Department of
ELDER AFFAIRS
STATE OF FLORIDA

Ron DeSantis
Governor

Richard Prudom
Secretary

2021 Area Plan Program Module Update

TEMPLATE AND INSTRUCTION

<ORGANIZATION NAME>

PSA: ____

For the Period January 1, 2020 - December 31, 2022

Submitted <Insert Month>, 2020

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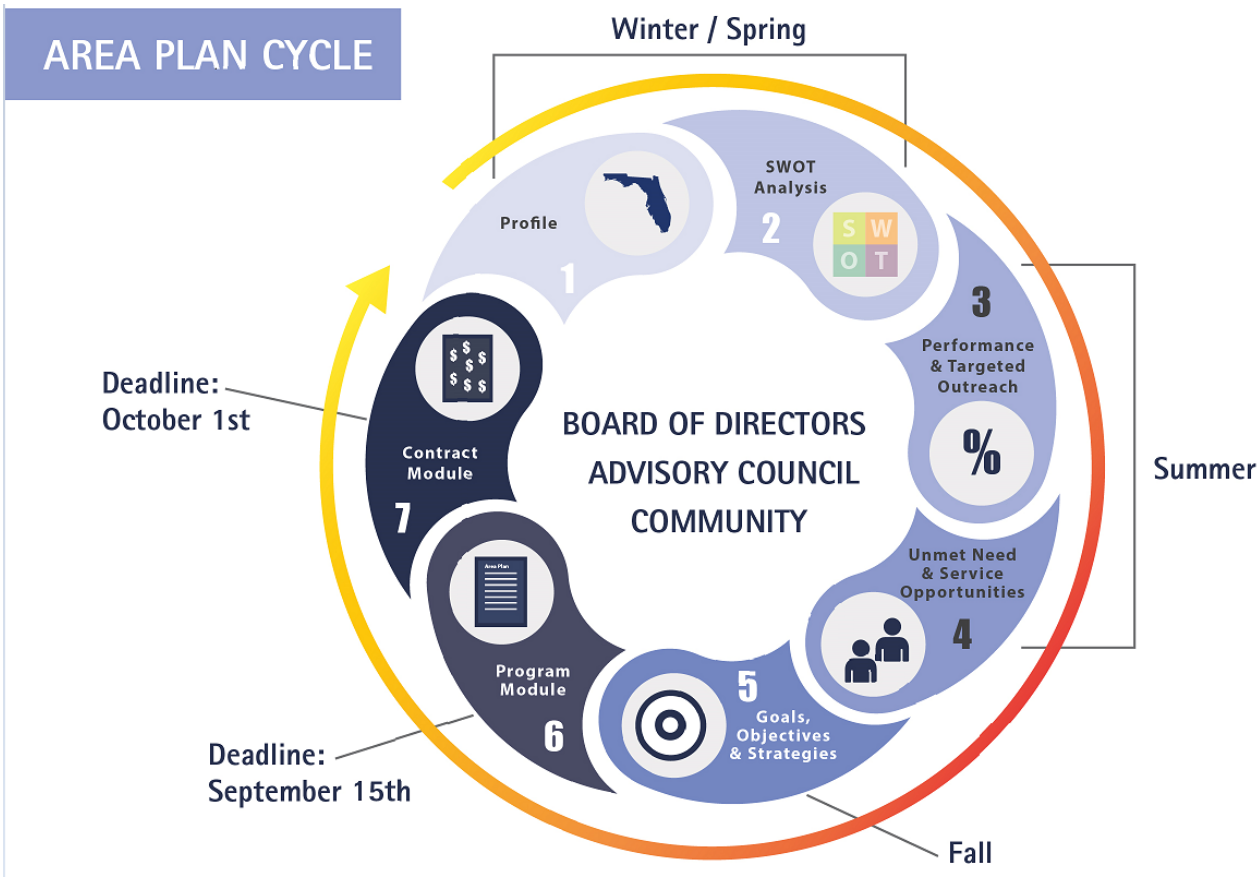
Introduction to the Area Plan

The Area Plan describes in detail the specific services to be provided to the population of older adults residing in a given Planning and Service Area (PSA). The plan is developed from an assessment of the needs of the PSA as determined by public input that involves public hearings, the solicited participation 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 profile of the PSA; a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis; an analysis of performance and unmet needs; the service plan including goals, objectives, and strategies; assurances; and other elements relating to the provision of services.

The Contract Module includes the elements of the plan relating to funding sources and allocations, as well as other administrative/contractual requirements, and otherwise substantiates the means through which planned activities will be accomplished.

In planning for the production of the Area Plan, AAAs should consider the following Area Plan development cycle.



This recommended planning cycle features the development of the PSA Profile, followed by the completion of the comprehensive SWOT analysis during the winter and spring of the Area Plan submission year. The summer should feature the development of the Performance and Targeted Outreach and Unmet Need and Services opportunities components of the Area Plan. With the completion of these components, the AAA will be prepared to address the Goals, Objectives, and Strategies component of the Area Plan.

With the completion of each stage in development of the Area Plan, the AAA is required to submit the respective components to Department of Elder Affairs (DOEA) through their contract manager for review and feedback.

In the spring of each year, the Department of Elder Affairs will publish a Notice of Instruction (NOI). This NOI will include the Area Plan Program Module Template, Area Plan Contract Module Template, indicator comparative performance file, and a table of due dates for submission of the Area Plan Cycle components.

Instructions

Before beginning Area Plan Program Module development activities, it is important that you complete a thorough review of the instructions for completion found in Appendix 5.

Program and Contract Module Certification

AREA AGENCY ON AGING (AAA) INFORMATION:

Legal Name of Agency: _____

Mailing Address: _____

Telephone: ( ) ___-____ FEDERAL ID NUMBER: _____

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

I hereby certify that the attached documents:

☐ Reflect input from a cross section of service providers, consumers, and caregivers who are representative of all areas and culturally diverse populations of the Planning and Service Area (PSA).

☐ Incorporate the comments and recommendations of the Area Agency's Advisory Council.

☐ Have been reviewed and approved by the Board of Directors of the Area Agency on Aging.

Additionally:

☐ Signatures below indicate that both the Program Module and the Contract Module have been reviewed and approved by the respective governing bodies.

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 this 2020-2022 Area Plan.

President, Board of Directors

Name:_____ Signature:_____

Date: _____

Advisory Council Chair

Name:_____ Signature:_____

Date: _____

Area Agency on Aging Executive Director

Name:_____ Signature:_____

Date: _____

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

AAA Board of Directors

Membership Composition:

<Enter Text Here>

Frequency of Meetings:

<Enter Text Here>

Officer Selection Schedule:

<Enter Text Here>

AAA Board Officers:

Title	Name	Term
Chair		<mm/yy> <mm/yy>
Vice Chair		
Treasurer		
Secretary		
Immediate Past Chair		
Other: (Title_____)		
Other: (Title_____)		

AAA Board of Directors Membership:

Name	Occupation / Affiliation	Home Address (include county)	Phone Number	Member Since	Current Term of Office
				<mm/yy>	<mm/yy> <mm/yy>

AAA Advisory Council

Council Composition:

<Enter Text Here>

Frequency of Meetings:

<Enter Text Here>

Member Selection Schedule:

<Enter Text Here>

Service Term(s):

<Enter Text Here>

AAA Advisory Council Members:

Name	Occupation / Affiliation	Home Address (include county)	Phone Number	Member Since	Current Term of Office	Age	Race	Eth.
				<mm/yy>	<mm/yy> <mm/yy>			

Funds Administered and Bid Cycles

The following funds are administered by <ORGANIZATION NAME> for PSA <INSERT NUM>. The current and anticipated Bid Cycles are provided for those programs that are administered through competitively procured subcontracts.

Funds Administered			Current Bid Cycle		Anticipated Bid Cycle	
			Published	Current Year of Cycle	Ant. Pub.	Ant. Award
Older Americans Act (OAA)	III B	☐	<mm/yy>	<y>	<mm/yy>	<mm/yy>
	III C.I	☐				
	III C.II	☐				
	III D	☐				
	III E	☐				
	Families First Act*	☐				
	CARES Act*	☐				
	VII*	☐				
General Revenue	ADI	☐				
	CCE	☐				
	HCE	☐				
Other	ADRC*	☐				
	ADRC CARES Act*					
	AoA Grants	☐				
	EHEAP*	☐				
	EHEAP CARES Act*	☐				
	LSP*	☐				
	NSIP*	☐				
	RELIEF*	☐				
	SHINE*	☐				
	USDA*	☐				

* This fund does not have an associated Bid Cycle.

Resources Used

- ☐ American Community Survey
- ☐ American FactFinder
- ☐ AoA Special Tabulation Data 60+
- ☐ BRFSS Survey Data
- ☐ Bureau of Economic and Business Research (BEBR)
- ☐ CIRTS
- ☐ Economic and Demographic Research (EDR)
- ☐ DOH Florida Charts
- ☐ DOEA Client Satisfaction Survey
- ☐ DOEA County Profiles, WOW Index
- ☐ DOEA Elder Needs Index Maps
- ☐ NAPIS
- ☐ Targeting Data and Dashboard
- ☐ Targeting Performance Maps
- ☐ National Association of States United for Aging and Disability (NASUAD)
- ☐ Assessing the Needs of Elder Floridians 2016
- ☐ Other (_____)
- ☐ Other (_____)

2021 Area Plan Program Module Update

Executive Summary

This section describes the role of <ORGANIZATION NAME> as a AAA and includes major highlights, key initiatives, and how the significant and particular needs of the PSA will be addressed.

<Enter Text Here>

Mission and Vision Statements

The Mission Statement defines the purpose and primary objectives of the AAA. The Vision Statement describes what the AAA intends to accomplish or achieve in the future.

Mission:

<Enter Text Here>

Vision:

<Enter Text Here>

Profile

This section provides an overview of the social, economic, and demographic characteristics of the PSA. The focus of this overview includes consideration of those geographic areas and population groups within the PSA of low-income older individuals, including low-income minority elders, as well as elders with limited English proficiency and those residing in rural areas.

Identification of Counties:

<Enter Text Here>

Identification of Communities:

<Enter Text Here>

Socio-Demographic and Economic Factors:

<Enter Text Here>

Economic and Social Resources:

<Enter Text Here>

Description of Service System:

<Enter Text Here>

Role in Interagency Collaborative Efforts:

<Enter Text Here>

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

SWOT Development Process Description:

<Enter Text Here>

Strengths:

<Enter Text Here>

Weaknesses:

<Enter Text Here>

Opportunities:

<Enter Text Here>

Threats:

<Enter Text Here>

Performance and Targeted Outreach

This section demonstrates the effectiveness of the AAA's efforts at the county level in reaching a comparable proportion of the specified sub-populations of seniors based on the prior year's performance and details the strategic plan that the AAA will employ conducting outreach to the targeted populations in the coming planning period. This section identifies specific location details for planned outreach to sub-populations in which performance was below standard in the previous year, including when and where activities and events will take place, information on target audiences, goals for number of older individuals and caregivers reached, and plans for how these outreach efforts will reach the targeted sub-populations

Performance Analysis:

<Enter Text Here>

Targeted Outreach Plan:

In developing the Targeted Outreach Plan, and pursuant to the Older Americans Act reauthorization of 2016 (OAA), this plan details at the county and PSA levels:

- The AAA's proposed methods for providing preference to older individuals with greatest economic need, older individuals with greatest social need, and low-income minority older individuals;
- Specific approaches to serve older individuals residing in rural areas;
- Specific approaches to improve access to services for groups that have limited English proficiency (LEP);
- Specific approaches to reach older individuals with disabilities, with particular attention to individuals with severe disabilities and individuals at risk for institutional placement;
- Specific approaches to identify and assist other significant unserved and underserved populations; and
- Methods the AAA will use to evaluate the effectiveness of any resources that will be used to meet the needs of the above consumer groups.

<Enter Text Here>

Unmet Needs and Service Opportunities

This section defines the significant unmet needs for services and how the AAA will address gaps in service.

Access to Services:

<Enter Text Here>

Caregiver:

<Enter Text Here>

Communities:

<Enter Text Here>

Health Care:

<Enter Text Here>

Home and Community-Based Services (HCBS):

<Enter Text Here>

Goals and Objectives

The Department has aligned the Area Plan goals and objectives with those of the Administration on Aging, which are indicated by this symbol: ▲. Additional goals and objectives particular to each AAA may be added.

GOAL 1: Empower seniors, 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 (ADRCs) **EXPLANATION**: The primary intent of this objective is to address ways you link people to information and services.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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 (LTC) is needed.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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

EXPLANATION: The primary intent of this objective is 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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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 it plans to reach populations in need of information and referral (I&R) services that might require more challenging outreach efforts.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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 details on the ADRC's provision of Statewide Medicaid Managed Care Long-term Program information, waitlist, eligibility, and grievance resolution services.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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 (HCBS)

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

DOEA Internal Performance Measures:

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

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

OUTPUTS:

<Enter Text Here>

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

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours
- Percent of new service recipients whose Activities of Daily Living (ADL) assessment score has been maintained or improved
- Percent of new service recipients whose Instrumental Activities of Daily Living (IADL) assessment score has been maintained or improved
- Percent of elders assessed with high or moderate risk environments who improved their environment score

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 customers who are at imminent risk of nursing home placement who are served with community-based services*
- *Percent of new service recipients with high-risk nutrition scores whose nutritional status improved*

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

DOEA Internal Performance Measures:

- *Percent of customers who are at imminent risk of nursing home placement who are served with community-based services*
- *After service intervention, the percentage of caregivers who self-report being very confident about their ability to continue to provide care*

OUTPUTS:

<Enter Text Here>

GOAL 3: Empower seniors 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/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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

EXPLANATION: The primary intent of this objective is to focus specifically on nutrition and physical activity, 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 effect physical activity might have on their overall health and/or chronic conditions.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 3.4: 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. Strategy examples can include the plan for the AAA to work with the Department to ensure that individuals who have been identified at-risk due to emotional or psychological distress receive the appropriate referral, and/or how the AAA tracks and confirms that an appropriate action is taken on behalf of each client in distress and the status update that is provided to the contract manager at the Department on a quarterly basis.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

GOAL 4: Ensure the legal rights of seniors 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 **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/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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

EXPLANATION: The intent of this objective is to expand existing efforts supporting ANE interventions.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

DOEA Internal Performance Measures:

- 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:

<Enter Text Here>

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/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

GOAL 5: Participate in community efforts to ensure your PSA is addressing the state's mission to create livable communities by promoting this work through the eight domains of livability framework. Support the work DOEA is doing in collaboration with AARP and the World Health Organization's (WHO) Age-Friendly Cities and Communities Program.

OBJECTIVE 5.1: ▲Community Support and Health System: Coordinate with community partners for increased access to affordable, person-centered health care and social services to promote active and independent living. **EXPLANATION:** The primary intent of this objective is to establish a working relationship with the local county health departments to promote planning and development of the age-friendly public health system.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

OBJECTIVE 5.2: ▲ **Housing: Promote safe, accessible, and affordable housing that supports aging in place.**

EXPLANATION: The primary intent of this objective is to work together with community partners to ensure a wide range of housing options are available for residents, and the community has access to home modification programs.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 5.3: ▲ **Transportation: Increase awareness of and promote safe and reliable transportation options to increase mobility and community participation.**

EXPLANATION: The primary intent of this objective is to make sure your community offers alternative transportation options that allows members to still have access to health care, shopping, social engagement programs, civic participation, employment, and services.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 5.4: ▲ **Communication and Information: Increase access to information through various methods including print, tv, and digital media.**

EXPLANATION: The primary intent of this objective is to ensure multiple means of communication are being used within a PSA to link people to information, services, and resources. These efforts need to take into consideration persons with disabilities.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 5.5: ▲ **Respect and Social Inclusion: Promote, engage, and celebrate the valuable contributions of all adults in the community.** **EXPLANATION:** The primary intent of this objective is to promote intergenerational programs through the PSA.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

OBJECTIVE 5.6: ▲ Civic Participation and Employment: Increase awareness of opportunities to contribute in the workplace and volunteer to make a difference in the community. **EXPLANATION:** The primary intent of this objective is to promote the Senior Community Service Employment Program (SCSEP), community service, and volunteer opportunities.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

OBJECTIVE 5.7: ▲ Social Participation: Increase awareness of and promote easy access to social and cultural activities for increased quality of life. **EXPLANATION:** The primary intent of this objective is to work collaboratively with the local senior centers and other organizations to prevent social isolation and increase engagement through evidence-based programs.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

OBJECTIVE 5.8: ▲ Outdoor Spaces and Buildings: Work with community partners to ensure accessible, inviting, and safe outdoor spaces and buildings that encourage active participation and recreation. **EXPLANATION:** The primary intent of this objective is to work collaboratively with local partners to ensure safe, accessible outdoor spaces.
STRATEGIES/ACTION STEPS: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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: <Enter Text Here>
OUTCOMES: <Enter Text Here>
OUTPUTS: <Enter Text Here>

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 appropriately 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:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

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 state and federal funds expended for consumer services

OUTPUTS:

<Enter Text Here>

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, the availability of special needs shelters in times of disaster, and educating clients on the importance of pre-registering for special needs shelters. Examples of actions may include the dissemination of evacuation zone rosters and maps to staff and partners, to ensure client locations are known for preparation and relief efforts.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

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. Examples of quality assurance actions may also include the AAA working to ensure that addresses for active clients were entered by staff and partners into CIRTS accurately and in the most effective format or to make corrections if a client location cannot be identified, to ensure that individuals' home addresses have the highest likelihood of being properly located and mapped by the Department to identify their assigned evacuation zone.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 6.5: **Promote volunteerism by and for seniors when possible**

EXPLANATION: The intent of this objective is to detail how incorporating volunteers might extend the AAA's capacity to provide services.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

DOEA Internal Performance Measures:

- Develop strategies for the recruitment and retention of volunteers

OUTPUTS:

<Enter Text Here>

Goal 7: Co-establish and participate in at least one Dementia Care and Cure Initiative (DCCI) Task Force in your Planning and Service Area (PSA).

OBJECTIVE 7.1: ▲ Coordinate with the Memory Disorder Clinic (MDC) and local community leaders in Alzheimer's disease and related dementias (ADRD) in your area to create a DCCI Task Force.

EXPLANATION: The primary intent of this objective is to form a Task Force to increase awareness of dementia and services and support for those living with dementia, along with their families and care partners, through public and private partnerships. The Task Force shall accomplish this through strategic planning and implementation of outreach and educational programs, partnerships with community leaders, and action-oriented plans.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 7.2: ▲ Collaborate with Task Force members to designate community entities as Dementia-Caring.

EXPLANATION: The primary intent of this objective is to provide free dementia sensitivity trainings to government and public service agencies, community entities, caregivers and families, first responders, health care professionals, businesses, and community organizations with dementia sensitivity trainings that will allow recipients to receive the designation of being Dementia-Caring.

STRATEGIES/ACTION STEPS: **<Enter Text Here>**
OUTCOMES: **<Enter Text Here>**
OUTPUTS: **<Enter Text Here>**

OBJECTIVE 7.3: ▲ Promote DCCI education and outreach activities throughout your PSA.

EXPLANATION: The primary intent of this objective is to spread awareness and sensitivity about dementia throughout your PSA to encourage safe and inclusive communities for all who seek to continue to be engaged throughout their lifetime, and by linking those living with dementia, their families, and care partners to local resources.

STRATEGIES/ACTION STEPS:

<Enter Text Here>

OUTCOMES:

<Enter Text Here>

OUTPUTS:

<Enter Text Here>

OBJECTIVE 7.4: ▲ Identify areas of need within the ADRD community throughout your PSA. **EXPLANATION:** The primary intent of this objective is to advocate for those living with dementia and recognize ways the Task Force can get involved in the community.
STRATEGIES/ACTION STEPS: **<Enter Text Here>**
OUTCOMES: **<Enter Text Here>**
OUTPUTS: **<Enter Text Here>**

Appendix 1: Direct Service Waiver Requests

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 D ☐ III E

Service: <Enter Service Description>

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 2: Assurances

Section 306 Older Americans Act

<INSERT ORGANIZATION NAME> assures the following:

1. The AAA assures that an adequate proportion, as required under section 307(a)(2) of the OAA and ODA Policy 205.00, Priority Services, of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services: services associated with access to services (transportation, outreach, information and assistance and case management services), in-home services, and legal assistance. (§306(a)(2))

2. The AAA assures it will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority older individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan (§306(a)(4)(A)(i))

3. Each AAA shall provide assurances that the AAA will include in each agreement made with a provider of any service under this title, a requirement that such provider will:

a. Specify how the provider intends to satisfy the service needs of low-income minority older individuals and older individuals residing in rural areas in the area served by the provider.
b. To the maximum extent possible services to low-income minority older individuals and older individuals residing in rural areas in accordance with their need for such services; and
c. Meet specific objectives established by the AAA, providing services to low-income minority older individuals and older individuals residing in rural areas within the planning and service area. (§306(a)(4)(ii))

4. The AAA assures it will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on:

a. Older individuals residing in rural areas;
b. Older individuals with greatest economic need (with particular attention to low-income minority older individuals and older individuals residing in rural areas);
c. Older individuals with greatest social need (with particular attention to low-income minority older individuals and older individuals residing in rural areas);
d. Older individuals with severe disabilities;
e. Older individuals with limited English-speaking ability; and

f. Older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals). (§306(a)(4)(B))

5. The AAA assures it will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas. (§306(a)(4)(C))

6. The AAA assures it will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities. (§306 (a)(5))

7. The AAA assures it will provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as older Native Americans) including:

a. Information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the AAA will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
b. An assurance that the AAA will, to the maximum extent practicable, coordinate the services provided under Title VI; and
c. An assurance that the AAA will make services under the area plan available to the same extent; as such services are available to older individuals within the planning and service area, whom are older Native Americans. (§306(a)(11))

8. The AAA assures it will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships. (§306(a))13)(A))

9. The AAA assures it will disclose to the Assistant Secretary and the State Agency:

a. The identity of each non-governmental entity with which such agency has a contract or commercial relationships relating to providing any service to older individuals; and
b. The nature of such contract or such relationship. (§306(a)(13)(B))

10. The AAA assures it will demonstrate that a loss or diminution on the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships. (§306(a)(13)(C))

11. The AAA assures it will demonstrate that the quantity and quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships. (§306(a)(13)(D))

12. The AAA assures it will, on the request of the Assistant Secretary of State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals (§306(a)(13)(E))

13. The AAA assures that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the AAA to carry out a contract or commercial relationship that is not carried out to implement this title. (§306(a)(14))

14. The AAA assures that preference in receiving services under this title will not be given by the AAA to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title. (§306(a)(15))

Area Agency on Aging Director

Name:_____ Signature:_____

Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATIONS TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

<INSERT ORGANIZATION NAME>, hereinafter called the "recipient,"

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to the title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the recipient receives federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of federal financial assistance extended to the recipient by the Department, this assurance shall obligate the recipient, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the federal financial assistance is extended or for another purpose involving the provision of similar service or benefits. If any personal property is so provided, this assurance shall obligate the recipient for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the recipient for the period during which the federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts, property, discounts, or other federal financial assistance extended after the date hereof to the recipient by the Department, including installment payments after such date on account of the applications for federal financial assistance which were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the recipient.

Area Agency on Aging Director

Name:_____ Signature:_____

Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES SECTION 504 OF THE REHABILITATION ACT OF 1973

<INSERT ORGANIZATION NAME>, hereinafter called the "recipient,"

HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to 84.5(a) of the regulation [45 C.F.R. 84(a], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all federal grants, loans, contracts, (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other federal financial assistance extended by the Department of Health and Human Services after the date of the Assurance, including payments or other assistance made after such date on applications for federal financial assistance that were approved before such date. The recipient recognizes and agrees that such federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means.

This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which federal financial assistance is extended to it by the Department of Health and Human Services or provided for in 84.5(b) of the regulation [45 C.F.R. 84.5(b)]. The recipient: a. (☐) employs fewer than fifteen persons; b. (☐) employs fifteen or more persons, and pursuant to 84.7(a) of the regulation [45 C.F.R. 847(a)], has designated the following person(s) to coordinate its efforts to comply with the regulation.

Name of Designee(s): _____

Recipients Address: _____

_____

_____

IRS Employer I.D. Number:_____

AAA Board President (or other authorized official)

I certify that the above information is complete and correct to the best of my knowledge.

Name:_____ Signature:_____

Date: _____

AVAILABILITY OF DOCUMENTS

<INSERT ORGANIZATION NAME> HEREBY GIVES FULL ASSURANCE that the following documents are current and maintained in the administrative office of the AAA and will be filed in such a manner as to ensure ready access for inspection by DOEA or its designee(s) at any time.

The AAA further understands that these documents are subject to review during monitoring by DOEA.

(1) Current board roster

(2) Articles of Incorporation

(3) AAA Corporate By-Laws

(4) AAA Advisory Council By-Laws and membership composition

(5) Corporate fee documentation

(6) Insurance coverage verification

(7) Bonding verification

(8) AAA staffing plan

- (a) Position descriptions
- (b) Pay plan
- (c) Organizational chart
- (d) Executive director's resume and performance evaluation

(9) AAA personnel policies manual

(10) Financial procedures manual

(11) Functional procedures manual

(12) Interagency agreements

(13) Affirmative Action Plan

(14) Civil Rights Checklist

(15) Conflict of interest policy

(16) Documentation of public forums conducted in the development of the area plan, including attendance records and feedback from providers, consumers, and caregivers

(17) Consumer outreach plan

(18) ADA policies

(19) Documentation of match commitments for cash, voluntary contributions, and building space, as applicable

(20) Detailed documentation of AAA administrative budget allocations and expenditures

(21) Detailed documentation of AAA expenditures to support cost reimbursement contracts

(22) Subcontractor Background Screening Affidavit of Compliance

Certification by Authorized Agency Official:

I hereby certify that the documents identified above currently exist and are properly maintained in the administrative office of the Area Agency on Aging. Assurance is given that DOEA or its designee(s) will be given immediate access to these documents, upon request.

AAA Board President (or other authorized official)

Name:_____ Signature:_____

Date: _____

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).

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Table of Contents			
The location of each section of the program module is accurately reflected.	☐	☐	☐
Program and Contract Module Certification			
The form is properly completed.	☐	☐	☐
The form is signed and dated by Board President (or Designee).	☐	☐	☐
The form is signed and dated by Advisory Council Chair.	☐	☐	☐
The form is signed and dated by Executive Director.	☐	☐	☐
AAA Board of Directors			
Composition details process for member selection and reflects the counties represented in the Area Plan.	☐	☐	☐
Frequency details the anticipated meeting schedule for the board	☐	☐	☐
Selection process and dates are provided	☐	☐	☐
Service term reflects the term for the board as well as the term of each individual board member	☐	☐	☐
AAA Board of Directors Tables			
Officer table details name and terms for board officers	☐	☐	☐
Member table details name, title, address, phone, term, age, race, and ethnicity for Board members	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
AAA Advisory Council			
Composition details process for member selection and reflects the counties represented in the Area Plan.	☐	☐	☐
Frequency details the anticipated meeting schedule for the Advisory Council	☐	☐	☐
Selection process and dates are provided	☐	☐	☐
AAA Advisory Council Table			
Member table details name, title, address, phone, term, age, race, and ethnicity for board members	☐	☐	☐
Funds Administered			
The form is properly completed including bid cycle information.	☐	☐	☐
Resources Used			
The form reflects the use of a variety of planning resources.	☐	☐	☐
Executive Summary			
This section describes major highlights.	☐	☐	☐
Mission and Vision Statement			
This section includes the mission and vision of the agency.	☐	☐	☐
Profile			
Identification of Counties			
This section identifies the counties within the PSA. Include at least one map to display the PSA.	☐	☐	☐
This section identifies the major communities within the PSA. Include at least one map to display the PSA.	☐	☐	☐
Socio-Demographic and Economic Factors			
This section includes a description of the social and economic climate in the PSA, including how this affects elders.	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Highlight the following characteristics:			
1. Elders with low incomes	☐	☐	☐
2. Socially isolated elders	☐	☐	☐
3. Minority and culturally diverse elders	☐	☐	☐
4. Elders in urban and rural areas	☐	☐	☐
Analysis includes the use of maps and charts to illustrate data provided	☐	☐	☐
Economic and Social Resources			
This section describes the economic and social resources available to elders in the PSA.	☐	☐	☐
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.	☐	☐	☐
Role in Interagency Collaborative Efforts			
This section describes collaborative efforts, partnerships, and special initiatives by the PSA and/or DOEA.	☐	☐	☐
SWOT Analysis			
SWOT Analysis			
Process Description	☐	☐	☐
Strengths	☐	☐	☐
Weaknesses	☐	☐	☐
Opportunities	☐	☐	☐
Threats	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Performance and Targeted Outreach			
Performance Analysis - 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 of individuals to be served in each county during each year of the three-year plan.	☐	☐	☐
Targeted Outreach Plan - The purpose of the targeting report is to show how effective the targeting efforts were of services provided to the specific population groups.	☐	☐	☐
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 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	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Unmet Needs and Service Opportunities			
Access to Services			
Abuse, Neglect, and Exploitation	☐	☐	☐
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 availability of and/or access to legal assistance	☐	☐	☐
Counties or communities with limited access to social services agencies	☐	☐	☐
Analysis of service implications of identified unmet access needs	☐	☐	☐
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	☐	☐	☐
Communities			
Transportation	☐	☐	☐
Limited access to senior centers	☐	☐	☐
Housing and safety needs	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Employment and employment training or related assistance	☐	☐	☐
Housing conditions and availability of affordable housing	☐	☐	☐
Analysis of service implications of identified unmet community needs	☐	☐	☐
Disaster Preparedness	☐	☐	☐
Volunteerism	☐	☐	☐
Health Care			
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	☐	☐	☐
Nutrition	☐	☐	☐
Self-Care limitations	☐	☐	☐
Health promotion	☐	☐	☐
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 waitlist not yet receiving any services	☐	☐	☐
Existing clients needing additional services	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Analysis of service implications of identified HCBS unmet needs.	☐	☐	☐
County level analysis for unmet needs/gaps in service. Use charts and graphics with narrative if desired.	☐	☐	☐
Goals and Objectives			
Goal 1: Empower seniors, 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	☐	☐	☐
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 that efforts are in place to fulfill unmet needs and serve as many clients as possible	☐	☐	☐
Objective 2.3. Provide high quality services	☐	☐	☐

PROGRAM MODULE REVIEW CHECKLIST	YES	NO	N/A
Objective 2.4. Provide services, education, and referrals to meet specific needs of individuals with dementia	☐	☐	☐
Objective 2.5. Improve caregiver supports	☐	☐	☐
Goal 3: Empower seniors 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. Advocate for prevention and early intervention of mental health and substance abuse services for elders	☐	☐	☐
Goal 4: Ensure the legal rights of seniors 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	☐	☐	☐
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: Participate in community efforts to ensure your PSA is addressing the state's mission to create livable communities by promoting this work through the eight domains of livability framework. Support the work DOEA is doing in collaboration with AARP and the World Health Organization's (WHO) Age-Friendly Cities and Communities Program.			
Objective 5.1. ▲ Coordinate with community partners for increased access to affordable, person-centered health care, and social services to promote active and independent living.	☐	☐	☐
Objective 5.2. ▲ Promote safe, accessible, and affordable housing that supports aging in place.	☐	☐	☐
Objective 5.3. ▲ Increase awareness of and promote safe and reliable transportation options to increase mobility and community participation.	☐	☐	☐
Objective 5.4. ▲Increase access to information through various methods including print, tv, and digital media.	☐	☐	☐
Objective 5.5. ▲ Promote, engage, and celebrate the valuable contributions of all adults in the community.	☐	☐	☐
Objective 5.6. ▲ Increase awareness of opportunities to contribute in the workplace and volunteer to make a difference in the community.	☐	☐	☐
Objective 5.7. ▲ Increase awareness of and promote easy access to social and cultural activities for increased quality of life.	☐	☐	☐
Objective 5.8. ▲ Work with community partners to ensure accessible, inviting, and safe outdoor spaces and buildings that encourage active participation and recreation.	☐	☐	☐
Goal 6: Maintain effective and responsive management			
Objective 6.1. Promote and incorporate management practices that encourage greater efficiency	☐	☐	☐
Objective 6.2. Ensure that 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 seniors whenever possible	☐	☐	☐
Goal 7: Co-establish and participate in at least one Dementia Care and Cure Initiative (DCCI) Task Force in your Planning and Service Area (PSA).			
Objective 7.1. ▲ Coordinate with the Memory Disorder Clinic (MDC) and local community leaders in Alzheimer's disease and related dementias (ADRD) in your area to create a DCCI Task Force.	☐	☐	☐
Objective 7.2. ▲ Collaborate with Task Force members to designate community entities as Dementia-Caring.	☐	☐	☐
Objective 7.3. ▲ Promote DCCI education and outreach activities throughout the PSA.	☐	☐	☐
Objective 7.4. ▲ Identify areas of need within the ADRD community throughout the PSA.	☐	☐	☐

Appendix 4: Performance and Planning Data

The Excel file provided with your Area Plan package includes a sheet detailing the performance in the previous year against the county-level demographics associated with the following indicators in data and dashboard formats:

- Below Poverty Level (Below 100% of Federal Poverty Level),
- Limited English,
- Living Alone,
- Low Income Minority (below 125% of Federal Poverty Level),
- Minority,
- Probable Alzheimer's Cases,
- Rural, and
- Low-Income Rural (currently only mapped and not included in the data and dashboard).

This spread sheet allows the AAA to compare the county level population percent for the indicators to the percent of the indicators for the screened and served population. Provided at the county level, this comparison should serve to highlight the areas that need to be addressed with strategic planning activities during the period of this Area Plan to ensure performance in the upcoming period meets expectations. To assist with planning, the dashboard provides the approximate count of clients needed in each demographic group to reach the same proportion as the county population. The dashboard also provides estimates of clients needed to exceed each demographic group's county proportion.

Program Module Comments and Recommendations: (to be completed by DOEA staff)	
Section	**Reviewed**
Table of Contents	☐
Comments:	
Program and Contract Module Certification	☐
Comments:	
AAA Board of Directors	☐
Comments:	
AAA Advisory Council	☐
Comments:	
Funds Administered and Bid Cycles	☐
Comments:	
Resources Used	☐
Comments:	
Executive Summary	☐
Comments:	
Mission and Vision Statements	☐
Comments:	
Profile	☐
Comments:	
SWOT Analysis	☐
Comments:	

Program Module Comments and Recommendations: (to be completed by DOEA staff)	
Section	**Reviewed**
Performance and Targeted Outreach	☐
Comments:	
Unmet Needs and Service Opportunities	☐
Comments:	
Goals and Objectives	☐
Comments:	
Direct Service Waiver Requests	☐
Comments:	
Assurances	☐
Comments:	
Program Module Checklist	☐
Comments:	

Appendix 5: Instructions

This file was designed as a template that, when completed, will become your final three-year Area Plan. Since formatting is already a part of the document, document features such as page numbering will automatically update as you work. Please limit editing to the specified areas as making other edits may compromise the template design and functionality.

- You may paste text from other sources into this template. However, to ensure the greatest success with inserting content from other sources, please remember to use the Paste Special function and paste as Unformatted Text into your Area Plan.

Steps for Creating Your Area Plan File

Before you begin editing the template, read all of the template instructions.

- 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 template instructions included throughout the body of the document can be removed when finalizing your plan or left in as additional clarification for the reader.
- Enter your organization name, PSA number, and submission month on the report cover.
- Enter your Planning and Service Area (PSA) number and submission month and year in the footer of the document.
- To enter information into the requisite narrative fields first select the <Enter Text Here> placeholder then begin typing.

Table of Contents

Each page must be sequentially numbered (this should occur automatically) and the location of each section must be listed in the Table of Contents (instructions below).

Once you have completed editing the file, you will need to update the Table of Contents.

- This can be accomplished by right clicking on the Table of Contents and selecting the *Update Field* then *Update Entire Table* function.

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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, the Advisory Council, and AAA understand that they are responsible for the development and implementation of the plan to ensure compliance with the Older Americans Act Section 306.

In addition, their signature verifies that the Program and Contract modules:

- Reflect input from a cross section of service providers, consumers, and caregivers who are representative of all areas and culturally diverse populations of the PSA,
- Incorporate the comments and recommendations of the AAA's Advisory Council, and
- Have been reviewed and approved by the respective governing bodies.

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AAA Board of Directors

In the Membership Composition section, enter the organizational requirements and processes by which members are selected. In particular, this section should clearly describe the efforts undertaken to ensure that the board's membership selection process results in membership that is closely representative of the demographics of the PSA. All counties in the PSA should be represented to the extent possible.

In the Frequency of Meetings section, enter the anticipated schedule of board meetings for the term of the area plan.

In the Officer Selection Schedule section, enter the anticipated schedule for the board's officer selection process for the term of the area plan.

In the AAA Board Officers table, enter the respective officers' name and term (beginning and ending date in the format (mm/yy)) for each position as appropriate.

In the AAA Board of Directors Membership table, enter the name (officers information first in the order of the AAA board officers table), occupation/affiliation, home address (including county), phone number, "Member Since" date (for continuing members, this date reflects their original appointment date to the board (mm/yy)), and current term for each AAA Board member.

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AAA Advisory Council Members

In the Council Composition section, enter the organizational requirements and processes by which members are selected. In particular, this section should clearly describe the efforts undertaken to ensure that the council's membership meets the requirements of the OAA including a selection process that results in membership that is closely representative of the demographics of the PSA. All counties in the PSA should be represented to the extent possible.

In the Frequency of Meetings section, enter the anticipated schedule of council meetings for the term of the Area Plan.

In the Member Selection Schedule section, enter the anticipated schedule for the council's member selection process for the term of the Area Plan.

In the AAA Advisory Council Members table, enter the name, occupation/affiliation, home address (including county), phone number, "Member Since" date (for continuing members, this date reflects their original appointment date to the Board (mm/yy)), current term of office (beginning and ending date in the format mm/yy), age, race, and ethnicity for each AAA Advisory Council member.

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Funds Administered and Bid Cycles

This section has been updated to include the current and anticipated bid cycles for those programs that the AAA administers through competitively procured subcontracts. In completing this section, please select from the options provided all funding sources administered by the organization. To select a source, "click" the checkbox following the source description.

When entering the elements for the Current Bid Cycle, insert the solicitation publication date (mm/yy) under the Published column header. Insert the procurement cycle date (mm/yy) under the Current Year of Cycle column header.

When entering the elements for the Anticipated Bid Cycle, insert the anticipated publication date for the RFP (mm/yy) under the Ant. Publish column header. Insert the anticipated RFP award date (mm/yy) under the Ant. Award column header.

In the event that the PSA is currently engaged in a bid cycle for one or more administered funds, please indicate the anticipated award date under the Awarded column header field for the respective fund.

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Resources Used

To complete this section, please check all resources referenced in order to develop the Targeted Outreach Plan. To select a resource, “click” the checkbox preceding the resource description. If available, the resources are provided as link to the resource itself. Click on the resource to access.

- American Community Survey – U.S. Census Bureau annual survey of households collecting demographic information as well as survey responses on a variety of topics.
- American FactFinder – This source provides access to data about the United States, Puerto Rico, and the Island Areas. The data in American FactFinder come from several censuses and surveys.
- Administration on Aging (AoA) Special Tabulation Data 60+ – A special package available through AoA using the Census Bureau estimates of the U.S. and state populations for aged 60 and over.
- Behavioral Risk Factor Surveillance System (BRFSS) Survey Data – A survey of the general population commissioned by the Florida Department of Health with financial and technical assistance from the Centers for Disease Control and Prevention (CDC) that collects information on a wide array of health and lifestyle topics.
- Bureau of Economic and Business Research (BEBR) produces Florida’s official state and local population estimates and projections. These estimates and projections are used for distributing state revenue-sharing dollars to cities and counties in Florida and for budgeting, planning, and policy analysis by state and local government agencies, businesses, researchers, the media, and members of the public.
- Client Information Registration and Tracking System (CIRTS) – Managed by the Department, CIRTS provides users with the ability to generate reports that identify numbers and circumstances of individuals seeking services and clients currently served in a planning and service area.
- DOEA Client Satisfaction Surveys – Surveys of caregiver and client participants in Department-administered programs such as CCE, ADI, etc. located on the Department website.
- DOEA Elder Index Maps – Maps created using the American Community Survey data, which allow users to locate census tracts with concentrations of seniors in poverty, with disabilities, in race/ethnic minorities, and over the age of 85.
- Office of Economic and Demographic Research (EDR) – EDR is a research arm of the Legislature principally responsible for forecasting economic and social trends that affect policymaking, revenues, and appropriations.

- Florida Charts – Florida Department of Health one-stop-site for public health statistics and community health data
- National Aging Program Information System (NAPIS) – NAPIS is the annual reporting from states of counts, characteristics, expenditures, and service utilization of seniors and caregivers that is submitted to the National Association of States United for Aging and Disabilities (NASUAD) to meet reporting requirements of the Title III and VII State Program Report Data Elements, dictated by the Administration for Community Living, of the U.S. Department of Health and Human Services.
- National Association of States United for Aging and Disability (NASUAD) – NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation, and the articulation of national policies that support home and community-based services for older adults and individuals with disabilities.
- Wider Opportunities for Women Elder Economic Security Standard™ Index (WOW Index) – The WOW Index measures how much income retired older adults require to live in the community and meet their basic needs.
- Targeting Data and Dashboard – Present the performance data for the previous year(s) in each of the targeting factors. Dashboard shows trends across counties, regions, and years.
- Targeting Performance Maps – Maps created using the proportion of clients in each targeting group, against the percentage available in the general 60+ population. Uses American Community Survey data as well as CIRTS data.

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Executive Summary

This section describes the major highlights of the Area Plan, such as how the agency is addressing significant needs, key initiatives, and the organization's role as an AAA. The suggested limit for the narrative response to this section is three pages.

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Mission and Vision Statements

This section includes the Mission and Vision of the AAA.

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Profile

This section should feature an overview of the social, economic, and demographic characteristics of the PSA as well as the conditions of older persons in the PSA.

Identification of Counties

Identify the counties within the PSA. Use at least one map to visually display the PSA in relation to the entire state and one map to identify rural areas of the PSA.

Identification of Major Communities

Identify major communities within the PSA. Use at least one map to visually display the PSA in relation to the entire state and one map to identify rural areas of the PSA.

Socio-Demographic and Economic Factors

Describe the socio-demographic and economic factors of the population in the PSA. 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.

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 income,
- Socially isolated elders,
- Minority and culturally diverse elders, and
- Urban and rural areas

Use maps and charts to illustrate data provided.

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 theme parks, a university, a vibrant arts community, or other significant amenities. Also include factors such as tourism and seasonal shifts in population. If the economic and social resources vary significantly across counties of the PSA, the differences should be included in the narrative.

Description of Service System

Describe the services that are in place to meet the needs of elders and individuals with disabilities, 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 including 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.

Role in Interagency Collaborative Efforts

Describe the AAA's role in advocacy for older individuals when 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. Discuss intergenerational partnership activities and volunteer initiatives including programs administered by the Corporation for National and Community Service, and other use of trained volunteers in providing services to older individuals and those with disabilities.

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SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis

Describe your AAA's SWOT development process and outcomes for each of the SWOT quadrants. The following resource may be helpful to you in conducting the SWOT analysis for your organization: Community Tool Box

The SWOT analysis (alternatively SWOT matrix) should be used as a structured planning method used to evaluate the strengths, weaknesses, opportunities, and threats that are presenting themselves to the organization. In conducting your analysis, emphasis should be placed on the recruitment and active participation of your Governing Board and Advisory Council members as well as assessing how prepared your AAA is to respond to the anticipated change in the number of older individuals during the 10-year period following your Area Plan submission.

- Strengths: characteristics of the organization that give it an advantage over others.
- Weaknesses: characteristics that place the organization at a disadvantage relative to others.
- Opportunities: elements that the organization could exploit to its advantage.
- Threats: elements in the environment that present a challenge for the organization.

The SWOT analysis should support the organization of information, provide insight into barriers that may be present while engaging in social change processes, and identify strengths available that can be activated to counteract these barriers. Identification of SWOTs is important because they can inform the planning steps necessary to achieve goals and objectives. In addition, this analysis can be used to do the following:

- Explore new solutions to problems,
- Identify barriers that will limit the ability to achieve goals/objectives,
- Decide on the direction that will be most effective,
- Reveal possibilities and limitations for change, and
- Revise plans to best navigate systems, communities, and organizations.

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Performance Analysis

The purpose of the performance analysis is to describe how effective the various strategies employed by the AAA were in reaching the specific population groups during the previous year.

- The narrative for this section should include a brief description of the strategies, particular successes, obstacles encountered, and any best practices identified over the course of the previous year.
- This narrative should include analysis across all indicators at the county and PSA levels paying particular attention to those indicators where the PSA percent of population for the indicator falls below the percent of total population for the indicator.
- The county level comparative performance data is provided in the companion Excel file provided with this template.

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Targeted Outreach Plan

The purpose of this three-year plan is to document the AAA's and providers' planned outreach activities to address the identified service needs of targeted populations. This summary should consist of the AAA's planned outreach activities at the county and PSA levels, including when and where activities and events will take place, information on target audiences, goals for number of older individuals and caregivers reached, and plans for how these outreach efforts will reach the targeted sub-populations. 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 plan is not limited to only those indicators where the county's percent of population for the indicator falls below the percent of total population for the indicator, this narrative should describe strategies to address the unique and particular needs of the PSA at the county and community levels (e.g. transportation for individuals in rural and/or isolated areas, access to SNAP and other food assistance for low income individuals).

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:

- Older individuals residing in rural areas;
- 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);

- 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);
- Older individuals with severe disabilities;
- Older individuals with limited English proficiency ability;
- Older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction;
- Older individuals at risk for institutional placement; and
- Caregivers
    - Caregivers of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction;
    - Grandparents[1] 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.

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

Not to be confused with Outreach, Education/Training is defined as:

- Speaking to groups or distributing materials to individuals at public gatherings about services and opportunities available to them within their communities;
- 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; to promote personal enrichment; and to increase or gain skills in a specific craft, trade, job, or occupation;

[1] 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, such as 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.

- Training individuals or groups in guardianship proceedings of older individuals if other adequate representation is unavailable can also be done; and
- 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.

A Targeted Outreach Plan 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, as well as the 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 the type of community events or activities; dates and locations of the events; numbers of participants; identified services needed; and information or referrals provided.

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Unmet Needs and Service Opportunities

This section defines the significant unmet needs of elders and/or gaps in service to elders at the county and PSA levels across a variety of indicators.

Your response should include an analysis of the various topics included in the categories outlined below.* Your analysis should include the actions that have been pursued thus far to address identified needs, the outcomes of those actions, and what actions will be taken to address new, emerging, or continuing needs. For new or emergent needs, describe the expected outcome(s) of all planned actions, including the following:

- Access to Services,
- Caregiver,
- Communities,
- Health Care, and
- Home and Community-Based Services (HCBS)

* The Program Module Review Checklist provided in Appendix 3 provides a detail of the topics that must be covered in each category.

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Goals and Objectives

Six goals and their objectives have been listed in a table format. Additional goals and objectives particular to your AAA may be added. Objectives that are aligned with the Administration on Aging's (AoA) goals are indicated with a ▲ symbol.

Navigation

- "Clicking" the Objective hyperlink in the template will navigate you to the corresponding essential element guidance in the Essential Elements table.
- From the Essential Elements table, you can "click" the up arrow (↑) under the Objective to return the corresponding Objective in the template.

Goals, Objectives, Strategies/Action Steps, 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.

Explanations

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

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.
- Each objective strategy must at a minimum cover the topics specified in the Essential Elements table.

Outcomes/Outputs

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

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Essential Elements

The following table provides a detail of the Essential Elements that should be included in the development of your responses to each Goal at the Objective level.

GOAL	
Objective	**Essential Elements**
Goal 1: Empower seniors, 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 (ADRCs). ↑	Strategies must include but not be limited to: • Improving the ability of the ADRC to connect people to information and services through the ADRC (e.g. building new relationships and/or partnerships and the effective use of technology). • Specific action steps to improve streamlined access based on implementation of call center technology standards, performance reports, and data analysis.
Objective 1.2. ▲ Encourage individuals, including people under 60, to plan for future long-term care needs by providing access to information ↑	Strategies must include but not be limited to: • Increasing public awareness of the costs of long-term care (LTC), the likelihood of the need for LTC services, and the LTC options available. • Increasing public awareness of the limitations of Medicare as a singular long-term care solution.

GOAL	
Objective	**Essential Elements**
Objective 1.3. Ensure that complete and accurate information about resources is available and accessible ↑	Strategies must include but not be limited to: • Ensuring that information in ReferNET is kept accurate and current, reflecting both the inclusion of new services and service providers; as well as the removal of inappropriate references. • Maintaining participation in F4A workgroups; as well as implementing and complying with data collection and reporting standards established through F4A and DOEA collaboration.
Objective 1.4. Ensure that elders have access to free, unbiased, and comprehensive health insurance counseling ↑	Strategies must include but not be limited to: • Establishing additional counseling sites. • Expanding the SHINE Program and access to more consumers (e.g. increasing the number of SHINE service sites).
Objective 1.5. Increase public awareness of existing mental and physical health and long-term care options ↑	Strategies must include but not be limited to: • Informing the public of available long-term care services through a variety of new and traditional media such as websites, social media, publications, or direct mail.
Objective 1.6. Identify and serve target populations in need of information and referral services ↑	Strategies must include but not be limited to: • Efforts to reach individuals with limited English proficiency; low-literacy, low-income, individuals residing in rural populations; persons with disabilities 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. • Establishing new partnerships and efforts to address, at a minimum, rurality; hunger; and Alzheimer's disease and related dementias.

GOAL	
Objective	**Essential Elements**

Objective 1.7. Provide streamlined access to Medicaid Managed Care and address grievance issues
↑
	Strategies must include but not be limited to:
	• Programmatic, fiscal, and operational management of all ADRC Medicaid related functions.
	• Providing Statewide Medicaid Managed Care Long-term Care (SMMC LTC) eligibility assistance.
	• Enhancing overall customer service through the performance and oversight of the following Medicaid compensable activities:
	  ○ Medicaid Outreach and LTC Program Education;
	  ○ Medicaid Eligibility Screening and Waitlist Placement;
	  ○ Enrollment Management System;
	  ○ Grievances and Complaints; and
	  ○ Quality Assurance.
	• Analysis of current capacity to employ these strategies, including details concerning process and performance improvement efforts.

GOAL	
Objective	**Essential Elements**
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 ↑	Strategies must include but not be limited to: • Identifying and serving individuals who are in need of HCBS with limited English proficiency; low-literacy, low-income individuals 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. • Identifying and using best practices in the prioritization and services for clients according the to the Department's prioritization criteria. • Developing and leveraging new partnerships, processes, and technologies in order to reach rural clients with services to address hunger, memory disorders, and caregiver supports.
Objective 2.2. Ensure that efforts are in place to fulfill unmet needs and serve as many clients as possible ↑	Strategies must include but not be limited to: • Identifying unmet needs and/or gaps through strategic partnerships and collaborations with other entities which have expertise in meeting the identified needs and/or gaps. • Developing specialized support services for aging caregivers.

GOAL	
Objective	**Essential Elements**
Objective 2.3. Provide high quality services ↑	Strategies must include but not be limited to: • Establishing procedures to assure client satisfaction and the delivery of quality services, including handling complaints from persons whose services have been denied, terminated, or reduced. • Utilizing the Local Coalition Work Group (LCWG) to advise in the planning and evaluation of the ADRC and to assist in the development of an ADRC Annual Program Improvement Plan. This strategy must provide a detailed list of current LCWG members and describe current integration of ADRC services with services provided by the staff of the Department's local CARES unit(s) and local Department of Children and Families Economic Self-Sufficiency unit(s). • Submission of the Annual Program Improvement Plan (APIP). The APIP plan must: detail the role of the ADRC's Local Coalition Work Group (LCWG) in the development and evaluation of the APIP; address specific ADRC performance improvement goals; actions steps to implement and evaluate the performance goals; and, quality assurance efforts specific to ADRC functions.

GOAL	
Objective	**Essential Elements**
Objective 2.4. Provide services, education, and referrals to meet specific needs of individuals with dementia ↑	Strategies must include but not be limited to: • Implementing caregiver programs that adopt or expand state and federal volunteer respite program models and innovative projects that address caregiver needs and reduce their stress. • Developing and maintaining effective partnerships with organizations and providers who have dementia expertise, training Information and Referral Specialists and other staff to recognize possible cognitive impairment, and person-centered services planning. • Providing services for rural aging caregivers of individuals with dementia.
Objective 2.5. Improve caregiver supports ↑	Strategies must include but not be limited to: • Providing education, training, and options to help caregivers make better decisions and deal with current and prepare for possible future needs. • 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. • Volunteer companions (retired seniors helping seniors) and older caregivers providing care for spouse, grandchildren, or other relatives.

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

GOAL	
Objective	**Essential Elements**
Objective 3.1. ▲ Continue to increase the use of Evidence-Based (EB) programs at the community level ↑	Strategies must include but not be limited to: • Management and coordination of programs that empower seniors to control their own health through community level interventions. • Sustaining continued funding. • Programs the build self-confidence and reduce disease progression for people with chronic conditions (e.g. advocacy for sustaining EB health promotion, including falls prevention and medication management).
Objective 3.2. Promote good nutrition and physical activity to maintain healthy lifestyles ↑	Strategies must include but not be limited to: • Engaging stakeholders and community partners in coordinated comprehensive nutrition and physical activity programs and community programs that help build social supports. • Increasing the use of congregate meal sites. • Developing social support for programs that promote active lifestyles and use of public facilities (e.g., walking or bike trails, classes at gyms or senior centers, athletic fields, etc.).

GOAL	
Objective	**Essential Elements**
Objective 3.3. Promote the adoption of healthy behaviors ↑	Strategies must include but not be limited to: • Conducting community-wide campaigns that combine highly visible messages to the public, community events, and support groups that encourage seniors to become or remain active. • Recruiting older adults to participate in the promotion of healthy behaviors through advertising and marketing to community partners. • Promoting the adoption of a healthy lifestyle by reducing smoking, alcohol, and/or drug consumption, and by encouraging sleep and stress management, socialization, and engaging in enjoyable pursuits, etc.
Objective 3.4. Advocate for prevention and early intervention of mental health and substance abuse services for elders↑	Strategies must include but not be limited to: • Public awareness activities to increase the understanding of mental and substance-use disorders. • Improving or developing partnerships with mental health and recovery advocates in the community. • Encouraging group-based activities composed of older adults, like those at a senior center. • Consideration of physical health issues such as nutrition, sleep habits, medication, and pain management. • Working with the Department to ensure that individuals who have been identified at-risk due to emotional or psychological distress receive the appropriate referral, and/or how the AAA tracks and confirms that an appropriate action is taken on behalf of each client in distress and the status update that is provided to the contract manager at the Department on a quarterly basis.

GOAL	
Objective	**Essential Elements**
Goal 4: Ensure the legal rights of seniors 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 ↑	Strategies must include but not be limited to: • 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.
Objective 4.2. ▲ Facilitate the integration of Older Americans Act elder rights programs into aging services ↑	Strategies must include but not be limited to: • Providing in-person and/or online cross training and the use of available technology and media outlets to inform older adults, the public, and professionals. • Promoting an understanding of individual rights; developing personal empowerment to exercise choices; and providing information regarding the benefits of services and opportunities authorized by law among vulnerable and at-risk seniors.
Objective 4.3. ▲ Improve the identification and utilization of measurable consumer outcomes for elder rights programs ↑	Strategies must include but not be limited to: • Participating in statewide efforts to develop a uniform statewide reporting system for legal services; establishing mechanisms for utilizing data available to improve awareness of the importance of legal assistance; increasing access to legal assistance; and, addressing the quality of legal assistance provided.
Objective 4.4. Promote primary prevention of elder abuse, neglect, and exploitation ↑	Strategies must include but not be limited to: • Public education of the special needs of elders and the risk factors for abuse in vulnerable adults. • Primary prevention activities focused on preventing elder abuse, neglect, and exploitation.

GOAL	
Objective	**Essential Elements**
Objective 4.5. Reduce the rate of abuse, neglect, and exploitation recidivism through education, outreach, and the provision of services ↑	Strategies must include but not be limited to: • Reducing the rate of recidivism through education and outreach for caregivers and clients to help them with coping skills and services to alleviate caregiver stress and possible family strife. • Establishing and maintaining collaborative relationships with other entities that endeavor to prevent elder abuse, neglect, and exploitation.
Objective 4.6. Increase the awareness of health care fraud and other elder rights issues ↑	Strategies must include but not be limited to: • Use of websites, social media, newspapers, and direct mail.

GOAL	
Objective	**Essential Elements**
Goal 5: Participate in community efforts to ensure your PSA is addressing the state's mission to create livable communities by promoting this work through the eight domains of livability framework. Support the work DOEA is doing in collaboration with AARP and the World Health Organization's (WHO) Age-Friendly Cities and Communities Program.	
Objective 5.1. ▲ Community Support and Health System: Coordinate with community partners for increased access to affordable, person-centered health care and social services to promote active and independent living. ↑	Strategies must include but not be limited to: • Developing partnerships with DOH at the county level to identify community needs/concerns through joint community surveys. • Collaboratively working with the county health department on the Community Health Improvement Plan (CHIP) to develop effective strategies to improve health outcomes and reduce costs. • Promoting the availability of existing public health programs within the community that conveys a collaborative approach to support healthy aging. • Increasing awareness of an age-friendly public health system by building a rapport between the public health and the aging sectors. • Providing opportunities to participate in fun, unique programs that support being healthy, examples include offering free exercise programs in a local park and exploring sponsorship opportunities through private insurance companies. • Promoting awareness of the Dementia Care and Cure Initiative (DCCI) task force in your PSA. • Promoting awareness of the Memory Disorder Clinic (MDC) in your PSA and the services it offers.
Objective 5.2. ▲ <u>Housing:</u> Promote safe, accessible, and affordable housing that supports aging in place. ↑	Strategies must include but not be limited to: • Developing partnerships with city housing departments to explore opportunities for affordable housing. • Developing partnerships with the DCF Homeless coalition lead agency. • Facilitating access to home modification programs. • Promoting availability of resources that enhance personal independence. • Bridging relationships between city, local builders, and developers on the importance of universal design in new construction.

GOAL	
Objective	**Essential Elements**
Objective 5.3. ▲ <u>Transportation:</u> Increase awareness of and promote safe and reliable transportation options to increase mobility and community participation. ↑	Strategies must include but not be limited to: • Partnering with local transportation coordinator through the Commission for the Transportation Disadvantaged. • Promoting the work and resources of Safe Mobility for Life Program. • Partnering with local agencies to ensure the community offers accessible, affordable, and reliable public transportation options. • Partnering with DOT on safe, complete streets and intersections. • Working with community transportation partners to develop ambassador leaders in the community to educate on the use of public transit system. • Working with local governments to address availability of benches and shelters at bus stops. • Creating partnerships to work together to implement neighborhood/community volunteer transportation programs. • Promoting use of alternative transportation options: walk, bike, public transit, ride share.
Objective 5.4. ▲ Communication and Information: Increase access to information through various methods including print, tv, and digital media. ↑	Strategies must include but not be limited to: • Developing assessment tools to determine how your community receives information and possible opportunities for improvement, with particular attention in rural areas and underserved populations. • Developing strategies through community partnerships to ensure effective communication reaches residents of all ages. • Partnering with local senior centers, universities, and private partners to offer technology classes.

GOAL	
Objective	**Essential Elements**
Objective 5.5. ▲ Respect and Social Inclusion: Promote, engage, and celebrate the valuable contributions of all adults in the community. ↑	Strategies must include but not be limited to: • Developing strategies to ensure older adults are valued, respected, and involved in decision making in their communities. • Developing intergenerational programs that bring together youth and older adults. • Partnering with local schools to provide opportunities to learn about aging and respect. DCCI task forces can develop dementia sensitivity trainings for schools/universities/vocational schools. • Implementing grand-friend programs: where older adults are paired with school children to improve their skills and offer mentoring. • Promoting a culture that values diversity, fairness, dignity, and equal opportunity for all. • Partnering with local neighborhood associations to develop check-in programs. • Facilitating opportunities for cross-cultural interactions among clients, caregivers, and program staff. Promoting a diverse governance and workforce that are representative of the population being served.

GOAL	
Objective	**Essential Elements**
Objective 5.6. ▲ Civic Participation and Employment: Increase awareness of opportunities to contribute in the workplace and volunteer to make a difference in the community. ↑	Strategies must include but not be limited to: • Encouraging older adults to stay engaged in the workforce. • Partnering with the local SCSEP to provide community service training opportunities that could lead to sustainable employment. • Promoting the local SCSEP and the importance of hiring elders. • Building bridges across age and culture. • Implementing programs with universities and senior centers to offer flexible education opportunities and intergenerational projects. • Promoting the Create the Good volunteer program with AARP. • Working with local agencies to promote volunteer and social engagement opportunities for older adults. • Promoting volunteer opportunities through DOEA programs: SHINE, ombudsman, guardianship, home delivered meals. • Developing recognition programs to show the value of your volunteers during the month of April.

GOAL	
Objective	**Essential Elements**
Objective 5.7. ▲ Social Participation: Increase awareness of and promote easy access to social and cultural activities for increased quality of life. ↑	Strategies must include but not be limited to: • Promoting education and awareness to erase the stigma of ageism. • Developing working relationship with faith-based organizations to work together to facilitate programs to promote engagement in the community. • Collaborating with the local senior centers to make sure a variety of activities are offered to appeal to a diverse population and ensure there is communication to promote the availability of programs. • Developing partnerships with community-based organizations, such as senior centers, community centers, faith-based organizations, and YMCAs to address loneliness and social isolation by establishing opportunities to increase social interactions and development of new friendships. • Offering language assistance to individuals with limited English proficiency. • Increasing awareness and access to programs and support across diverse populations within the aging and disability communities, regardless of a person's literacy level, ethnicity, race, gender, religion, sexual orientation, gender identity, or socioeconomic status.
Objective 5.8. ▲ Outdoor Spaces and Buildings: Work with community partners to ensure accessible, inviting, and safe outdoor spaces and buildings that encourage active participation and recreation. ↑	Strategies must include but not be limited to: • Working collaboratively with local parks and recreation department to ensure community parks for all ages. • Advocating for safe, walkable sidewalks and entrances to building are safe, accessible, clearly visible for all. • Developing working relationships with neighborhood associations.

GOAL	
Objective	**Essential Elements**
Goal 6: Maintain effective and responsive management	
Objective 6.1. Promote and incorporate management practices that encourage greater efficiency ↑	Strategies must include but not be limited to: • The development and monitoring of standards, criteria, or specific procedures to be used by the service providers in evaluating the quality of services provided. • Management analysis of performance and performance gaps based on internal monitoring, quality assurance, and performance-based standards and outcomes. • Management analysis of improvement objectives based on internal monitoring, quality assurance, and performance-based standards and outcomes. • Active participation of the Advisory Council and Board of Directors in the analysis of improvement objectives as identified by the AAA through internal monitoring, and performance-based standards and outcomes quality assurance activities. • Incorporating call centers standards and data analysis for internal monitoring and quality assurance. • Complying with F4A data collection and analysis requirements and quality assurance activities that are commensurate with F4A policies and procedures (current and as updated over life of this plan).
Objective 6.2. Ensure federal and state funds are used to effectively and efficiently serve elders' needs ↑	Strategies must include but not be limited to: • Effectively reporting budgetary surplus/deficit projections. • Analyzing management policies to reduce and eliminate unspent contracted program funds. • Enhancing communication and collaboration with providers to ensure the appropriate and documented transfer of funds among providers.

GOAL	
Objective	**Essential Elements**
Objective 6.3. Ensure that providers continue to strengthen the disaster preparedness plans to address specific needs of elders ↑	Strategies must include but not be limited to: • Developing and maintaining formal agreements with local, state, and federal entities that provide disaster relief and recovery. • Identifying and planning for consumer needs and the availability of special needs shelters in times of disaster. • Including in plans to disseminate evacuation zone rosters and maps to staff and partners, to ensure client locations are known for preparation and relief efforts.
Objective 6.4. Accurately maintain the Client Information and Registration Tracking System (CIRTS) data ↑	Strategies must include but not be limited to: • Actively comparing CIRTS data to information in client files to verify the accuracy of CIRTS data. • Providing training and ongoing technical assistance to ensure that employees understand how appropriately use CIRTS. • Ensuring that addresses for active clients were entered by staff and partners into CIRTS accurately and in the most effective format or to make corrections if a client location cannot be identified, to ensure that individuals' home addresses have the highest likelihood of being properly located and mapped by the Department to identify their assigned evacuation zone.
Objective 6.5. Promote volunteerism by and for seniors whenever possible ↑	Strategies must include but not be limited to: • Identifying, evaluating, and implementing "best practices" that enhance the recruitment and use of trained volunteers in providing direct services to older individuals and individuals with disabilities.

GOAL	
Objective	**Essential Elements**
Goal 7: Co-establish and participate in at least one Dementia Care and Cure Initiative (DCCI) Task Force in your PSA.	
Objective 7.1. ▲ Coordinate with the Memory Disorder Clinic (MDC) and local community leaders in Alzheimer's disease and related dementias (ADRD) in your area to create a DCCI Task Force. ↑	Strategies must include but not be limited to: • Forming a Task Force to increase awareness of dementia and of services and support for those living with dementia, along with their families and care partners. • Assisting the Task Force with planning and implementing outreach and educational programs, partnerships with community leaders, and action-oriented plans.
Objective 7.2. ▲ Collaborate with Task Force members to designate community entities as Dementia-Caring. ↑	Strategies must include but not be limited to: • Collaborating with the Task Force to provide free dementia sensitivity trainings to government and public service agencies, community entities, caregivers and families, first responders, health care professionals, businesses, and community organizations. • Supporting dementia sensitivity trainings that will allow recipients to receive the designation of being Dementia-Caring.
Objective 7.3. ▲ Promote DCCI education and outreach activities throughout your PSA. ↑	Strategies must include but not be limited to: • Spreading awareness and sensitivity about dementia. • Encouraging safe and inclusive communities for all who seek to continue to be engaged throughout their lifetime. • Linking those living with dementia, their families and care partners to local resources.
Objective 7.4. ▲ Identify areas of need within the ADRD community throughout your PSA. ↑	Strategies must include but not be limited to: • Advocating for those living with dementia and recognizing ways the Task Force can get involved in the community.

Performance Measures Listing

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

- Note: The AAAs will not be monitored on the measures listed in italics, but the AAA must still include strategies to address the measures within the goals and objectives framework.

Outcome Measures:

- *Percent of most frail elders who remain at home or in the community instead of going into a nursing home*
- 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 family and family-assisted caregivers who self-report they are very likely to provide care*
- *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)*
- Percent of elders with high or moderate risk environments who improved their environment score
- Percent of Adult Protective Services (APS) referrals who are in need of immediate services to prevent further harm who are served within 72 hours

Output Measures:

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

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
- Develop strategies for the recruitment and retention of volunteers

Appendix 1: Direct Service Waiver Requests

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. A DSW request must be completed for each direct service proposed.

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 AAA is necessary to assure an adequate supply of such services;
ii. Such services are directly related to such State agency's or AAA's administrative functions; or
iii. Such services can be provided more economically, and with comparable quality, by such State agency or AAA and/or the AAA'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, the 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 an RFP, RFI, or 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 because 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.

(Return to form)

Appendix 2: Assurances

As part of the Area Plan development and submission process, Appendix 2 details the specific assurances required of the OAA related to the receipt and provision of services with this federal funding stream.

- Please complete all required fields and required signatures for each assurance form.

(Return to form)

Appendix 3: Program Module Review Checklist

This checklist is provided as a tool with which your AAA can review its Area Plan to ensure that all required aspects of the Area Plan have been addressed prior to submission.

- In completing this checklist, please select from the three options provided (Yes, No, N/A) to indicate whether or not the individual elements have been addressed or if the element is not applicable.

(Return to checklist)