rural areas				
Include the use of maps and charts to illustrate data provided				
P.IV (b) Unmet Needs/Gaps				
A. Types of Information to Demonstrate Unmet Needs				
1. Home and Community-Based Services (HCBS)				
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				
Number of people 60+ who qualify for Food Stamps, but are not receiving them				

Program Module	YES	NO	N/A	PAGE
People on wait list not yet receiving any services				
Existing clients needing additional services				
Analysis of Service implications of identified HCBS unmet needs.				
2. Caregiver				
Caregiver unmet needs				
Number of elder caregivers, including number of grandparents raising grandchildren				
Condition of elder caregivers				
Analysis of Service implications of identified caregiver unmet needs				
3. Access to Services				
Information about services				
Counties or communities with limited access to transportation				
Counties or communities with limited access to significant supportive services				
Counties or communities with limited access to social services agencies				
Analysis of Service implications of identified unmet access needs				
4. Health Care				

Program Module	YES	NO	N/A	PAGE
Preventative health				
Medical care needs				
Ancillary health care needs (hearing aids and eyeglasses)				
Availability of medical/health care, including mental health counseling				
Analysis of Service implications of identified unmet health care needs				
5. Communities				
Transportation				
Limited access to senior centers				
Housing and safety needs				
Employment training or related assistance				
Housing conditions and availability of affordable housing				
Analysis of Service implications of identified unmet community needs				
B. Significant differences among counties				
Include a county level analysis for unmet needs/gaps in service. Use charts and graphics with narrative if desired.				
P.V. Targeting and Outreach				
A. 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.				
B. 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.				
Used table provided, properly completing the cells of the table.				

Program Module	YES	NO	N/A	PAGE
C. Targeting Plan Summary				
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				
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				
P.VI. Goals and Objectives				
Goal 1: Empower older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health and long-term care				
Objective 1.1. ▲ Provide streamlined access to health and long-term care options through Aging and Disability Resource Centers				
Objective 1.2. ▲ Encourage individuals, including people under 60, to plan for future long-term care needs by providing access to information				
Objective 1.3. Ensure that complete and accurate information about resources is available and accessible				

Program Module	YES	NO	N/A	PAGE
Objective 1.4. Ensure that elders have access to free, unbiased, and comprehensive health insurance counseling				
Objective 1.5. Increase public awareness of existing mental and physical health and long-term care options				
Objective 1.6. Identify and serve target populations in need of information and referral services				
Objective 1.7. Provide streamlined access to Medicaid Managed Care and address grievance issues				
Goal 2: Enable individuals to maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers				
Objective 2.1 Identify and serve target populations in need of home and community-based services				
Objective 2.2. Ensure efforts are in place to fulfill unmet needs and serve as many clients as possible				
Objective 2.3. Provide high quality services				
Objective 2.4. Provide services, education, and referrals to meet specific needs of individuals with dementia				
Objective 2.5. Improve caregiver supports				
Objective 2.6 Facilitate the voluntary transition of identified nursing home residents to a safe community setting				
Goal 3: Empower older people and their caregivers to live active, healthy lives to improve their mental and physical health status				
Objective 3.1. ▲Continue to increase the use of Evidence-Based (EB) programs at the community level				
Objective 3.2. Promote good nutrition and physical activity to maintain healthy lifestyles				
Objective 3.3. Promote the adoption of healthy behaviors				
Objective 3.4. Promote social connectivity, community service, and lifelong learning to maintain positive mental health				
Objective 3.5. Advocate for prevention and early intervention of mental health and substance abuse services for elders				
Goal 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation				
Objective 4.1. Collaborate and coordinate within the community and aging network to increase accessible legal services				
Objective 4.2. ▲ Facilitate the integration of Older Americans Act elder rights programs into Aging Services				
Objective 4.3. ▲ Improve the identification and utilization of measurable consumer outcomes for elder rights programs				
Objective 4.4. Promote primary prevention of elder abuse, neglect, and exploitation				

Program Module	YES	NO	N/A	PAGE
Objective 4.5. Reduce the rate of abuse, neglect, and exploitation recidivism through education, outreach, and the provision of services				
Objective 4.6. Increase the awareness of health care fraud and other elder rights issues				
Goal 5: Promote planning and collaboration at the community level that recognize the benefits and needs of its aging population				
Objective 5.1. Foster opportunities for elders to be an active part of the community				
Objective 5.2. Promote safe and affordable communities for elders that will benefit people of all ages				
Goal 6: Maintain effective and responsive management				
Objective 6.1. Promote and incorporate management practices that encourage greater efficiency				
Objective 6.2. Ensure federal and state funds are used to effectively and efficiently serve elders' needs				
Objective 6.3. Ensure that providers continue to strengthen the disaster preparedness plans to address specific needs of elders				
Objective 6.4. Accurately maintain the Client Information and Registration Tracking System (CIRTS) data				
Objective 6.5. Promote volunteerism by and for older people whenever possible				

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

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Appendix 3. Program Module Review Checklist:

Other changes: Identify section and provide comments or recommendations.