AREA PLAN ON AGING
FOR THE
SOUTHWESTERN CONNECTICUT
PLANNING AND SERVICE AREA

As defined in response to requirements under
THE OLDER AMERICANS ACT of 1965, as amended
For the four-year period of
October 1, 2017 through September 30, 2021
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APPLICATION FOR AREA AGENCY ON AGING DESIGNATION AND AWARD UNDER TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED FEDERAL FISCAL YEARS 2018 THROUGH 2021

COVER SHEET

1. Applicant Agency Name: Southwestern CT Agency on Aging

   Address: 1000 Lafayette Boulevard, 9th Floor
             Bridgeport CT 06604

   Phone: 203 333 9288  Email: mallen@swcaa.org

   Director (Name and Title): Marie L. Allen, Executive Director

2. Chairperson of Governing Board

   Name and Title: Sam Deibler, Chairman, Board of Directors

   Address: XXXXXXXXXXXXXXXXXXX
            XXXXXXXXXXXXXXXXXXX

   Phone: XXXXXXXXXXX Email: XXXXXXXXXXX
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SECTION I: Standard Assurances and Required Exhibits
EXHIBIT I-2 Statement to Serve Target Population

Instructions: Outline the Area Agency’s strategies for targeting older individuals with greatest economic need, greatest social need, older individuals at risk for institutional placement, low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas, older individuals with Alzheimer’s disease and related disorders and older individuals with severe disabilities.
Statement to Serve Target Population

1. **Strategies for targeting older individuals with greatest economic need**
   a. Include proposed service to older individuals with greatest economic need in criteria utilized in Title III allocations process.
   b. Require all Title III grantees to provide outreach to target population older adults.
   c. As funds are available provide support to Adult Day Care programs or other community long-term services and supports to provide scholarships for low-income seniors or to increase the services available to older individuals with greatest economic need.
   d. Provide enrollment assistance to help low income individuals access all available entitlements and services, with concentration in Bridgeport, Norwalk, Stratford and Stamford.
   e. Participate in community health and wellness fairs to educate low income individuals; with concentration in Bridgeport, Norwalk, Stratford and Stamford.
   f. Publish current program and income eligibility guidelines on the agency website.
   g. Partner with Senior Centers and Municipal Agents to assist with enrollment of individuals into all eligible programs including Title III & V.

2. **Strategies for targeting older individuals with greatest social need**
   a. Include proposed service to older minority individuals with greatest social need in criteria utilized in Title III allocations process.
   b. Require all Title III grantees to provide outreach to target population older adults.
   c. Participate in community health and wellness fairs focusing on Bridgeport, Easton, Norwalk and Stamford, reaching individuals who may experience or be at-risk for isolation, exclusion or depression.
   d. Partner with Behavioral Health, LGBTQ or Veterans agencies, to assist with enrollment of individuals into all eligible programs including Title III & V.
   e. Publish current program and income eligibility guidelines on the agency website.
   f. Recruit toward a diverse workforce to meet the language and cultural needs of clients.

3. **Strategies for targeting older individuals at risk for institutional placement**
   a. As funds are available, provide support to Adult Day Care programs or other community long-term services and supports to increase the services available to older individuals at risk for institutional placement.
   b. Require all Title III grantees to provide outreach to target population older adults.
   c. Inform discharge planners of available resources to maintain and support individuals in the community.
   d. Participate in community health and wellness fairs to educate caregivers about available Long-term Services and Supports.

4. **Strategies for targeting low-income minority older individuals**
   a. Include proposed service to low-income minority older individuals in criteria utilized in Title III allocations process.
   b. Require all Title III grantees to provide outreach to target population older adults.
   c. Provide enrollment assistance to help low income, minority individuals access all available entitlements and services, with concentration in Bridgeport, Norwalk, Stratford and Stamford.
d. Participate in community health and wellness fairs to educate low income minority individuals; with concentration in Bridgeport, Norwalk, Stratford and Stamford.

5. **Strategies for targeting older individuals with limited English proficiency**
   
a. Include ability of potential grantees to serve older individuals with limited English proficiency in criteria utilized in Title III allocations process.
   
b. Require all Title III grantees to provide outreach to target population older adults.
   
c. Utilize Language Line, CLAS standards or other translation tools to assist limited English proficiency individuals with information and access to all available services and supports.
   
d. Maintain language/translation preference on SWCAA’s website.
   
e. Recruit toward a diverse workforce to meet the language and cultural needs of clients

6. **Strategies for targeting older individuals residing in rural areas**
   
a. Require all Title III grantees to provide outreach to target population older adults.
   
b. Cultivate partnership with Easton’s Municipal Agent to provide information and assistance through presentations or enrollment events.
   
c. Marketing in Easton for the purpose of soliciting volunteers to become trained Certified CHOICES Counselors.

7. **Strategies for targeting older individuals with Alzheimer’s Disease and related disorders**
   
a. As funds are available, provide support to Adult Day Care programs to provide scholarships for needy older individuals with Alzheimer’s Disease or related disorders who are in need of day care services.
   
b. Require all Title III grantees to provide outreach to target population older adults.
   
c. As funds are available, provide State Alzheimer’s Aide funding to Adult Day programs to allow them to include additional clients with dementia disorders.
   
d. Collaborate with the regional Alzheimer’s Association office to provide Statewide Respite Program support to individuals with Alzheimer’s and related dementia.
   
e. Participate in health and wellness fairs and community events, with the intent to educate and inform adult children and other caregivers about Long-term Services and Supports.

8. **Strategies for targeting older individuals with severe disabilities**
   
a. Require all Title III grantees to provide outreach to target population older adults.
   
b. Collaborate with the local Disability Resource Center to provide enrollment assistance during their community presentations.
   
c. Utilize National Family Caregiver Supplemental Services funds for assistive/adaptive technology when applicable.
EXHIBIT I-3  Description of Area Agency on Aging’s Effort to Meet the Needs of Target Populations in its Planning and Service Area

Description of area agency on aging efforts to meet the needs of older individuals with greatest economic need, greatest social need, older individuals at risk for institutional placement, low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas, older individuals with Alzheimer’s disease and related disorders and older individuals with severe disabilities.

Instructions: Each year, the Area Agency on Aging shall:

- (I) identify the number of persons in each of the target groups in its planning and service area;
- (II) describe the methods used to satisfy the services needs of such older individuals; and
- (III) provide information on the extent to which the Area Agency on Aging has been successful in meeting the established targets for services to these populations.
Description of Area Agency on Aging’s effort to meet the needs of target populations in its Planning and Service Area

1. Identify the number of persons in each of the target groups in its planning and service area.
   Current census data indicates the total population age 60 and over in the SWCAA area is 131,275 (AGid Special Census Tabulation, 2009-2013), an increase of 2.6% since the preparation of the current Area Plan 4 years ago.

   a. Greatest economic need
      i. 9,780 of these older adults, 7.36%, live at or below the poverty line. (AGid Special Census Tabulation, 2009-2013) Both the number of older adults and the percentage at poverty have increased over the past 4 years. This percentage is higher than the Connecticut percentage of 6.97%.
      ii. 51% of the older adults living at or below the poverty line in the SWCAA area live in the Greater Bridgeport region.
      iii. The percentage of residents in the City of Bridgeport who are age 60 and above and living at or below the poverty line is 17.11%.
      iv. The DHHS poverty guidelines set 100% of the poverty line at $1,005 a month for a single person or $1,353 a month for a couple. However, the Elder Index, which measures how much income is required to meet basic needs, calculates that in Fairfield County the minimum monthly income needed is $2,388 for a single person or $3,323 for a couple. (Mutchler, Li, & Xu, 2016)

   b. Greatest social need
      i. Census data indicates that 25.67% of SWCAA area older adults report having one or more disabilities. (AGid Special Census Tabulation, 2009-2013)
      ii. 7.65% of the SWCAA area population aged 60 and over identified themselves as having limited English proficiency.
      iii. 21.6% of the SWCA area population age 60 and over are members of minority groups with more than 50% of older adults in Bridgeport being minority.
      iv. The reported households who speak a language other than English at home in Bridgeport is 46.3% and in Stamford 40.2%. (Connecticut State Innovation Model State Health Profile: Data Packet, 2016)

   c. Older individuals at risk for institutional placement
      i. The Target Population Workbook prepared for the Aging Services Division of the CT Department of Social Services by NASUAD and The University of Southern Maine reported in 2012 that in Southwestern CT 1,574 older individuals or 1.2% of the older adult population was at risk of institutionalization. (Cho & Bratesman, 2012)
      ii. One-fifth of those seniors lived in Bridgeport.

   d. Low-income minority older individuals
      i. 5,013 of SWCAA area older individuals, 3.94%, are both minority and live at or below the poverty line. This percentage is higher than the Connecticut percentage of 2.52%. (AGid Special Census Tabulation, 2009-2013)
ii. 61% of the low-income minority individuals in the SWCAA area live in the Greater Bridgeport region.

iii. The percentage of residents in the City of Bridgeport who are aged 60 and above, and are minority and live at or below the poverty line is 12.96%.

e. **Older individuals with limited English proficiency**
   i. 7.65% of the SWCAA area population age 60 and over identified themselves as having limited English proficiency. (AGid Special Census Tabulation, 2009-2013)
   ii. The cities with the highest percentages of older adults with limited English proficiency are Bridgeport at 18.88% and Stamford at 11.03%.
   iii. The reported households who speak a language other than English at home in Bridgeport is 46.3% and in Stamford 40.2%. (Connecticut State Innovation Model State Health Profile: Data Packet, 2016)

f. **Older individuals residing in rural areas**
   i. The only town in the SWCAA area designated as rural is Easton. While the rural nature of Easton is indicated by the lack of public transportation and in-town access to medical and commercial establishments, it is a direct suburb of Bridgeport and is one of the wealthier towns in the SWCAA area and in Fairfield County. (Abraham & Buchanan, 2016)
   ii. Approximately 1,735 individuals age 60 and over live in Easton. This represents 1.32% of the adults age 60 and over in the SWCAA area. 1.52% of the Easton older adults are at or below the poverty level and 1.73% are minority. Both of these percentages were below 1% 4 years ago. (AGid Special Census Tabulation, 2009-2013)

g. **Older individuals with Alzheimer’s disease and related disorders**
   i. The Alzheimer’s Association estimates the number of older individuals with Alzheimer’s disease in Connecticut in 2016 at 74,000. (Alzheimer's Statistics Connecticut, 2016)
   ii. The Alzheimer’s Association estimates that the number of older individuals with Alzheimer’s disease in Connecticut will increase by 8.1% between 2016 and 2020.

h. **Older individuals with severe disabilities**
   i. Census data indicates that 25.67% of SWCAA area older adults report having one or more disabilities. (AGid Special Census Tabulation, 2009-2013)
   ii. The American Community Survey estimates the overall rate of people with disabilities in the US population in 2015 was 12.6% but the rate for people age 65 and older was 35.4%. (Kraus, 2017)
   iii. All disability types (hearing, vision, cognitive, ambulatory, self-care, and independent living) have increases in disability percentages with age. (Kraus, 2017)

ii. **Describe the methods used to satisfy the services needs of such older individuals.**
   a. **Greatest economic and social need and low-income minority older individuals**
      The SWCAA Title III allocations process requires applicants to project the number of clients to be served who will be at or below 100% of the poverty level and/or minority. In addition, applicants must describe an outreach plan designed to reach older adults who are: at or below 100% of the poverty level, minority, at 101-150% of the poverty level, with limited English proficiency, with severe disabilities, at risk of institutionalization,
and with Alzheimer’s or related disorders. Funding is allocated based on an evaluation process which includes consideration of the percentage of socially and economically disadvantaged older adults in each region. Applications are not considered if the projected number of older adults who are at or below 100% of the poverty level or minority is not at least in proportion to their representation in the community. Funding decisions include criteria that heavily weigh the applicant’s ability to serve socially and economically disadvantaged seniors.

Staff of SWCAA’s nutrition assessment waiver and Bridgeport outreach waiver are in the community identifying community older individuals who have economic or social needs or are low-income minority and assisting them to access available community services.

SWCAA is the trusted leader relative to all aging issues in the planning and service arena of southwestern CT. This translates to proactively executing, under the leadership and direction of the Board and Advisory Council, a wide range of resources related to older adults, such as health insurance, housing and in-home care.

SWCAA is specifically designed to lead in the development of comprehensive and coordinated community based systems for Long-term Services and Supports. These systems are designed to assist, maintain and improve the quality of life and independence of older persons regardless of their level of functioning, income, language preference, ethnic background, sexual identification or religious affiliation.

Through the delivery of information, SWCAA Information Specialists, work diligently to break down barriers to services through community presentations, one to one counselling events, health and wellness fairs, hosting community forums (Senior Centers/Municipal Agent) and content at media outlet events (Facebook, electronic publications, radio, TV, billboards).

b. **Older individuals at risk for institutional placement and older individuals with Alzheimer’s Disease and related disorders**

All Title III grantees are required to have a system in place to advise participants of additional services that may be available to them and to assist them in accessing such services. When responses to Form 5 questions or interactions between grantee staff and participants indicate that a participant may be at risk in the community, the grantee staff can provide assistance or help the participant make contact with a social worker who can provide additional access to services. Some grant projects provide direct services to individuals at risk for institutional placement who are unable to pay full cost for those services. Some grant projects include outreach workers or social workers who can assist these participants; others may make referrals to the SWCAA information and assistance staff. Staff of SWCAA’s nutrition assessment waiver and Bridgeport outreach waiver are in the community identifying community older individuals who are at risk for institutional placement and assisting them to access available community services.

In addition to other assistance available in the community, referrals may be made to one of the Medicaid waiver programs or to the Statewide Alzheimer’s Respite Program or the National Family Caregiver Program at SWCAA. These programs provide case management services that help the family caregiver, the at-risk older adult, or an older individual with Alzheimer’s Disease by immediately offering respite in the form of in-
home care or adult day care and/or supplemental services while informing the caregivers of other available supports.

Adult Day programs who are State Alzheimer’s Aide grant recipients are able to provide services to additional older adults with irreversible and deteriorating dementia of the Alzheimer's type as a result of that funding.

Older adults often require someone to assist them in advocating for their needs and obtaining services. SWCAA’s Information Specialists provide assistance in meeting the needs of older adults who may be at risk of institutional placement by way of individual appointments, telephone or email conversations or community presentations. Informational topics include; available services and resources for the care recipient as well as specialized support services for the caregivers.

SWCAA continues to develop and maintain effective partnerships with organizations and providers who have dementia expertise and person-centered philosophy. The CHOICES 800 line along with direct staff extensions, provide streamlined access for both caregivers and clients, thus reducing the number of discouraging steps a caregiver may otherwise have to go through to obtain the information they are seeking.

We provide relevant referrals from agency to agency to ensure that information or assistance is received in a timely manner, as well as accepting reciprocal referrals regardless of how or where contact is made in the community (No Wrong Door).

c. Older individuals with limited English proficiency
The majority of SWCAA’s Title III grantees employ staff who are bi-lingual and many of them also provide materials in languages in addition to English. At least one grantee each in Bridgeport, Norwalk, and Stamford focus most of their grant services with non-English speaking older adults. SWCAA’s Bridgeport outreach worker is bi-lingual and works almost exclusively to assist minority and low-income older adults in Bridgeport.

Our Information Specialists provide callers who have limited English proficiency the option to use our translation service “Language Line”. Within the I&A Department, there are 2 staff members who are proficient in Spanish and assist with individuals who prefer to communicate in Spanish. Our website also has a language feature which will translate all webpages into 100+ languages.

d. Older individuals residing in rural areas
Some Easton residents receive Home Delivered Meals or attend congregate meal sites in other towns. SWCAA maintains a strong partnership with Easton’s Municipal Agent, providing support through enrollment events and presentations. Our Information Specialists also provide substantive support to the Municipal Agent on complex cases. SWCAA is developing and exploring new partnerships and technologies in order to better reach rural clients.

e. Older individuals with severe disabilities
Efforts to reach individuals with disabilities who receive Medicare but are under the age of 65 are made through partnerships, collaborations or presentations with Behavioral Health agencies; NAMI, Access Independence, or LifeBridge. Information Specialists provide relevant referrals from agency to agency to ensure that information or assistance
is received in a timely manner, as well as accepting reciprocal referrals regardless of how or where contact is made in the community (No Wrong Door).

III. Provide information on the extent to which the Area Agency on Aging has been successful in meeting the established targets for services to these populations.

a. Greatest economic need

<table>
<thead>
<tr>
<th></th>
<th>% SWCAA 60+ Population</th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMS 100% Poverty</td>
<td>7.36%</td>
<td>33%</td>
<td>32%</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>SAMS Near Poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHIP 150% FPL</td>
<td></td>
<td>38.9%</td>
<td>49%</td>
<td>49.8%</td>
<td>48.4%</td>
</tr>
</tbody>
</table>

b. Greatest social need

We are unable to obtain data from SAMS regarding the number of participants with disabilities or the number of participants with limited English proficiency.

<table>
<thead>
<tr>
<th></th>
<th>% SWCAA 60+ Population</th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMS Minority</td>
<td>21.6%</td>
<td>40%</td>
<td>39%</td>
<td>38%</td>
<td>37%</td>
</tr>
<tr>
<td>SAMS Poverty &amp; Minority</td>
<td>3.94%</td>
<td>21%</td>
<td>20%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>SHIP Minority</td>
<td>31%</td>
<td>40.1%</td>
<td>35.3%</td>
<td>36.5%</td>
<td></td>
</tr>
<tr>
<td>SHIP English not first language</td>
<td>21.6%</td>
<td>20.2%</td>
<td>19.8%</td>
<td>14.5%</td>
<td></td>
</tr>
</tbody>
</table>


c. Older individuals at risk for institutional placement

- We are unable to obtain information on this category from SAMS or SHIP data.
- The closest available SAMS category, At Risk, counts clients age 75 and over who need help with 2 or more ADL/IADLs.

<table>
<thead>
<tr>
<th></th>
<th>% SWCAA 60+ Population</th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMS At Risk</td>
<td>1.2%</td>
<td>55%</td>
<td>53%</td>
<td>55%</td>
<td>57%</td>
</tr>
</tbody>
</table>

- Additional clients served who would likely be at risk for institutional placement without community services could include: 1,282 average per year home delivered meal clients, 54 average per year clients who received homemaker services, 22 average per year clients who received home health aide services, 26 average per year clients who received Title III assistance to attend Adult Day Services, and 79 clients who received Title III case management.
- Through both the Statewide Respite and NFCSP, SWCAA has assisted 231 individuals to remain in their home with supportive services avoiding/delaying institutional placement.

d. Low-income minority older individuals

<table>
<thead>
<tr>
<th></th>
<th>% SWCAA 60+ Population</th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMS Poverty &amp; Minority</td>
<td>3.94%</td>
<td>21%</td>
<td>20%</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>SHIP Minority &amp; low income</td>
<td>13.8%</td>
<td>12.7%</td>
<td>9.2%</td>
<td>40.9%</td>
<td></td>
</tr>
<tr>
<td>SHIP Minority &amp; 150% of FPL</td>
<td>12.9%</td>
<td>8.7%</td>
<td>6.6%</td>
<td>17.2%</td>
<td></td>
</tr>
</tbody>
</table>
FY 17 (October 1, 2016 – March 31, 2017) Information and Assistance was provided to 1408 individuals in Bridgeport; 62.5% were below 150% of FPL, 44.5% language preference is other than English, 71% were a minority designation.

e. Older individuals with limited English proficiency

- We are unable to obtain information on this category from SAMS data.

<table>
<thead>
<tr>
<th></th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHIP English not first language</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% SWCAA 60+ Population</td>
<td>7.65%</td>
<td>21.6%</td>
<td>20.2%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

- Three of SWCAA’s grant programs serve exclusively Spanish-speaking older adults. The majority of SWCAA’s grant programs employ bi-lingual staff and serve both English speaking older adults and those with limited English proficiency.
- SWCAA’s Bridgeport Outreach Waiver employee is bi-lingual and the majority of older individuals she assists have limited English proficiency.
- FY 17 (October 1, 2016 – March 31, 2017) Information and Assistance was provided to 1408 individuals in Bridgeport; 62.5% were below 150% of FPL, 44.5% language preference is other than English, 71% were a minority designation.

f. Older individuals residing in rural areas

<table>
<thead>
<tr>
<th></th>
<th>FY17 Participants</th>
<th>FY16 Participants</th>
<th>FY15 Participants</th>
<th>FY14 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAMS Rural Residents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% SWCAA 60+ Population</td>
<td>1.32%</td>
<td>0.43%</td>
<td>0.43%</td>
<td>0.32%</td>
</tr>
</tbody>
</table>

- Four Adult Day programs who are State Alzheimer’s Aide grant recipients are able to provide services to additional older adults with irreversible and deteriorating dementia of the Alzheimer's type as a result of that funding.

- We are unable to obtain information on this category from SAMS or SHIP data.
- During the first half of FFY 2017, the SWCAA State Alzheimer’s Respite Program has served 180 clients. 16% of these clients are at or below the poverty level, 31% are minority and 46% are At Risk.
- Four Adult Day programs who are State Alzheimer’s Aide grant recipients are able to provide services to additional older adults with irreversible and deteriorating dementia of the Alzheimer's type as a result of that funding.

- We are unable to obtain information on this category from SAMS or SHIP data.
- During the first quarter of FFY 2017, Access Independence has served 48 disabled seniors through a Title III grant. 75% of those clients are classified in the SAMS At Risk category.
- Four Adult Day programs who are State Alzheimer’s Aide grant recipients are able to provide services to additional older adults with irreversible and deteriorating dementia of the Alzheimer's type as a result of that funding.
EXHIBIT I-4  Organizational Structure of the Area Agency on Aging

Instructions: Provide a graphic representation of the unit or multiple units, which have primary responsibility for Older Americans Act Programs or state-funded, State Unit on Aging Programs. Designate all Area Agency staff with an *.
EXHIBIT I-5  Job Descriptions of Area Agency Staff

Instructions: Attach job descriptions of Area Agency staff designated in the preceding exhibit.
SOUTHWESTERN CT AGENCY ON AGING  
JOB DESCRIPTION  
EXECUTIVE DIRECTOR

<table>
<thead>
<tr>
<th>Job Title: Executive Director</th>
<th>FLSA Status: Exempt, Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Administration</td>
<td>Reports to: Board of Directors</td>
</tr>
<tr>
<td>Effective Date: November 27, 2016</td>
<td></td>
</tr>
</tbody>
</table>

POSITION SUMMARY:
As a key member of the Southwestern CT Agency on Aging’s Management Team, the Executive Director acts as Chief Executive Officer and directs the operation of the organization under the direction of its governing body. The Executive Director has principal responsibility for all programmatic and financial operations. The Executive Director is responsible for building and maintaining strong relationships with State, Federal, local government and private funders and increasing the capacity of community partners including focal points in each municipality. The Executive Director is responsible for working with the Board of Directors to develop the strategic direction of the Agency. The Executive Director must implement Agency goals and achieve mission-based outcomes.

WORKING RELATIONSHIPS:
Reports directly to the Board President and members of the Personnel Committee. The Executive Director works with the Board to set overall organizational policies and priorities. Supervises all members of the Management team including Director of Care Management, Finance Director, , Director of Programs, Operations Director, Quality Assurance Manager, Executive Assistant and Grants Manager.

ROLES & RESPONSIBILITIES:
- Plans, develops and implements programs and activities which further the mission of the organization on behalf of the service area’s elderly residents. *
- Implements all of the functions and responsibilities of an Area Agency on Aging in accordance with the Older Americans’ Act and all applicable state and federal regulations and policies.*
- Seeks resources for the implementation of organizational goals.*
- Assure quality and integrity in all Agency programs and services.*
- Improve processes and service delivery to effectively impact mission.*
- Meets in full, all fiscal policies necessary for clean audits and funding reviews.*
- Makes periodic reports to the governing body on the activities and the fiscal status of the organization.*
- Efficiently operates all programs, projects and Agency affairs within the parameters of the Agency budget.*
- Advocates and educates legislators to keep them informed of the needs and opportunities within the aging network.*
- Strategically promotes the work of the Agency to the general public; maintain a presence with policy makers.*
- Recruits, retains and mentors staff; supervises and leads the Management Team.*
- Develop personnel policies and benefits package that increase loyalty and meet the needs of staff.*
- Represents the organization through public appearances and relevant committee participation.*
- Seeks knowledge in the field of gerontology and shares appropriate information.*
- Performs other related duties as assigned.

* indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Strong written and verbal communication skills
- Excellent organizational skills
- Leadership and supervisory experience
- Ability to motivate and influence others
- Strong financial and accounting acumen
- Computer proficiency

**QUALIFICATIONS:**  
Master’s Degree in Human Service, Public Administration, Business or related field. Minimum five years of progressive responsibility in a non-profit, social service agency. Proven fiscal and leadership capabilities.

**PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:**

- Standard office conditions, equipment and noise level present.
- Performs computer work and is expected to sit an average of five hours per day.
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
- Capable of presenting complex information in comprehensible format to both large and small groups.
- Must be able to sit and get in and out of a vehicle numerous times per day.
- Must travel by car throughout Fairfield County.
- Must be able to handle diverse work environments including visits in client’s homes.
EXECUTIVE ASSISTANT

POSITION SUMMARY:
As a member of the administrative team, the Executive Assistant performs administrative duties for the Executive Director and supervises the reception staff. The Executive Assistant is responsible for assisting with all contracts, State and Federal correspondence, personnel and Board communication. The position requires a high level of confidentiality and the ability to manage the work environment for the Director. Responsible for office management, employee events, contract support, calendar management, database management and correspondence. Utilizes project management and proof reading skills to assist in the completion of activities including grants and newsletter.

WORKING RELATIONSHIPS:
Reports directly to the Executive Director. Supervises the front desk and administrative staff to provide coverage for the reception area.

ROLES & RESPONSIBILITIES:
- Provide administrative support to the Executive Director:
  - Provide correspondence and presentation assistance to the Executive Director*
  - Assist in the research, proofreading and collation of grants and/or contracts*
  - Maintain Personnel files*
  - Track and log employee time records; send necessary information to Finance Director for completion of payroll*
  - Maintain annual agendas for staff and Board meetings*
  - Assemble and mail new hire folders*
  - Schedule office orientation for new hires*
  - First point of contact for orientation of new hires*
  - Supervise and manage all functions of receptionist*
  - Liaison for all office related repairs, safety issues, purchasing and building management*
  - Assist with coordination of all Board, Advisory and other Agency meetings*
  - Record minutes of Advisory Council meetings*
  - Assist with bulk mailing of newsletter*
  - Respond and refer computer and telephone issues to support as needed*
  - Assist in preparation of grants and attachments*
  - Performs other duties as assigned

* indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Ability to organize ideas, tasks and material expeditiously with clarity
- Ability to establish and maintain successful professional relationships
- Ability to work with minimum supervision
- Computer literate
- Ability to operate general office equipment
- Excellent verbal and written communication skills
• Excellent interpersonal skills

QUALIFICATIONS:
• High School graduate or equivalent
• Two years experience with administrative responsibilities
• High level of confidentiality

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:
• Standard office conditions, equipment and noise level present
• Performs computer work and is expected to sit at least 4 hours per day
• Ability to focus on a computer screen for long periods of time
• Ability to use standard office equipment including calculator/adding machine, copier, personal computer/laptop, printer, postage meter and fax machine
• Ability to follow written and verbal instructions
• Daily completion of numerous clerical tasks
• Must lift or move boxes of office supplies weighing a maximum of 25 pounds
• Ability to handle diverse populations (including non-English-speaking)
• Ability to display patience and empathy towards clients/providers/co-workers
• Ability to handle a stressful work environment
• Comfortable working with the public
• Must travel by car throughout Fairfield County
SOUTHWESTERN CONNECTICUT AGENCY ON AGING, INC.

JOB DESCRIPTION

RECEPTIONIST/ADMINISTRATIVE SUPPORT

<table>
<thead>
<tr>
<th>Job Title: Receptionist/Administrative Support</th>
<th>FLSA Status: Non-exempt, Hourly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Administration</td>
<td>Reports to: Executive Assistant</td>
</tr>
<tr>
<td>Effective Date: November 27, 2016</td>
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</tbody>
</table>

POSITION SUMMARY:
The Receptionist greets all incoming calls and visitors; receives and routes a high volume of calls through the switchboard; supplies information to callers, relays messages and announces visitors; and performs other administrative tasks.

WORKING RELATIONSHIPS:
Reports directly to the Office Manager, works closely with all staff to properly route incoming calls.

ROLES & RESPONSIBILITIES:
- Maintains positive attitude and demeanor while interfacing with visitors, staff and volunteers*
- Prepare and forward answering services messages to staff*
- Receives and effectively routes calls through the switchboard*
- Receives and effectively routes visitors to the Agency*
- Receives, sorts and distributes incoming and outgoing mail*
- Stamp all incoming checks and give to Finance on a daily basis*
- Maintains daily ‘in/out” board for all staff*
- Assists with Agency bulk mailings*
- Schedules meetings in outlook*
- Maintains company calendar for employee absence*
- Accept and electronically file 60 day reports for care management*
- Monitor compliance and follow up with requests for 60 day reports*
- Print and file all tools for reassessments*
- ERS test letters*
- Maintain absent logs for Adult Day Care and Meals on Wheels*
- Complete administrative tasks*
- Participates in training as deemed necessary*
- Performs all other duties as assigned

*Indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Excellent verbal communications skills
- Excellent interpersonal skills
- Ability to establish and maintain successful professional relationships
- Computer literate
- Ability to operate general office equipment
- Ability to multi-task

QUALIFICATIONS:
- High School graduate or equivalent
- Minimum one year experience operating telephone switchboard

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:
- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit at least 6.5 hours per day
- Ability to focus on a computer screen for long periods of time
- Ability to use standard office equipment including calculator, copier, personal computer, printer, postage meter and fax machine
- Ability to follow written and verbal instructions
- Daily completion of repetitious or clerical tasks
- Must be able to travel in diverse weather conditions
- Ability to handle diverse populations (including non-English-speaking)
- Ability to display patience and empathy towards clients/providers/co-workers
- Ability to handle a stressful work environment
**Job Description**

**Director of Finance**

**Position Summary**
As a member of the Senior Management Team, the Director of Finance participates in setting broad organizational fiscal goals, objectives and policies. The Director of Finance supports the Agency mission with oversight of all financial and accounting policies, systems and processes, tax and regulatory requirements and payroll systems. Responsible for financial strategy including budget development, financial risk analysis, fiscal reporting to funders and monitoring all financial processes. Responsible for all department systems.

**Working Relationships:** Reports directly to the Executive Director. Interacts with members of the Board and Finance Committee. Works with the accounting offices of providers, banking institutions, funders and others as needed. Supports the independent auditors. Supervises and mentors the Staff Accountant and the Benefits Coordinator; works closely with Operations.

**Roles & Responsibilities:**
- Responsible for accurate and efficient accounting and financial systems, policies and processes that meet the current and future business requirements of the Agency.*
- Ensure the Agency complies with all internal policies and relevant regulations and ensure filings and reports are completed in a timely manner.*
- Ensure the Agency complies with all federal and state regulations and reports are completed in a timely manner.*
- Provide oversight of the external audit process including all required support to the audit team.*
- Report to the Finance Committee and Board of Directors regarding financial position and finance strategies.*
- Prepare, present and revise all Agency budgets.*
- Oversee the cash forecast and banking relationships.*
- Maintains the General Ledger, performing analysis as needed.*
- Download the bi-monthly Remittance Advice.*
- Oversight of check requests, invoices into the general ledger, confirm allocations per the OPM standards & the CAP plan.*
- Oversight of check preparation for signature.*
- Reconcile all bank accounts.*
- Oversight to prepare monthly grant payments and records the expenditures in a funds accounting format.*
- Manage monthly closing, including preparation of Revenue Journal Entries.*
- Provide coaching, guidance and support; set professional development plans to assist employees to reach their full potential through the Performance-Based Management process.*
- Supervise the Accounting Assistant and manages the workflow for the Finance Department.*
- Prepare reports including (but not limited to) Respite, Grant projects and Veterans’ Program.*
- Oversee billing for the Respite Program and Veterans’ Program.*
- Performs other duties as requested.

* indicates essential function

**Knowledge, Skills and Abilities Required:**

QUALIFICATIONS:

Bachelor’s Degree in Accounting. Minimum of five years experience in finance and/or accounting office. Experience with nonprofits organizations preferred. Ability to strategize and evaluate systems and processes leading to organizational improvements. Strong computer skills, and knowledge of computer based general ledger systems.

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Standard office conditions, equipment and noise level present.
- Performs computer work and is expected to sit an average of six hours per day.
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
- Ability to handle a time-sensitive, stressful work environment.
- Advanced written and verbal communication abilities.
SOUTHWESTERN CT AGENCY ON AGING
JOB DESCRIPTION
STAFF ACCOUNTANT

Job Title: Staff Accountant
Department: Finance
Effective Date: November 28, 2016

FLSA Status: Non-Exempt, Salaried
Reports to: Director of Finance

POSITION SUMMARY
Position in the Finance Department working with accounting and financial systems. Maintains and controls the General Ledger Accounts of the organization, applying the Generally Accepted Accounting Principles (GAAP) that includes analytical work and thorough review of financial records.

WORKING RELATIONSHIPS: Reports directly to the Director of Finance. Works with the accounting offices of providers, banking institutions, and others as needed. Supports the independent auditors.

ROLES & RESPONSIBILITIES:
- Assist the Director of Finance with the daily, monthly and year-end operations of the Finance Department including grant management and budget review and analysis.*
- Provide support for the external audit process.*
- Audit check requests, inputs invoices into the general ledger, all entries are made with proper allocations per the OPM standards & the CAP plan.*
- Prepare checks for signature.*
- Prepare bank deposits*
- Maintains the General Ledger, performing analysis as needed.*
- Perform general account analysis and reconciliations, including bank statements, investment accounts, fixed assets, accruals and prepaid accounts.*
- Monitor, track and approve monthly grant payment requests.*
- Reconcile grantee budgets to TII requirements.*
- Maintain grant funding and carryover reporting schedule.*
- Responsible for the annual preparation of the State Project Report.*
- Prepare monthly grant payments and records the expenditures in a funds accounting format.*
- Prepare reports including (but not limited to) Respite, Grant projects and Veterans Program.*
- Complete billing for the Respite, National Family Caregiver Programs and Veterans Program.*
- Performs other duties as requested.*

* indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
Full knowledge of accounting principles, with an emphasis on Not-for-Profit Fund Accounting. Full understanding of Accounts Payable & Receivable systems. Strong knowledge of spreadsheet computer programs, and computer based accounting systems. Strong knowledge of general ledger accounting and maintenance. Supervisory experience required.

QUALIFICATIONS:
Bachelor’s Degree in Accounting. Minimum of five years experience in finance and/or accounting office. Experience with nonprofits organizations preferred. Ability to strategize and evaluate systems and processes leading to organizational improvements. Strong computer skills, and knowledge of computer based general ledger systems.
PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Standard office conditions, equipment and noise level present.
- Performs computer work and is expected to sit an average of six hours per day.
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
- Ability to handle a time-sensitive, stressful work environment.
- Advanced written and verbal communication abilities.
SOUTHWESTERN CT AGENCY ON AGING  
JOB DESCRIPTION  
PAYROLL AND BENEFITS COORDINATOR

<table>
<thead>
<tr>
<th>Job Title: Accounting Assistant</th>
<th>FLSA Status: Non-Exempt, Hourly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Finance</td>
<td>Reports to: Director of Finance</td>
</tr>
<tr>
<td>Effective Date: November 27, 2016</td>
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</tbody>
</table>

POSITION SUMMARY  
The Accounting Assistant reports to the Controller. Responsible for all aspects of SWCAA payroll. This position is responsible for coordinating employee Short Term Disability and Workers’ Compensation benefits. This is a part-time position.

ROLES & RESPONSIBILITIES:

- Manage the payroll function ensuring efficient systems, process and controls.*
- Assists in the monthly closing, including preparation of Payroll and 403-B Journal Entries.*
- Review and recommend insurance options annually.*
- Coordinate, track and monitor insurance benefits for all employees as it relates to payroll deductions*
- Report and manage Workers Compensation claims*  
- Report and manage Short Term Disability claims*  
- Manage Family and Medical Leave Act claims* 
- Primary contact for the Health Reimbursement Account* 
- Prepare annual census, Workers Compensation and other Department of Labor reports* 
- Review all Agency timesheets and PTO.*  
- Manage changes to employee 403-B, payroll, tax status, PTO, loans and garnishments*  
- Maintain an accurate database of all active and discharged employees with pertinent insurance and demographic information within ADP.*  
- Prepare and collect signatures for all required PAR timesheets.*  
- Performs other tasks as requested*

*Indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

Proven accounting and financial reporting ability. Extreme attention to detail and accuracy of data input. Experience in a computerized office environment. The ability to focus on repetitious detail. Strong verbal and written communication skills. Experience and knowledge in the management of insurance, Workers Compensation, employee benefit systems. Medicaid coding and billing experience. Strong computer skills.

QUALIFICATIONS:

High school diploma or equivalent. Knowledge and experience in payroll. Ability to communicate clearly with a diverse audience. Ability to work within a variety of software and computer environments. Ability to work independently as well as part of a team. Must maintain confidentiality in all aspects of work.
PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit an average of seven hours per day
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
- Ability to resolve conflicts in a professional environment
- Ability to handle a time-sensitive, stressful work environment
- Ability to carry up to 10 lbs.
**SOUTHWESTERN CT AGENCY ON AGING**

**JOB DESCRIPTION**

**GRANT PROJECT MANAGER**

<table>
<thead>
<tr>
<th>Job Title: Grant Project Manager</th>
<th>FLSA Status: Exempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Administration</td>
<td>Reports to: Executive Director</td>
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<tr>
<td>Effective Date: March 2017</td>
<td></td>
</tr>
</tbody>
</table>

**POSITION SUMMARY:**
As a key member of the Southwestern CT Agency on Aging’s Management Team, the Grant Project Manager is responsible for enhancing the Agency’s community presence and acting as a liaison between the Agency and the aging network. The position is responsible for meeting all grant allocation goals in the community, site visits, grantee monitoring and state reporting.

**WORKING RELATIONSHIPS:**
Reports directly to the Executive Director. The Project Manager works with the Executive Director, Grants Manager, Management Team and volunteers to set overall organizational policies and priorities. The position works closely with the Board’s Allocation Committee through the grants and site visit process. Works closely with the Staff Accountant on grant payments.

**ROLES & RESPONSIBILITIES:**
- Facilitate monitoring and mentoring for grantees*
- Manage the grant application process*
- Maintains and enhances relationships with community partners,*
- Monitor and oversee the Nutrition projects*
- Oversee the grant payment process with the Staff Accountant*
- Coordinate and submit all required State reports*
- Monitor spending in all Title III programs for compliance*
- Manage all required site visits in coordination with Board and Advisory leadership*
- Facilitate the grant application and evaluation process*
- Coordinate all necessary meetings for the review of grants*
- Coordinate communication with all prospective and current grantees*
- Mentor & Lead staff responsible to meet all contractual activities for the CDSMP and DSMP*
- Performs other related duties as assigned.

* Indicates essential function

**KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:**
- Strong written and verbal communication skills.
- Excellent organizational skills.
- Leadership and supervisory experience.
- Ability to motivate and influence others.
- Creativity and flexibility.

**QUALIFICATIONS:**
- Bachelor’s degree in Communication, Business, Public Health, Human Services or related degree.
- Five years experience working in management leadership with planning responsibilities.
PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Standard office conditions, equipment and noise level present.
- Performs computer work and is expected to sit an average of five hours per day.
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
- Must be able to sit and get in and out of a vehicle numerous times per day.
- Must travel by car throughout Fairfield County.
- Must be able to handle diverse work environments including visits in client’s homes.
SOUTHWESTERN CT AGENCY ON AGING  
JOB DESCRIPTION  
COMMUNITY HEALTH PROMOTER

<table>
<thead>
<tr>
<th>Job Title: Community Health Promoter</th>
<th>FLSA Status: Non-Exempt, Hourly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Finance</td>
<td>Reports to: Grants Project Manager</td>
</tr>
<tr>
<td>Effective Date: March, 2017</td>
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</tr>
</tbody>
</table>

POSITION SUMMARY
The Community Health Promoter reports to the Grants Project Manager. This position is responsible for meeting or exceeding the deliverables outlined in the Chronic Disease Self Management and the Diabetes Management contracts.

ROLES & RESPONSIBILITIES:
The Community Health promoter identifies community volunteers interested in serving as Leaders to present evidence-based programs targeting older adults to help combat chronic disease. The employee is responsible for locating potential sites to present the program and for recruiting participants from the community at-large. The position requires training to a mastery level in both the CDSMP and DSMP programs.

- Coordinate Four DSMP workshops per contract year with a target of 40 course completers (June 30 – June 29)*
- Recruit a minimum 56 participants for the Six CDSMP workshops per contract year (October 1 – September 30)*
- Recruit a minimum of Six English speaking and Two Spanish speaking Leaders per contract year and have them complete the Leader training*
- Coordinate one Leader Refresher Course each year; encourage participation from all Leaders
- Achieve and maintain Mastery level trainer status for both CDSMP and DSMP programs*
- Coordinate all classes, provide marketing assistance to host sites and ensure that all materials are available for workshops*
- Monitor program fidelity by attending one session of each workshop*
- Maintain required records including attendance records and questionnaires; enter information in the NCoA system*
- Participate in statewide collaboration meetings *
- Encourage and maintain new partnerships with hospitals, employers and community groups to raise awareness, identify host sites and recruit participants*
- Prepare and distribute annual reports as required by contractor*
- Maintain quality records of trainers and workshops; manage data entry as directed by funder*
- Explore the expansion of the evidence-based program to medium-large employers, hospitals and other innovative locations in southwestern Connecticut
- Performs other duties as requested*

*Indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
Knowledge and interest in health promotion. Marketing and outreach capabilities. Ability to work within a variety of software and computer environments. Ability to work independently as well as part of a team. Able to build strong relationships with community organizations and volunteers

QUALIFICATIONS:
High school diploma or equivalent. Proven experience in health promotion, volunteer management and/or marketing.

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit an average of seven hours per day
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
- Ability to resolve conflicts in a professional environment
- Ability to handle a time-sensitive, stressful work environment
- Ability to carry up to 10 lbs.
**SOUTHWESTERN CONNECTICUT AGENCY ON AGING, INC.**

**JOB DESCRIPTION**

**NUTRITION EDUCATOR**

<table>
<thead>
<tr>
<th>Job Title: Nutrition Educator</th>
<th>FLSA Status: Non-Exempt, Salary</th>
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<tbody>
<tr>
<td>Department: Grants Department</td>
<td>Date: October 1, 2017</td>
</tr>
<tr>
<td>Reports to: Grants Project Manager</td>
<td></td>
</tr>
</tbody>
</table>

**POSITION SUMMARY:**

The Nutrition Educator is a part-time exempt (20 hours per week) position responsible for educating participants of the Title III home-delivered meal program. The Educator utilizes a series of face-to-face, telephone and program monitoring tools to educate participants about good nutrition and prioritize participants for assessment and counseling services provided by the regions two Elderly Nutrition Providers. The Educator reports to the Grants Project Manager and has frequent contact with the Providers.

**ROLES & RESPONSIBILITIES:**

- Develop and maintain a system for face-to-face education as needed*
- Develop and maintain a system of telephone contact for at least 30 clients per month*
- Make appropriate referrals for nutrition assessment and counseling *
- Receive and distribute educational materials and learning objectives from Nutrition Providers *
- Enter new consumers in SAMS and assign service definitions as appropriate*
- Maintain accurate and timely data in SAMS to maintain client records*
- Provide monthly report on records review and assessments to Supervisor*
- Maintain appropriate case notes and records for nutrition services*
- Other duties as assigned by the Supervisor *

* Indicates essential function

**KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:**

- Experience working with seniors and aging network service providers
- Prior knowledge and experience with entitlement and community-based programs and services
- Ability to work independently and as a team player
- Ability to use independent judgment, decision making and prioritizing tasks
- Ability to relate to diverse populations
- Organizational and time management skills
- Computer literate including knowledge of Excel and Access.
- Knowledge of Gerontology and community resources for senior adults
- Verbal and in written communication skills

**QUALIFICATIONS:**

- Dietary Technician required; Registered preferred
- At least two years of geriatric and/or community-based social services experience

**PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:**

- Perform computer work and is expected to sit an average of five hours per day
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
• Must be able to sit and get in and out of a vehicle numerous times per day
• Must travel by car throughout Fairfield County
• Must be able to handle diverse work environments including visits in client’s homes
• Must be able to climb stairs as needed to complete client visits.
• Must be able to handle diverse populations such as disabled or non-English speaking
• Ability to display patience and empathy toward client
• Ability to problem solve and/or resolve conflicts with clients and community services
• Ability to handle a time-sensitive, stressful work environment
• Ability to meet deadlines and prioritize tasks
**Job Title:** Grants Manager

**FLSA Status:** Exempt, Salary

**Department:** Title III

**Reports to:** Marie Allen, Executive Director

**Effective Date:** November 27, 2016

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**POSITION SUMMARY:**
As a key member of the Southwestern CT Agency on Aging’s Management Team, the Grants Manager is responsible for managing the process of awarding federal Older Americans Act funds and matching state and agency funds to local service providers. Responsibilities include ensuring that the process meets all federal and state regulatory requirements; ensuring that all grantees meet regulatory, financial, and programmatic requirements; providing technical support to grantees and prospective applicants; and working with others in the development of new programs and services.

**WORKING RELATIONSHIPS:**
The position reports directly to the Executive Director. The position is responsible for the direct supervision of the MIS & Grants Assistant. The Grants Manager provides staff support on the Allocation Committee and works closely with the nutrition providers. The Grants Manager presents all relevant information to the Board and Advisory Council.

**ROLES & RESPONSIBILITIES:**
- Creates, updates, produces, and distributes funding application materials*
- Provides technical assistance to potential applicants *
- Reviews and processes Letters of Intent and applications*
- Monitors all grants for fiscal and program compliance*
- Conducts on-site visits and program evaluations*
- Authorizes grant payments as appropriate*
- Provides training and technical assistance to grantees as needed*
- Coordinates the allocation process including budget projections, site visits, board and advisory participation and regulatory compliance*
- Prepares and distributes grant award documents*
- Provides required reports to the State Unit on Aging.*
- Works with the Finance department to monitor grantee spending and ensure <15% carry over in each funding type*
- Participates in statewide grant-related committees*
- Participates in area or agency committees planning for or developing new programs and services.*
- Acts as the liaison to the Advisory Council to better understand the community needs*
- Contributes to the Area Plan and follow up reports*
- Performs other duties as requested by the Executive Director.

* indicates essential function

**KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:**
- Knowledge of Older Americans Act, federal and state regulations, and ability to implement these in grant process.
- Ability to monitor, organize, and review paperwork requirements of grants and provide required reports to the State Unit on Aging.
- Ability to understand budgets, provide technical assistance regarding financial reporting to grantees, monitor financial reports, and manage payment system.
• Knowledge of program evaluation processes and ability to evaluate grantees for compliance and program performance.
• Ability to work with grantees and prospective applicants to assist them to provide quality programs within funding guidelines.

QUALIFICATIONS:

• Bachelor’s degree in business, social work, public administration, or similar degree.
• Individual must possess a minimum of five years combined senior management and/or program management and budgeting experience in a multi-faceted, diverse, organization.
• Experience with geriatric populations, advocacy and/or nonprofits preferred.

Physical and Mental Requirements and Working Conditions:

• Standard office conditions, equipment and noise level present.
• Performs computer work and is expected to sit an average of seven hours per day.
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
• Must be able to sit and get in and out of a vehicle numerous times per day.
• Must travel by car throughout Fairfield County.
• Must be able to work with diverse populations such as disabled or non-English speaking.
• Ability to resolve conflicts both inter-departmental and client/community services.
• Ability to handle a time-sensitive, detail-oriented work environment.
POSITION SUMMARY:
The Grants Assistant is responsible for maintaining the state-required Management Information System (MIS) database, including working with grantees to obtain accurate data. The Grants Assistant also provides general administrative support to the grants office and may be required to assist in providing administrative support for the overall agency.

WORKING RELATIONSHIPS:
Reports directly to the Grants Manager. May work with other members of support staff to assist in data entry requirements including waiver information and providing general administrative support for the agency. Liaison with the State’s MIS Coordinator.

ROLES & RESPONSIBILITIES:
- Manage MIS database in format required by the State of Connecticut *
- Assure database is accurate and all information entered in a timely manner *
- Work with grantees to train them on MIS reporting and troubleshoot problems *
- Extract necessary reports and data from MIS system *
- Act as liaison between state database staff and all SWCAA staff who utilize the database.*
- Provide Agency support for reception desk coverage, set up and preparation for meetings, as requested *
- Performs all other duties assigned

* indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Knowledge of and experience with general office computer programs
- Skill with data entry and database management
- Good organizational and written communication skills
- Communicate in a professional manner with all stakeholders

QUALIFICATIONS:
- Associate Degree
- Minimum of two years experience using a data base and other office systems
- Experience in customer service and administrative responsibilities

PHYSICAL AND MENTAL REQUIREMENTS
- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit at least 7 hours per day
- Ability to focus on numbers for long periods of time
- Ability to focus on a computer screen for long periods of time
- Ability to use standard office equipment including calculator/adding machine, copier, personal computer/laptop, printer and fax machine
- Ability to follow written and verbal instructions
- Must lift or move boxes of office supplies weighing a maximum of 25 pounds
SOUTHWESTERN CT AGENCY ON AGING

JOB DESCRIPTION

PROGRAM DIRECTOR

Job Title: Program Director  FLSA Status: Exempt, salary
Department: Information & Assistance  Reports to: Marie Allen, Executive Director
Effective Date: November 27, 2016  

POSITION SUMMARY:
As a key member of the Southwestern CT Agency on Aging’s Management Team, the Program Director is responsible for planning, administering and monitoring the activities of the CHOICES program, Title III elder abuse funds, SMP, Nutrition Assessment, National Family Caregiver and CT Respite Care Programs. The Program Director reports on appropriate Area Plan requirements; participates in planning, program development, needs assessments, and special projects.

WORKING RELATIONSHIPS:
The position reports to the Executive Director. The position is responsible for the direct supervision of the Information Specialists, Outreach Coordinator, Respite Care Manager and the Nutrition Assessment Coordinator. The Program Director must work closely with community Aging and Disability Resource Partners to ensure education, information and support of all aging issues. The Program Director presents all relevant topics to the Board of Directors and the Advisory Council.

ROLES & RESPONSIBILITIES:
- General administrative oversight for the CHOICES Program and Information Services*
- Directs, supervises and mentors the Information Specialists, NFCSP/Respite Care Manager, SMP Coordinator, Aging and Disability Resource Coordinator and Administrative Assistant*
- Directs, supervises and mentors the Nutrition Assessment Coordinator*
- Represents SWCAA at statewide meetings for State and Federally funded programs*
- Assists in carrying out and monitoring the contract requirements for CHOICES, SMP, ADRC and the Title III caregiver and elder abuse funds*
- Accountable for planning, supervising and meeting the contract requirements of the National Family Caregiver Support Program and the Statewide Respite Program*
- Responsible for overseeing training for Information Services staff*
- Responsible for updating and maintaining the information on the website related to community services*
- Lead staff member on elder abuse prevention issues at the local and statewide level *
- Monitors Area Plan requirements and progress for programs listed above*
- Participates in the coordination and the evaluation the Needs Assessments *
- Presents findings to the community and SWCAA’s Board and Advisory Committees*
- Actively participates in all management meetings and works to develop and implement agency strategic goals*
- Performs other duties as requested by the Executive Director

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Knowledge of Older Americans Act, federal and state regulations, Medicare/Medicaid regulations and/or challenges facing the senior population
- Computer proficiency in Microsoft Office software
- Knowledge of the aging population and aging network
- Staff management and leadership expertise
- Verbal and written communication skills
- Organizational and time management skills
• Critical thinking and long-term planning skills

QUALIFICATIONS:

• Preferred Master’s Degree in Social Work and/or Community Services or related field
• Individual must possess a minimum of five years combined senior management and/or program/project management experience in a multi-faceted, diverse, senior or community-based organization
• Experience with geriatric populations, advocacy and/or nonprofits preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

• Standard office conditions, equipment and noise level present.
• Performs computer work and is expected to sit an average of seven hours per day.
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary.
• Must be able to sit and get in and out of a vehicle numerous times per day.
• Must travel by car throughout Fairfield County.
• Must be able to work with diverse populations such as disabled or non-English speaking.
• Ability to resolve conflicts both inter-departmental and client/community services.
• Ability to handle a time-sensitive, detail-oriented work environment.
The Administrative Assistant provides administrative support to Director of Programs and Program Department. The role includes answering phones to department triage calls and communicating with staff and volunteers responsible for information and assistance to the region’s elder population. The position is responsible for accurate data entry, filing, scheduling and planning of meetings, trainings and community events as required. Reports directly to the Director of Programs.

**ROLES & RESPONSIBILITIES:**

- Triage departmental calls; distribute and provide assistance as needed*
- Prepare, compile and sort documents for data entry*
- Transcribe information into required electronic format, computer data base(s), files and forms*
- Verify data by reviewing, correcting, deleting, or reentering data; combining data from multiple systems when information is incomplete; purging files to eliminate duplication of data*
- Develop user-friendly system to gather maximum information from submitters*
- Generate monthly and quarterly statistics for mandatory reports *
- Scan documents if necessary into document management systems or databases*
- Maintain logbooks or records of activities and tasks in multiple formats*
- Respond to requests for information and retrieve relevant files when requested*
- Comply with data integrity, data entry requirements and security policies*
- Maintains customer confidence and protects operations by keeping information confidential*
- Assist and mentor new and experienced CHOICES Counselors to enhance community reporting*
- Assist in distributing reports, newsletters and resource guides*
- Schedule meetings for Program Director *
- Assist staff and Program Director with special events*
- Compile information packets for staff updates and trainings*
- Monitor inventory, order supplies and materials as needed*
- Proofread reports, newsletter, web materials, etc., for accuracy*
- Analyze data reports to identify trends and support efficient management practices*
- Performs related responsibilities as required*

**KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:**

- Ability to learn and relay information on programs and services for older adults
- Ability to multi-task and prioritize tasks
- Excellent organizational and time management skills
- Problem solving skills
- Excellent verbal and written communication skills
- Ability to work independently as well as with a team
- Expert in database systems (entry and maintenance)
- Expert in all Microsoft Office applications including, Word, Excel, Publisher, PowerPoint and Outlook
QUALIFICATIONS:

- Associate’s Degree in Administrative Services with at least three years administrative experience.

PHYSICAL AND MENTAL REQUIREMENTS

- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit at least 7 hours per day
- Ability to use standard office equipment including calculator/adding machine, copier, personal computer/laptop, printer and fax machine
- Ability to follow written and verbal instructions
- Must lift or move boxes of office supplies weighing a maximum of 25 pounds
- Must be able to process and retain information
- Must be able to present information in an acceptable manner to an individual or a group of individuals
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
- Ability to display patience and empathy toward clients
- Ability to work with diverse populations
**OUTH WESTERN CONNECT ICUT AGENCY ON AGING, INC.**

**JOB DESCRIPTION**

**INFORMATION SPECIALIST**

<table>
<thead>
<tr>
<th>Job Title: Information Specialist</th>
<th>FLSA Status: Non-Exempt, Salary</th>
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<tbody>
<tr>
<td>Department: I &amp; A</td>
<td>Reports to: Program Director</td>
</tr>
<tr>
<td>Date: November 27, 2016</td>
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**POSITION SUMMARY:**
The Information Specialist is responsible for providing information, enrollment and application assistance, outreach and navigation assistance to support older adults. The position includes telephone and face-to-face counseling as well as community presentations. Position requires advanced competency in benefits counseling, thorough knowledge of local, state and federal programs. Reports to the Director of Programs.

**WORKING RELATIONSHIPS:** Reports directly to the Program Director

**ROLES & RESPONSIBILITIES:**

- Provide information and referral assistance to interested individuals and professionals on aging, disability and long term care related issues over the phone, in person, or via email including but not limited to individual counseling sites and through educational presentations.*
- Conduct detailed assessment and provide assistance and referrals to older and disabled adults and their caregivers over the phone and in person in order to link them to appropriate benefits and services.*
- Offer timely and appropriate responses and referrals to individuals in crisis.*
- Offer detailed information and active assistance to caregivers and other callers with options related to Medicare as well as all other federal, state and local assistance programs.*
- Keep current on all issues related to Medicare program, state benefits and Medicare fraud.*
- Conduct outreach and presentations to all 14 towns served, promoting all SWCAA programs and services, determined by the community’s needs which may occur during non-traditional work hours.*
- Keep accurate and detailed records in multiple formats as required by each funding source; confirm information for accuracy.*
- Screen and facilitate Senior Housing Assistance/Critical Needs funds; complete reports per directions.*
- Submit Client Contact forms on a weekly basis.*
- Input PAMS on a monthly basis.*
- Maintain AIRS certification by completing required re-certification trainings.*
- Provide timely reports to meet all funder requirements.*
- Perform other duties as requested.*

*indicates essential function

**KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:**

- Knowledge of and experience with aging and long-term options services, programs and issues including detailed knowledge of caregiver issues and services.
- Direct experience in human services with an emphasis on the elderly
- Strong ability to interview and counsel with empathy
• Strong verbal and written communication skills needed
• Computer proficient in all Microsoft Office applications
• AIRS Certification (Aging Specialty)
• Bilingual (Spanish speaking) a plus

QUALIFICATIONS:

• Bachelor’s Degree in Human Services or related field a must.
• An Associate's degree with at least three years’ experience in the aging network can be substituted for Bachelor's degree.
• Valid CT Driver’s license and reliable transportation
• Maintain/obtain AIRS certification by completing required online training and/or recertification trainings
• Maintain/obtain CHOICES Certification
• Basic computer proficiency
• Bilingual English/Spanish preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

• Must be skilled in accessing information on and keeping current regarding the wide variety of aging, long-term care and caregiver issues and services.
• Must be able to present information in a comfortable, professional manner to an individual or a group of individuals.
• Must have skills directly related to working with caregivers.
• Ability to work with computer software and at times sit an average of five hours per day
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
• Must be able to sit and get in and out of a vehicle
• Must travel by car throughout Fairfield County
• Must be able to handle diverse work environments
• Must be able to climb stairs as needed to conduct outreach and education
• Must be able to handle diverse populations such as disabled or non-English speaking
• Ability to display patience and empathy toward client
• Able to lift 10 lbs.
POSITION SUMMARY:
The Caregiver Information Specialist is responsible for providing information, assistance, outreach and education over the phone and in person. Position requires advanced competency in benefits counseling, thorough knowledge of local, state and federal programs. Assistance in carrying out the contract requirements of CHOICES/ SMP programs. Reports to the Director of Programs.

WORKING RELATIONSHIPS: Reports directly to the Program Director

ROLES & RESPONSIBILITIES:
• Provide information and referral assistance to interested individuals and professionals on aging, disability and long term care related issues over the phone, in person, or via email including but not limited to individual counseling sites and through educational presentations*
• Conduct detailed assessment and provide assistance and referrals to older and disabled adults and their caregivers over the phone and in person in order to link them to services*
• Offer timely and appropriate responses and referrals to individuals in crisis. *
• Offer detailed information and active assistance to caregivers and other callers with options related to Medicare as well as all other federal, state and local assistance programs. *
• Keep current on all issues related to Medicare program, state benefits and Medicare fraud. *
• Conduct outreach and presentations to all 14 towns served, promoting all SWCAA programs and services, determined by the community’s needs which may occur during non-traditional work hours
• Keep accurate and detailed records in multiple formats as required by each funding source; confirm information for accuracy*
• Input all SHIP client contacts on a weekly basis *
• Maintain AIRS certification by completing required re-certification trainings *
• Provide timely reports to meet all funder requirements. *

• SMP Volunteer Coordinator
  o Enter data into SIRS database for SMP program and print reports as needed*
  o Recruit and train SMP volunteers following SMP VPRM program guidelines*
  o Coordinate SMP outreach and Education activities between staff and volunteers*
  o Work with Regional SMP Coordinator to meet all contract deliverables*
  o Send updates to SMP Counselors via email, fax and/or regular mail*
  o Maintain inventory and order all SMP materials including brochures, applications, educational materials and promotional items as needed*
  o Perform filing and other duties for SMP*
  o Perform other duties as requested*

* -indicates essential function
KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

- Knowledge of and experience with aging and long-term options services, programs and issues including detailed knowledge of caregiver issues and services.
- Direct experience in human services with an emphasis on the elderly
- Strong ability to interview and counsel with empathy
- Strong verbal and written communication skills needed
- Computer proficient in all Microsoft Office applications
- Bilingual (Spanish speaking) a plus

QUALIFICATIONS:

- Bachelor's Degree in Human Services or related field a must.
- An Associate's degree with at least three years experience in the aging network can be substituted for Bachelor's degree.
- Maintain/obtain AIRS certification by completing required online training and/or re-certification trainings
- Maintain/obtain CHOICES Certification
- Basic computer proficiency
- Bilingual English/Spanish preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Must be skilled in accessing information on and keeping current regarding the wide variety of aging, long-term care and caregiver issues and services.
- Must be able to present information in a comfortable, professional manner to an individual or a group of individuals.
- Must have skills directly related to working with caregivers.
- Ability to work with computer software and at times sit an average of five hours per day
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
- Must be able to sit and get in and out of a vehicle
- Must travel by car throughout Fairfield County
- Must be able to handle diverse work environments
- Must be able to climb stairs as needed to conduct outreach and education
- Must be able to handle diverse populations such as disabled or non-English speaking
- Ability to display patience and empathy toward client
- Able to lift 10 lbs.
**Job Title:** Community Outreach Worker  
**FLSA Status:** Non-Exempt, Hourly  
**Department:** Program  
**Reports to:** Program Director  
**Effective Date:** November 27, 2016

**LOCATION:** SWCAA primarily with rotating locations at Bridgeport Housing Communities. Senior Centers and Social Service Agencies.

**POSITION SUMMARY:**
The Community Outreach Worker is responsible to conduct outreach activities, greet and screen clients seeking services, conducting program eligibility and assessment, identify community resources, provide information and referral services, provide advocacy and emergency services, and program recordkeeping. This position requires the ability to work with low-income populations, meet monthly goals, exercise good judgment, and coordinate with a wide range of service organizations. The types and number of programs vary by location and may include homeless services, emergency services, weatherization services, employment and training, and other special projects.

**WORKING RELATIONSHIPS:** Reports directly to the Program Director

**ROLES & RESPONSIBILITIES:**

- Recruit targeted individuals for program participation, workshops, community meetings, surveys, and other activities by developing and distributing outreach materials, directly contacting targeted community members, networking with appropriate community organizations and forging strong relationships with Resident Services Coordinators/Managers and Senior Center Directors.*
- Greet clients seeking services; orient customers to and assist with a core set of self-service resources; perform initial customer screening including suitability and eligibility; provide program information; and conduct group and individual learning sessions to help the community understand resources.*
- Conduct home/community visits*
- Conduct outreach and presentations to all 14 towns served, promoting all SWCAA programs and services, determined by the community’s needs which may occur during non-traditional work hours *
- Complete participant records and maintain confidentiality and HIPPA standards to include eligibility documents, assessment forms, information and referral logs, surveys, and other records as assigned. Respond to clients’ requests for assistance by assessing service needs and providing direct intervention, information, and referral services as appropriate. Follow-up on referrals in order to assess outcomes and provide additional services as required.*
- Provide participant advocacy services to assist participants in receiving needed services and to develop additional resources for services. *
- Coordinate with other internal and external staff and programs so that opportunities for participants can be maximized. This program supplements existing City resources. *
- Maintain close professional relationships and acts as the liaisons with Bridgeport’s aging network staff. Make presentations regarding the services of assigned programs to ensure that appropriate referrals are made to state and federal programs, respond to agency inquiries concerning services to low-income and minority participants, and attend workshops and conferences as appropriate to maintain knowledge of issues facing client base.*
- Utilize SWCAA’s resource file of available social service agencies and assistance providers in the target area for use in referring customers for services and benefits *
• Submit client contact forms on a weekly basis
• Input PAMS on a monthly basis

* -indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

• Experience working with seniors, persons with disabilities and aging network service providers
• Ability to learn and implement principal practices of community based health and social service delivery systems
• Proficiency with basic computer software programs; able to track and manage information
• Ability to learn State and federal financial requirements including Title 19; Title 18 and other insurance program and payer sources
• Ability to obtain a comprehensive understanding of psychosocial, physical, environmental, spiritual, and emotional needs, concerns and issues related to the client population
• Ability to work independently and as a team player and to form strong professional relationships
• Ability to utilize critical thinking skills, advocacy and professional judgment
• Ability to relate to diverse populations in a variety of living environments
• Strong organizational and time management skills
• Ability to process and retain large amounts of complex information
• Knowledge of Gerontology and community resources for senior adults
• Strong verbal and written communication skills

QUALIFICATIONS:

• BA/BS required. Human Service degree or related discipline preferred.
• Experience in Geriatric population or community –based service delivery system
• Valid CT Driver’s license and reliable transportation
• Maintain/obtain AIRS certification by completing required online training and/or re-certification trainings
• Maintain/obtain CHOICES Certification
• Basic computer proficiency
• Bilingual English/Spanish preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

• Perform computer work and is expected to sit an average of five hours per day
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
• Must be able to sit and get in and out of a vehicle numerous times per day
• Must travel by car throughout Fairfield County
• Must be able to handle diverse work environments including visits in client’s homes
• Must be able to climb stairs as needed to complete client visits
• Ability to use standard office equipment including calculator/adding machine, copier, personal computer/laptop, printer, fax machine, projector.
• Must lift or move boxes of supplies weighing a maximum of 25 pounds
• Must be able to present information in an acceptable manner to an individual or a group of individuals
• Ability to work with a diverse population
SOUTHWESTERN CONNECTICUT AGENCY ON AGING, INC.

JOB DESCRIPTION

SPECIALIZED CARE MANAGER

<table>
<thead>
<tr>
<th>Job Title: Specialized Care Manager</th>
<th>FLSA Status: Salary Non-Exempt</th>
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<tbody>
<tr>
<td>Department: Program Department</td>
<td>Reports to: Program Director</td>
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<tr>
<td>Date: November 27, 2016</td>
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POSITION SUMMARY:
The Special Projects Care Manager is responsible to administer all key elements of care management for the Statewide Alzheimer’s Respite Program, the National Family Caregiver’s Program, the Veterans’ Self Directed Home & Community Based Services Program and the MS Society. This is a middle management position working in concert with the Program Director to support the goals of the Department.

WORKING RELATIONSHIPS:
The position reports to Program Director while working in collaboration with the Program Department staff and administrative support to meet all responsibilities.

ROLES & RESPONSIBILITIES:
- Responds to applications and performs assessment of Statewide Alzheimer’s Respite Program, the National Family Caregiver’s Program, the Veterans’ Self Directed Home & Community Based Services Program and the MS Society clients.*
- Assists caregivers and/or clients with application process; provides clear, accurate description of program guidelines and eligibility requirements.*
- Develops and monitors plan of care for all clients.*
- Maintains accurate client care notes and service utilization reports.*
- Maintains accurate service authorization and enters information in the approved data system; works with Finance staff as necessary to facilitate billing.*
- Assess needs and coordinate services on clients’ behalf including referrals to community resources*
- Develops and maintains professional relationship with all agency staff, clients and providers. *
- Provides information and referral for CHCPE or Title III services as appropriate.*
- Conduct home-visits as required to evaluate the efficacy of the care plan.*
- Manage all contract deliverables including surveys, reports and funder requests for additional information.*
- Provides program information to supplement the Area Plan Progress Report.*
- Attends appropriate workshops, meetings and conferences to enhance knowledge and skills.*
- Represents SWCAA as point of contact for Veterans, National Family Caregiver, Respite and MS Society contracts.*
- Other duties as assigned *

* Indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Experience working with seniors, caregivers and aging network service providers in a care management capacity
- Ability to obtain a comprehensive understanding of psychosocial, physical, environmental, spiritual and emotional needs of clients and their caregivers.
- Knowledge of Gerontology and community resources for senior adults.
• Prior knowledge and experience in meeting grant deliverables include accurate, concise program reporting.
• Attention to detail required to ensure accurate billing and service authorizations
• Ability to work independently and as a team player
• Ability to use independent judgment, decision making and prioritizing tasks
• Ability to relate to diverse populations in a variety of living environments
• Strong organizational and time management skills
• Global thinking to align Department and Agency goals
• Proficient in Microsoft Office applications
• Strong verbal and written communication skills.

QUALIFICATIONS:

• BA/BS in nursing, social work or a related discipline
• Two years of geriatric assessment experience preferred
• Previous experience in the aging network preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

• Perform computer work and is expected to sit an average of five hours per day
• Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
• Must be able to sit and get in and out of a vehicle numerous times per day
• Must travel by car throughout Fairfield County
• Must be able to handle diverse work environments including visits in client’s homes
• Must be able to climb stairs as needed to complete client visits.
• Must be able to handle diverse populations such as disabled or non-English speaking
• Ability to display patience and empathy toward client
• Ability to problem solve and/or resolve conflicts with clients and community services
• Ability to handle a time-sensitive, stressful work environment
• Ability to meet deadlines and prioritize tasks
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SOUTHWESTERN CONNECTICUT AGENCY ON AGING, INC.

JOB DESCRIPTION
RESPITE CARE ASSOCIATE

Job Title: Respite Care Associate FLSA Status: Non Exempt
Department: Information Services Reports to: Program Director
Date: May, 2016

POSITION SUMMARY:
The Respite Care Associate is responsible for the assessment and monitoring of appropriate respite care services through the Connecticut Statewide Respite Care Program and the National Family Caregiver Support Program. The position is responsible for monitoring the care plans of Alzheimer’s Respite clients and managing the service authorization process. Knowledge of other populations and care management to support the work of the Program Department. Works collaboratively and supports the workload with the Specialized Care Manager.

WORKING RELATIONSHIPS:
Reports directly to the Program Director with oversight from Specialized Care Manager. Works in collaboration with Information Specialists and Finance staff.

ROLES & RESPONSIBILITIES:

- Assists client/caregiver with application process; provides clear, accurate description of program guidelines and eligibility requirements *
- Assess needs and coordinate services on clients’ behalf including referrals to community resources *
- Support all Department programs (MS, Veterans) when appropriate*
- Assist with annual reassessments on clients and adjust plan of care as necessary*
- Develops and monitors plan of care for clients in collaboration with caregiver and Specialized Care Manager*
- Maintain program timelines as directed by the Specialized Care Manager*
- Support client/caregiver with follow-through regarding recommendations*
- Authorize and change Service Orders as needed*
- Maintains accurate client care notes including vital information for all reports *
- Document client interactions including quarterly phone calls*
- Make referrals to appropriate programs/services as needed*
- Coordinate surveys and mailings on quarterly basis *
- Responsible for re-certifications*
- Conduct quarterly phone calls to all active clients to evaluate the need for additional services.
- Assist with information and data for the biannual and quarterly reports as required by State contract*
- Develops and maintains professional relationship with all agency staff, clients and providers.*
- Provides information and application assistance for CHCPE as appropriate*
- Review and reconcile billing *
- Track and monitor annual costs in collaboration with Specialized Care Manager*
- Attend appropriate workshops, training and conferences to enhance knowledge and skills regarding Alzheimer’s Disease, dementia, caregiver issues in compliance with State contract and improve evaluation and assessment skills*
- Other duties as assigned

* Indicates essential function
KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

- Experience working with seniors and aging network service providers in a care management capacity
- Prior knowledge and experience maintaining compliance with various funding sources.
- Understanding caregiver issues.
- Ability to work independently and as a team player
- Ability to use independent judgment, decision making and prioritizing tasks.
- Ability to obtain a comprehensive understanding of psychosocial, physical, environmental, spiritual and emotional needs of clients and their caregivers.
- Ability to relate to diverse populations in a variety of living environments
- Strong organizational and time management skills
- Proficient in Microsoft Office applications
- Knowledge of Gerontology and community resources for senior adults.
- Strong verbal and written communication skills.

QUALIFICATIONS:

- BA/BS in nursing, social work or a related discipline
- Two years of geriatric assessment experience preferred
- Previous experience in the aging network preferred

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:

- Perform computer work and is expected to sit an average of five hours per day
- Ability to use standard office equipment including calculator, copier, fax machine, lap top, personal computer, printer and other equipment as necessary
- Must be able to sit and get in and out of a vehicle numerous times per day
- Must own a vehicle and maintain insurance to travel to client home visits
- Must be able to handle diverse work environments including visits in client’s homes
- Must be able to climb stairs as needed to complete client visits.
- Must be able to handle diverse populations such as disabled or non-English speaking
- Ability to display patience and empathy toward client
- Ability to problem solve and/or resolve conflicts with clients and community services
- Ability to handle a time-sensitive, stressful work environment
- Ability to meet deadlines and prioritize tasks
WEBSITE COORDINATOR

Job Title: Website Coordinator  
FLSA Status: Non-exempt, Hourly

Department: Administration  
Reports to: Director of Programs

Effective Date: November 27, 2016

POSITION SUMMARY:
The Website Coordinator is responsible for managing the content the Agency’s website. The position is responsible for timely, accurate upload of service and program information.

WORKING RELATIONSHIPS:
The position works closely with the Program Director to ensure streamlined access to information for community partners, seniors and caregivers. Reports directly to the Program Director and is part of all development of new web content.

ROLES & RESPONSIBILITIES:
- Review and record requests for new data on the Agency’s website*
- Upload and delete content as requested*
- Streamline access to information by managing the web directory*
- Manage all analytics related to web traffic*
- Coordinate the upload of grant data and resources*
- Performs all other duties as assigned*

*Indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
- Excellent computer skills
- Ability to operate general office equipment
- Ability to multi-task

QUALIFICATIONS:
- High School graduate or equivalent
- Minimum five years experience with uploading and managing web content

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:
- Standard office conditions, equipment and noise level present
- Performs computer work and is expected to sit at least 6.5 hours per day
- Ability to focus on a computer screen for long periods of time
- Ability to use standard office equipment including calculator, copier, personal computer, printer, postage meter and fax machine
- Ability to follow written and verbal instructions
- Daily completion of repetitious or clerical tasks
- Must be able to travel in diverse weather conditions
- Ability to handle diverse populations (including non-English-speaking)
- Ability to display patience and empathy towards clients/providers/co-workers
- Ability to handle a stressful work environment
STATE HEALTH INSURANCE ASSISTANCE PROGRAMS
VOLUNTEER COUNSELOR JOB DESCRIPTION

Description: Provide one-on-one assistance to help Medicare beneficiaries, their caregivers or representatives with questions and problems related to Medicare & related health insurances. Counselors also assist their counseling site to create awareness of SHIP services in the state. Optional - conduct community presentations on Medicare & related health insurance options.

Responsibilities:
- Complete new volunteer counselor certification requirements
- Provide confidential/ objective individual counseling to beneficiaries or their representatives on Medicare and related health insurance issues.
- Advocate on behalf of beneficiaries to help them resolve Medicare and related health insurance issues
- Educate individual beneficiaries on Medicare related issues (including Medigap, Medicare Advantage, Medicare Part D and Medicare Savings Programs)
- Utilize SHIP and Medicare related materials and resources to stay up-to-date on issues affecting Medicare beneficiaries
- Maintain a SHIP/CHOICES volunteer counselor binder to keep information current
- Use Medicare.gov website to help beneficiaries compare prescription and/or Medicare Advantage plan options
- Assess beneficiary needs and make appropriate referrals when necessary
- Comply with SHIP/CHOICES policies and procedures, including those regarding confidentiality
- Report your SHIP/CHOICES activities (every quarter at a minimum)
- Promote SHIP/CHOICES in your community
- Treat beneficiaries and/or their representatives with respect and be professional in your approach at all times

Desired Qualifications:
- Ability to listen, identify beneficiary issues and problem solve
- Ability to maintain objectivity and confidentiality
- Willingness to advocate on behalf of beneficiaries
- Ability to work independently or as part of a team
- Effective oral and written communication skills
- Good organizational skills
- Willingness and ability to learn and retain information
- Confidence using a computer and internet
- Sensitivity in working with older adults and diverse populations
- Optional - ability to present information in a group setting
- MUST ALWAYS KEEP ALL CLIENT INFORMATION CONFIDENTIAL!
Southwestern Connecticut Agency on Aging, Inc.
Job Description
SYSTEM ADMINISTRATOR

Job Title: System Administrator  FLSA Status: Exempt, Salary
Department: Operations  Reports to: Executive Director
Effective Date: November 27, 2016

POSITION SUMMARY:
Provides direction, support and oversight of all data systems and data management. Works on Agency-wide data management strategy. Oversees the technology components of the CT Home Care Program including HP uploads, data integrity, data management and archival processes. Responsible for helping the Agency maximize effective systems in support of the mission including guidance and instruction to all administrative and program personnel.

WORKING RELATIONSHIPS:
Works collaboratively and with data system authority over all departments of the Agency. Project Manager and coordinator of outsourced IT vendors. Provides guidance and oversight to key system stakeholders.

ROLES & RESPONSIBILITIES:
- Enhances data integration accomplishments and competence by planning delivery of solutions; answering technical and procedural questions for less experienced team members; teaching improved processes; knowledge transfer and resource to Operations team members.*
- Studies data sources by interviewing users; defining, analyzing, and validating data objects; identifying the relationship among data objects.*
- Plans data integration process by developing common definitions of sourced data; designing common keys in physical data structure; establishing data integration specifications; examining data applications; examining data models and data warehouse schema; assessing tools for data integration, transformation, and routing; identifying areas of required clean up; forecasting resource requirements; establishing delivery timetables.*
- Delivers data integration by implementing shared databases; integrating data shared across legacy, new development, and purchased package environments; developing system modification specifications; mapping data; establishing interfaces; developing and modifying functions, programs, routines.*
- Manage procedures to export, transform, and load data; meeting performance parameters; resolving and escalating integration issues; coordinating actions among users, operations staff, and pre-determined outside vendors; recommending adjustments as objectives change; documenting operational procedures and data connections.*
- Validates data integration by developing and executing test plans and scenarios including data design, tool design, data extract/transform, networks, and hardware.*
- Ensures adoption of new systems and procedures through robust system of training and identifying trends that indicate the need for additional training.*
- Maintains data warehouse performance by identifying and resolving data conflicts; upgrading data definitions.*
- Develops and rewrites data policy, standards, and procedures.*
- Maintains Agency accomplishments by communicating essential information; coordinating actions; obtaining expert input; reviewing open issues and action items; contributing information to team meetings and reports; transferring knowledge of data integration process, techniques, and issues to application and support teams.*
- Updates job knowledge by participating in educational opportunities; reading professional publications; maintaining personal networks; participating in professional organizations.*
• Accomplishes organization goals by accepting ownership for accomplishing new processes and building skills and knowledge of systems and processes throughout the Agency workforce.*
• Performs other tasks as required.*

* indicates essential function

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:
• Some post high school coursework in Computer Science, Information Systems or related field.
• One (1) or more years of related job experience is required.
• In depth knowledge of Window 7, 8, 2008 and 2012.
• Working knowledge of personal computer hardware, software and Salesforce, including specific applications such as Microsoft Office 2013 and Microsoft Outlook.
• Interpersonal and communication skills necessary to answer technical questions in non-technical terms and troubleshoot/solve problems for various levels of end users.
• Analytical ability to identify and resolve information technology problems and critically assess situations and solve problems.
• Ability to understand technical documentation and specifications related to computer systems.
• Ability to adapt and respond to multiple priorities and demands and work effectively under stress, within deadlines, and changes in work priorities.
• Ability to work as a member of a team and establish effective working relationships and use good judgement, initiative and resourcefulness.

QUALIFICATIONS:
Bachelor’s Degree preferred with coursework in Computer Systems Technology, PC Networking, Data Recovery and Analysis. Specific training in SQL, Access and/or Salesforce preferred.

PHYSICAL AND MENTAL REQUIREMENTS AND WORKING CONDITIONS:
• Standard office conditions, equipment and noise level present.
• Performs computer work and is expected to sit at least 7 hours per day.
• Ability to focus on a computer screen for long periods of time.
• Ability to use standard office equipment including calculator/adding machine, copier, personal computer/laptop, printer, postage meter and fax machine.
• Ability to follow written and verbal instructions.
• Must lift or move boxes of office supplies weighing a maximum of 15 pounds.
**EXHIBIT I-6  Focal Points Designated in the Planning and Service Area**

<table>
<thead>
<tr>
<th>Instructions: Please provide name, address, phone number, contact person and date of designation for each focal point. When completed, include a page that briefly describes the process and criteria used by the Area Agency to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Designate entities as focal points,</td>
</tr>
<tr>
<td>□ Continue or renew focal point designation, and</td>
</tr>
<tr>
<td>□ Monitor these focal points</td>
</tr>
</tbody>
</table>

Please include focal points that are grantees of the AAA, those that are no longer grantees but continue to be focal points and those that are service providers. If applicable, indicate why a senior center in the planning area is not a focal point.
### Focal Points Designated in the PSA

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
<th>Contact Person</th>
<th>Designation Date</th>
<th>Designation Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Independence</td>
<td>80 Ferry Blvd Stratford, CT 06615</td>
<td>203-378-6977</td>
<td>Charlie Conway</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>Bridgeport Social Services</td>
<td>752 East Main St. Bridgeport, CT 06608</td>
<td>203-576-7471</td>
<td>Maritza Bond</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>Darien Human Services</td>
<td>2 Renshaw Road Darien, CT 06820</td>
<td>203-656-7328</td>
<td>Alexandra Ramsteck</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Easton Social Services</td>
<td>650 Morehouse Road Easton, CT 06612</td>
<td>203-268-1137</td>
<td>Alison Witherbee</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Bigelow Center for Senior Activities</td>
<td>100 Mona Terrace Fairfield, CT 06430</td>
<td>203-256-3169</td>
<td>Teresa Giegengack</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Monroe Senior Center</td>
<td>235 Cutlers Farm Rd. Monroe, CT 06468</td>
<td>203-452-3771</td>
<td>Barbara Yeager</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>New Canaan Human Services</td>
<td>61 Main Street New Canaan, CT 06840</td>
<td>203-594-3079</td>
<td>Bethany Zaro</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Norwalk Senior Center</td>
<td>11 Allen Road Norwalk, CT 06851</td>
<td>203-847-3115</td>
<td>Beatrix Winter</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>SilverSource</td>
<td>945 Summer Street Stamford, CT 06905</td>
<td>203-324-6584</td>
<td>Kathleen Bordelon</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>Stratford Baldwin Center</td>
<td>1000 West Broad St. Stratford, CT 06615</td>
<td>203-385-4055</td>
<td>Diane Puterski</td>
<td>October 2011</td>
<td>G, P</td>
</tr>
<tr>
<td>Trumbull Senior Center</td>
<td>23 Priscilla Place Trumbull, CT 0611</td>
<td>203-452-5199</td>
<td>Michele Jakab</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Weston Senior Center</td>
<td>9 School Road Weston, CT 06883</td>
<td>203-222-2608</td>
<td>Wendy Petty</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Westport Department Of Human Services</td>
<td>110 Myrtle Ave. Westport, CT 06880</td>
<td>203-226-8311</td>
<td>Elaine Daignault</td>
<td>October 2011</td>
<td>P</td>
</tr>
<tr>
<td>Wilton Senior Center</td>
<td>180 School Road Wilton, CT 06897</td>
<td>203-834-6240</td>
<td>Lizabeth Doty</td>
<td>October 2011</td>
<td>P</td>
</tr>
</tbody>
</table>

**Designation Type Key:**
- G: Grantee
- N: No longer a grantee
- P: Provider
**Focal Points as defined by the Older American’s Act, Section 102 DEFINITIONS**

“(21) The term ‘focal point’ means a facility established to encourage the maximum colocation and coordination of services for older individuals.”

According to a publication of the Administration on Aging, U.S. Department of Health and Human Services, under contract 105-89-1012 with the **National Council on Aging**, a focal point is a highly visible facility where anyone in a community can obtain information and access to aging services. To older adults, it is a well-known, accessible place to turn for information, services, and opportunities. To families, it is a resource to support their efforts in caring for older relatives. A focal point is a visible sign of the community’s caring for its older adults.

**Designation of Focal Points**

Every three years SWCAA will post a Request for Focal Point Designation (to coincide with the area plan). Existing Focal Points will complete a streamlined application to continue in the role. Awards will be announced to the SWCAA Board of Directors and Advisory Council, community partners, grantees, current focal points, and through social and local media. Applications will be reviewed by SWCAA staff and Advisory Council to determine eligibility. The First Selectman and Mayors in the corresponding city/town will be asked to provide a letter of support as part of the designation process.

**Focal Point Criteria**

The following is a list of criteria considered in determining eligibility for designation: Focal points should provide the following programs and services. If there are any programs and services that are not provided by the organization, focal point applicants will be asked to describe how they work with other organizations to coordinate services for older adults in their community.

- Case management
- Education
- Recreation
- Health and Wellness
- Caregiver support
- Benefits counseling
- Information & Assistance
- Volunteer opportunities
- Transportation
- Meal program
- Multi-cultural services
- Translation assistance (if applicable)

**How focal points are monitored.**

Annual surveys will be given to all focal point designees. For grantee designees, surveys will be distributed at the annual grantee site visit typically held during the months of January through March. For senior center designees, the surveys will be distributed at the quarterly Senior Center Directors meeting, coordinated by SWCAA. For all other designees the survey will be mailed. Surveys will review the type of services provided by the focal point. Training received and requested by the focal point will also be monitored.

**How focal points continue or renew focal point designation.**

Based on the information collected in the above mentioned surveys, and receipt of a Request for Focal Point Designation application or re-application (once every three years), the status of each
focal point will be determined. If focal points continue to meet the criteria, their designation will be renewed for an additional three year period.

Each focal point and First Selectman or Mayor will be invited to attend the SWCAA Annual Meeting held in October. Each focal point will receive a special public recognition. In addition, an induction ceremony will take place for all new and returning focal points once every three years.
EXHIBIT I-8  Request for Waiver from Procurement or to provide Direct Services

Instructions: Provide information for Request for Waivers from Procurement or to Provide Direct Services using the appropriate form provided by SDA.
Title III B Waiver Request

AAA Name: Southwestern CT Agency on Aging, Inc.

Date Submitted: April 28, 2017

Waiver Title: Bridgeport Outreach and Information and Assistance

Time Period of Waiver (Federal Fiscal Years): 10/1/17 – 9/30/21

Please check which Categories of this waiver you are requesting:

_x_ (1) Information & Assistance
___ (2) Aging and Disability Resource Center (person-centered counseling)
___ (3) Other:

Program Waiver Justification

Statement of Need: In a brief paragraph, provide information regarding the need of the service and the need for the AAA to provide the service directly. Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. If applying for more than one Category (i.e., Information & Assistance, Aging and Disability Resource Center, etc.), your request should indicate how services would be coordinated between categories. Include any relevant data to support or justify your need statement.

Statement of Need: The Southwestern CT Agency on Aging responds to over 1,400 calls per year requesting information and assistance on a variety of topics including housing, long term services and supports, long term planning, nutrition, Medicaid, food stamps and other services. In Category One, the I & A waiver provides full time staff (Information Specialist) to assist in responding to calls and helping callers navigate complex State and Federal programs. Access to information and services ranked as the highest priority in SWCAA’s Area Plan community assessment completed. Consumers struggle to identify unbiased, clear information and application assistance. Websites are confusing and many of the consumers lack secure access to apply for services via State portals. In addition to the information, assistance and language translation, Bridgeport residents will have access to a Community Outreach Worker who will provide benefits education & enrollment and case management services when appropriate. The Services for Information and Assistance will be coordinated using a triage approach. Individuals needing application assistance, with limited English or in need of a home visit or case management will be referred to the Bridgeport Outreach Worker. Walk-ins and consumers requiring one-time information and assistance will be served via the I&A Specialist.

Assurances:

1. Title III service under the waiver are effective as SWCAA has a proven record of assisting clients with information on all services to help an individual age with independence and dignity. Services are efficient as the CHOICES 800 telephone line helps triage calls to the subject expert on staff. SWCAA maintains low Administrative & General expenses and awards salary aligned with the median rate for the position documented by the CT Department of Labor.

2. SWCAA’s coordination with State and Federal systems makes it the logical resource for Information & Assistance. There have been ongoing attempts to have the City of Bridgeport take responsibility for the Bridgeport Outreach position. A hiring freeze and a strategy to hire only for mandated services prevents the duplication. Should this
strategy change, SWCAA would not apply for the benefits education, part of the 
translation and case management service definitions.

3. Bridgeport is the largest city with the greatest number of low-income, minority clients. It 
has one part time outreach employee dedicated to older adults. By contrast, Westport 
has 25% of the seniors and two full time outreach employees. The FFY 2018-2021 
clearly identifies “access to information and services” as a priority. Access to information 
is listed as Objective Two in our area plan.

4. SWCAA has and will continue to comply with all data collection as evidenced by timely 
reporting for the SPR.

5. The Waivers were presented in concept at the March 16, 2017 Board meeting and were 
unanimously approved.

Category 1: Information and Assistance Title III-B Funds $171,682

Number of clients to be served: 3,000

Number of units to be provided: 3,550

Category 2: ______________________ Title III-B Funds $____________

Number of clients to be served: _______________________________

Number of units to be provided: _______________________________

Category 3: _______________Title III-B Funds $________

Number of clients to be served: _______________________________

Number of units to be provided: _______________________________

Total Budget Summary for all waivers:

Title III-B Waiver – Category 1: $171,682
Title III-B Waiver – Category 2: _______________
Title III-B Waiver – Category 3: _______________

Title III-B Waiver Total All Categories

Match: At least 15% $30,297

Program Income: _______________

Total Program: $201,979

Other Resources: _______________

Grand Total: $201,979

A. NARRATIVE: In narrative form, address the following items in two pages or less:
1. **Service Description:**
   a. For each category of services to be provided under this waiver (i.e., Information & Assistance, Aging and Disability Resource Center, etc.), provide a brief overview of the services to be provided, including the service definitions to be used, and how these services will be coordinated.

In category 1, three Service Definitions apply to this waiver application. Information and Assistance is a service for older individuals that (A) provides the individuals with current information on opportunities and services available to the individuals in their communities, including information related to assistive technology; (B) assesses the problems and capacities of the individuals; (C) links the individuals to the opportunities and services that are available; (D) to the maximum extent practicable, ensures that the individuals receive the services needed by the individuals, and are aware of the opportunities available to the individuals, by establishing adequate follow-up procedures. Service may be reported for individual participants where possible or by using group identifiers where individual reporting is not practicable. Language Translation is a service designed to reduce barriers in communications so that the social functioning of participants who do not speak English can be assisted. Public Education is included to cover activities undertaken to increase public awareness of problems or concerns facing the older populations and solutions to these problems. These activities may include public service announcements in the media, preparation of pamphlets, reports, presentations, seminars and newsletters. The target audience of these activities is the general population, and it is usually not possible to specify the number of participants with any degree of precision.

   b. Complete the table below following the examples provided. For each Category, list the services to be provided, target population and geographic areas served.

**Example 1:** Category 1: Information & Assistance

<table>
<thead>
<tr>
<th>Services</th>
<th>Target Population</th>
<th>Geographic Areas Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>I &amp; A, Outreach</td>
<td>Medicare Beneficiaries</td>
<td>Entire AAA region</td>
</tr>
</tbody>
</table>

**Example 2:** Category 2: Aging and Disability Resource Center

<table>
<thead>
<tr>
<th>Services</th>
<th>Target Population</th>
<th>Geographic Areas Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-Centered Counseling</td>
<td>Persons needing LTSS; those with complex issues, those requiring short term support</td>
<td>Entire AAA Region</td>
</tr>
<tr>
<td>Benefits counseling</td>
<td>Individuals referred for meals on wheels</td>
<td>City of Bridgeport</td>
</tr>
</tbody>
</table>

**Category 1: Information and Assistance**

<table>
<thead>
<tr>
<th>Services</th>
<th>Target Population</th>
<th>Geographic Areas Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information &amp; Assistance</td>
<td>Medicare/Medicaid Beneficiaries</td>
<td>SW region</td>
</tr>
<tr>
<td>Language Translation</td>
<td>Medicare/Medicaid Beneficiaries</td>
<td>SW region</td>
</tr>
<tr>
<td>Public Education</td>
<td>Medicare/Medicaid Beneficiaries</td>
<td>SW region</td>
</tr>
</tbody>
</table>
Category 2: __________________________

<table>
<thead>
<tr>
<th>Services</th>
<th>Target Population</th>
<th>Geographic Areas Served</th>
</tr>
</thead>
</table>

Category 3: __________________________

<table>
<thead>
<tr>
<th>Services</th>
<th>Target Population</th>
<th>Geographic Areas Served</th>
</tr>
</thead>
</table>

2. **Service Delivery:** Describe how the service will be provided, how potential consumers will be informed about the availability of the services and how the services will be targeted and tracked within the MIS system (SAMS). Provide a chart outlining the FTE staff position(s) dedicated to each category of the waiver and the coordination between Title III-B waiver categories.

Initially, all calls will be triaged by the Information Specialist. This will streamline the coordination between the two staff members working as part of the Information and Assistance team. If there is a request for follow up and the client is: 1) a resident of Bridgeport; 2) Spanish-speaking; 3) is in need of more in-depth person centered assistance including assessment and identification of opportunities and services to meet the client’s needs; or 4) in need of a home visit- the caller will be referred to the Community Outreach Worker. If phone contact and/or an office visit can assist the client, then the Information Specialist will more often complete the contact.

Translation will be available to non-English speaking clients. Given Bridgeport’s high percentage of non-English speaking clients, the Community Outreach Worker job description includes a bilingual (English Spanish) requirement.

Public education will help inform the region of the availability of Information and Assistance. SWCAA also uses its Advisory Council and frequent community service presentations and in-services to inform aging network providers of the NFCSP and CRSP programs. Clients calling the CHOICES line with Medicare inquiries are always screened for additional questions and concerns whenever possible.

Services will be reported in SAMS using the information recorded from the Form 5 with One Contact for Language Translation and a combination of individually and aggregate reporting Information and Assistance based on whether the contact results in application assistance and/or the substantial manner of contact. Either the Information Specialist or the Community Outreach Worker will enter data in SAMs. Public Education will be entered as One Session per activity. (Please note: combining these items under Category One skews the per unit expense calculation. The project effort would need to be re-calculated after removing Public Education time and expense to present an accurate per unit of I & A expense.)

<table>
<thead>
<tr>
<th>Service Definition</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: Information and Assistance</td>
<td>Information and Assistance; Public Education</td>
</tr>
<tr>
<td>Category 1: Information and Assistance</td>
<td>Information and Assistance; Translation Services</td>
</tr>
</tbody>
</table>
2. **Client Satisfaction**: Describe how the service staff will determine client satisfaction and make improvement if problems are identified. Provide copy of survey tool. Clients will receive a survey (attached) at the end of the first contact. Participants in large-scale educational events will also be encouraged to complete a client satisfaction survey to inform our future presentations. The Program Department supervisor will review the responses and incorporate the feedback in department meetings.

3. **Sub-Contracts (if applicable)**: Describe plans for sub-contracting services components. N/A

**BUDGET**: Attach a line item budget for each waiver requested using the form provided by SDA. Please see attached. *Please note: your Title III-B waiver budget request shall not exceed 25% of the AAA’s Title III-B allocation for the previous federal fiscal year, prior to transfers, per SUA-SPI-17-01.*

---

We, the undersigned approve and submit the attached service description for Title III-B waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

________________________  ____________________
Area Agency on Aging Director  Date

________________________  ____________________
Authorized Official of Agency on Aging (optional)  Date

---

**For SDA Use Only**

____ Approved  ____________________

Time Period of Approved Waiver

____ Denied

________________________  ________________
Commissioner, State Department on Aging  Date
Title III-C2 Waiver Request

AAA Name: Southwestern CT Agency on Aging

Date Submitted: April 28, 2017

Waiver Title: Nutrition Education

Time Period of Waiver (Federal Fiscal Years): October 1, 2017 – September 30, 2021

Geographic Areas Served: Southwestern CT

Program Waiver Justification

Statement of Need: In a brief paragraph, provide information regarding the need for the service and need for the AAA to provide the service directly. Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. Please attach any relevant data to support or justify your need statement.

Limited nutrition resources highlight the need to manage program participation and educate the participants of the importance of healthy nutrition. The growth of the senior population has placed stress on the resources available to fund nutritious meals in the home. By splitting the responsibilities for oversight and education at both the Elderly Nutrition and AAA level, the program will more effectively serve clients with the greatest need for nutrition. The project is designed to provide nutrition education through a process that maximizes funds available for food. Per the SAMS report, nutrition education was provided to 551 clients in FFY 2016. Funding limitations will not sustain the effort; however, the AAA is committed to this cost-effective realignment of the service so that we can provide a reasonable amount of education while maximizing the funds available for food.

Assurances:

1. Title III service under the waiver are effective as SWCAA has a proven record of assisting clients to help an individual age with independence and dignity. Services are efficient as we allocate resources, human and financial, to ensure the greatest impact on clients and our communities. SWCAA maintains low Administrative & General expenses and awards salary aligned with the median rate for the position documented by the CT Department of Labor.

2. SWCAA’s oversight of the Elderly Nutrition Project ensures conflict-free access for clients while serving clients with the greatest needs. Shared responsibility for creating the educational curriculum reduces overall costs.

3. Although ENPs could provide Nutrition Education, it would be more costly due to the duplication of effort and there would be no incentive to ensure that meals are meeting the greatest needs.

4. SWCAA has and will continue to comply with all data collection as evidenced by timely reporting for the SPR.

5. The Waivers were presented in concept at the March 16, 2017 Board meeting.

Number of clients to be served: 520
Number of units of Nutrition Education to be provided: **520**

Number of units of Nutrition Assessments to be provided: **45**

Number of units of Nutrition Counseling to be provided: **50**

(Please refer to attached Program Instruction: SUA-SPI-10-02 for definitions for the above services. A Social Services Assessment is not a service provided under this waiver.)

**Budget Summary:**

- **Title IIIC-2 Waiver:** $43,149
  - Nutrition Education $38,649
  - Nutrition Counseling $4,500
  - Nutrition Assessment

  - Match: At least 15%: $6,820
  - Program Income:
  - Total Program:
  - Other Resources:
  - Grand Total: **$49,969**

Title III-C2 Waiver request shall not exceed 10% of the AAA’s Total C-2 allocation for the previous federal fiscal year, prior to transfers.

A. **NARRATIVE:** In narrative form, address the following items in two pages or less.

1. **Service Description:** Provide a brief (1 paragraph) overview of the services to be provided, including the definitions to be used.

   The service provided is **nutrition education** – as defined by the Appendix of Definitions in the SPR instructions, “A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.”

2. **Service Delivery:** Describe how the service will be provided, how potential clients will be informed about the availability of the services and how the services will be targeted and tracked within MIS system (SAMS). Provide a chart or narrative which outlines the FTE staff positions dedicated to each component of this waiver.

   Each new client will complete a Form 5 to enroll in the Home Delivered meal program at the Elderly Nutrition Provider. The Form 5 will be mailed/delivered to the AAA each month. Clients with scores of five or more on the Form 5 will be prioritized for a visit from the Nutrition Educator. The educator will provide nutrition education based on the curriculum developed by the ENP with the oversight of the Registered Dietician on staff. If the Educator assesses the client to identify the need for additional counseling to help
the client maximize his/her health, a referral will be made to the appropriate ENP for
assessment and counseling. The Nutrition Educator will ensure that a unit of health
education in the form of a welcoming, senior-friendly nutrition flier is included at least
twice per year in the delivery of each client’s meals. The flier will include contact
information for any client to call the Nutrition Educator and receive one-on-one
education should they have questions or concerns about their level of nutrition. The
Educator will work closely with the ENPs to manage waiting lists and manage education
units annually.

Services will be reported in SAMS using the information recorded from the Form 5 with
one unit of Nutrition Education at the time of delivery. A part time Dietary Technician/
Nutrition Educator will provide this service. Either the Nutrition Educator or the MIS
Coordinator will enter the data in SAMS. The .5 FTE position will be supervised by the
Grants Project Manager and work closely with the two Elderly Nutrition Projects.

3. **Client Satisfaction:** Describe how the service staff will determine client
satisfaction and make improvements if problems are identified. Provide
copy of survey tool.

The Elderly Nutrition Projects will include questions regarding education and counseling
and share the summarized information from their client satisfaction surveys.

4. **Sub-Contracts:** Describe plans for sub-contracting services components.
SWCAA will sub-contract the Nutrition Assessment and the Nutrition Counseling
Service to the Elderly Nutrition Project in the appropriate region based on the
identification of the need while the AAA Educator is speaking with the client.
Emphasis will be placed on clients with a score of four or more on the Form 5
assessment.

Counseling and assessments will be subcontracted to the Elderly Nutrition Projects
winning the bid in each sub-region. Assessments are a prerequisite of Counseling. In
rare cases, more than one unit of counseling will be provided to a single client based on
the professional judgment of the Registered Dietician. Nutrition Projects will provide
evidence of counseling via the monthly invoice. SWCAA’s MIS Coordinator will enter
the information in SAMs to ensure compliance with funding limits per the Program
Instruction.

B. **BUDGET:** Attach a line item budget using the form provided by SDA.

We, the undersigned approve and submit the attached service description for Title III
Waiver and assure that the description represents a formal commitment to carry out the
service program and to utilize federal funds as described herein.

____________________________________  _____________________
Signature of Area Agency Director         Date

SWCAA Area Plan 2018-2021
Page 68 of 139
Authorized Official of Agency on Aging (optional) Date

For SDA Use Only

_____ Approved  Time Period of Approved Waiver

_____ Denied

Commissioner, State Department on Aging Date
Title III D Waiver Request

AAA Name: Southwestern CT Agency on Aging

Date Submitted: April 28, 2017

Waiver Title: CDSMP

Time Period of Waiver (Federal Fiscal Years): October 1, 2017 – September 30, 2021

Geographic Areas Served: Southwestern CT

NOTE: For the CDSMP Waiver Submission address the statements under the “CDSMP Submission” heading. For all other Title III-D Waiver submissions, please address narrative items listed under, “Title III-D Waiver Submission”.

CDSMP Waiver Submission

Program Waiver Justification
Statement of Need: Provide information regarding the need of the CDSMP Regional Coordinator relevant to the delivery of self-management programs in your AAA service area (1 to 2 paragraphs). Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. Please attach any relevant data to support or justify your need statement.

The third rated goal determined by the Area Plan assessment completed by the Southwestern CT Agency on Aging is access to health & wellness. The desired outcomes for the CDSMP include an increase in healthy behaviors such as exercise and cognitive symptom management techniques, such as relaxation. Positive changes in health status such as less pain, fatigue and worry will occur. Additional outcomes include an increase in self-efficacy, better communications with health providers, and fewer visits to physicians and emergency rooms. The desired outcome of the CDSMP program are closely aligned to the priority Goal 3 identified through the Area Plan process.

Assurances:
1. Title III service under the waiver are effective as SWCAA has a proven record of assisting clients with information on all services to help an individual age with independence and dignity. Services are efficient as the CHOICES 800 telephone line helps triage calls to the subject expert on staff. SWCAA maintains low Administrative & General expenses and awards salary aligned with the median rate for the position documented by the CT Department of Labor.
2. SWCAA’s coordination with State and Federal systems makes it the logical resource for aging issues. Health & Wellness are a priority and add to the ability of an older adult to maintain independent with a higher degree of quality in their life.
3. SWCAA has a well-established network of aging providers to support the CDSMP goals.
4. SWCAA has and will continue to comply with all data collection as evidenced by timely reporting for the SPR.
5. The Waivers were presented in concept at the March 16, 2017 Board meeting and were unanimously approved.

Number of clients to be served: 50
The number of clients served equals CDSMP Completers which is defined as attending 4 out of 6 workshop sessions.

Number of units to be provided: 50
Each CDSMP completer equals 1 unit of service. Number of clients served should equal number of units provided.
Budget Summary:

Title III-D Waiver: $18,138
Match: Not required
Program Income: ______________
Total Program: $24,138
Other Resources: $6,000
(Include $6,000 state fund allotment)
Grand Total: $24,138

A. CDSMP NARRATIVE: In narrative form, address the following items in two pages or less.

1. Service Description: Provide a brief (1 paragraph) overview of the Chronic Disease Self-Management Program and/or the Chronic Pain Self-Management Program that will be delivered in your AAA service area.

   The Southwestern CT Agency on Aging will deploy new strategies to effectively manage the CDSMP project this year. We have hired a part-time health promoter whose single focus will be on evidence-based disease prevention programs. SWCAA will also participate in the ACL’s HBAI Learning Collaborative with the goal of creating a sustainable future for CDSMP and embedding CDSMP into health programs throughout the region. Our goal will be to expand the promotion of CDSMP through hospital and employer contacts that will raise awareness and participation.

2. Service Delivery: Describe how the Regional Coordinator will deliver the CDSMP Program in your AAA service area. Be sure to include the following mandatory deliverables in your narrative:
   - 1 Leader Refresher per federal fiscal year.
   - 1 Leader Training per federal fiscal year.
   - Collection and entry of data collection forms in the NCoA online system.
   - Monitoring of Program Fidelity
   - Maintenance of active leader list
   - Maintenance of RC Master Trainer certification as applicable (workshop or leader training)
   - Partnership development
   - Tracking of CDSMP in SAMS, when directed by SDA

   The Health Promoter will poll current leaders to identify the best time of the year for a Refresher Course. Arrangements will be made with master trainers utilizing the Grants Project manager and one other leader (perhaps the SDA Coordinator). A convenient location will be identified or the Agency conference room will be utilized. A minimum of eight leaders will complete the refresher Course. New leaders will be recruited using volunteer recruitment websites including State Farms and AARP. A Leader Training will be planned for spring, 2018. One Leader Roundtable meeting will be held during the year. All leaders will be invited to attend. The Health Promoter will work closely with the Leaders to obtain the required forms after each workshop and enter the data in the NCoA online system. SWCAA’s Health Promoter will keep a detailed record of each Leader, their trainings and workshops and their preference for workshop locations. The
Health Promoter will attend one session for each workshop completed to ensure the fidelity per the program guidelines. The Health Promoter will maintain the RC Master Trainer status as a condition of employment. The Health Promoter job description makes the expectations clear for staff and closes the communication loop between contract/AAA/staff deliverables. A minimum of six CDSMP community based workshops will be conducted in the southwest region with a minimum total of 50 course completers in attendance. Volunteers play a vital role in the delivery of the CDSMP and in the sustainability of the program. Coordination of workshops and support from the Health Promoter will enhance SWCAA’s relationship with CDSMP volunteers. During the upcoming Area Plan period, the focus will be to expand the promotion of CDSMP through hospital and employer contacts that will raise awareness and participation. SWCAA will make every effort to comply with all data entry requirements.

3. **Client Satisfaction:** Distribute and collect completed CDSMP Evaluation Surveys at the end of the six week workshop. CDSMP workshop evaluations are distributed to all workshop participants at the completion of each workshop series. Workshop leaders are supervised by the Project Manager and all newly trained leaders will have a Fidelity Check using the evaluation tool designed by Stanford University. A Leader Refresher (Roundtable) will be offered at least once during the year.

4. **Sub-Contracts:** Describe plans for sub-contracting services components such as workshop facilitation.

N/A

B. **BUDGET:** Attach a line item budget using the form provided by SDA. Be sure to include the $6,000 state fund allotment that supports your Agency’s CDSMP efforts.

We, the undersigned approve and submit the attached service description for Title III-D waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

____________________________________  __________________
Area Agency on Aging Director  Date

____________________________________  __________________
Authorized Official of Agency on Aging (optional)  Date

____________________________________  __________________
For SDA Use Only

____ Approved  __________________

____ Denied  Time Period of Approved Waiver

____________________________________  __________________
Commissioner, State Department on Aging  Date
Title III-E Waiver Request

AAA Name: Southwestern CT Agency on Aging
Date Submitted: April 28, 2017
Waiver Title: Caregiver Waiver
Time Period of Waiver (Federal Fiscal Years): October 1, 2017 – September 30, 2021
Geographic Areas Served: Southwestern CT

Program Waiver Justification

Statement of Need: Provide information regarding the need for the service and the need for the AAA to provide the services directly (1 to 2 paragraphs). Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. Please attach any relevant data to support or justify your need statement.

The federal government responded to the needs of caregivers by amending the Older Americans Act (OAA) in 2000 to provide for the National Family Caregiver Support Program. As a result it was determined that there was great need for organized, professional support to enable individuals to maintain their role as caregivers and therefore, keep their loved ones at home and prevent pre-mature institutionalization.

SWCAA is requesting a waiver to keep the following services in-house to provide more uniform access to information and services. Respite and supplemental services will provide tangible relief to caregiver’s burdens, particularly in towns and cities’ with limited capacity. SWCAA provides the services directly to keep up with the demand via the 800 CHOICES number and to ensure that municipal budgets do not remove these critical supports in difficult economic times. All services offered through the waiver are designed to support the caregiver and avoid premature institutionalization for the client.

Assurances:
1. Title III service under the waiver are effective as SWCAA has a proven record of assisting clients with information on all services to help an individual age with independence and dignity. Services are efficient as the CHOICES 800 telephone line helps triage calls to the subject expert on staff. SWCAA maintains low Administrative & General expenses and awards salary aligned with the median rate for the position documented by the CT Department of Labor.
2. SWCAA’s coordination with State and Federal systems makes it the logical resource for Information & Assistance.
3. Access to information for clients and caregivers is listed as Objective Two in our area plan.
4. SWCAA has and will continue to comply with all data collection as evidenced by timely reporting for the SPR.
5. The Waivers were presented in concept at the March 16, 2017 Board meeting and were unanimously approved.

Service Delivery – Caregivers/Grandparents

Services are divided into two sections: Section 1: Title III-E Waiver (non-Respite Care and non-Supplemental Services) and Section 2: Respite Care and Supplemental Services. Services are also divided into two populations: Caregivers and Grandparents.
When completing the section below, provide information of the number of caregivers and grandparents expected to be served and the number of units served to those individuals.

**Section 1**

<table>
<thead>
<tr>
<th>Service</th>
<th># of Caregivers</th>
<th>Units</th>
<th># of Grandparents</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Services</td>
<td>50</td>
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<td></td>
</tr>
<tr>
<td>(Includes NFCSP Outreach*</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NFCSP Benefits Education*</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>NFCSP Public Education*)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Access Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NFCSP Information and Assistance*</td>
<td>1050</td>
<td>1200</td>
<td></td>
<td></td>
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<tr>
<td>NFCSP Case Management</td>
<td>60</td>
<td>325</td>
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**Caregiver Counseling, Training and Support Groups**

<table>
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<tr>
<th>Service</th>
<th># of Caregivers</th>
<th>Units</th>
<th># of Grandparents</th>
<th>Units</th>
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</thead>
<tbody>
<tr>
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<td>150</td>
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<tr>
<td>NFCSP Caregiver Support Groups</td>
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<tr>
<td>NFCSP Caregiver Training</td>
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</tr>
</tbody>
</table>

Title III-E Waiver Funding for Services to Caregivers $214,669

Title III-E Waiver Funding for Services to Grandparents $_________________

*Denotes a service which may be recorded aggregately. In order to record services aggregately, provide a detailed explanation in the service delivery section.

**Section 2**

<table>
<thead>
<tr>
<th>Service</th>
<th># of Caregivers</th>
<th>Units</th>
<th># of Grandparents</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Care</td>
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<tr>
<td>Supplemental Services</td>
<td>40</td>
<td>350</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Title III-E Request for Funding for Respite/Supplemental services to Caregivers $60,000

Title III-E Request for Funding for Respite/Supplemental Services to Grandparents $
Total Title III-E Waiver Funds from Section 1 $214,669
Total Title III-E Funds – Respite and Supplemental Services from Section 2 $60,000

Match: At least 25%: $71,556

Program Income: 

Total Program: $286,225

Other Resources: 

Grand Total: $286,225

A. Narrative: In narrative form, address the following items in two pages or less.

1. Service Description: Provide a brief overview (1 paragraph) of the services to be provided, including the definitions to be used.

SWCAA will implement a menu of services including: Public Education which will primarily include media events, billboards, participation in community wellness fairs; Counseling to assess and assist a prospective client through the application process; Case Management to monitor and oversee a care plan and functional changes of the client to respond with appropriate intervention; and Information and Assistance which will primarily provide telephonic information regarding services and opportunities.

Service Definitions:

- NFCSP Public Education- Education provided by the NFCSP and includes activities undertaken to increase public awareness of the problems or concerns confronting older adults or caregivers and recommended solutions to these problems. These activities may include public service announcements in the media, preparation of pamphlets, reports, presentations, seminars and newsletters. It may also include participation in radio and talk shows with the intent of educating caregivers. This service will be reported aggregately and may include large-scale media campaigns such as billboards or radio spots.

- NFCSP Case Management- Assistance either in the form of access or care coordination in circumstances where older persons and/or their caregivers who participate in the NFCSP experience diminished functioning capacities, personal conditions or other characteristics which indicate the need for the provision of services by formal providers. Activities include, assessing needs. Counseling/educating a caregiver, developing a care plan, implementing a care plan, authorizing payment for services, monitoring and adjusting the care plan and conducting annual reassessment. Case Management services will only be reported after the individual is enrolled in the NFCSP.

- NFCSP Caregiver Counseling- Assistance provided by the NFCSP that helps caregivers in an individual setting make decisions and solve problems related to their care giving roles by providing appropriate options and education. Counseling occurs before an application is approved.

- NFSCP Information and Assistance- Assistance will be provided on opportunities and services that are available to the caregiver and the care recipients; assess problems and capacities; provide a link to available services and opportunities; assure that caregivers and recipients receive the needed services and are aware of available opportunities by establishing adequate follow up procedures.
2. **Service Delivery:** Describe how the service will be provided, how potential clients will be informed about the availability of services and how the services will be targeted and tracked within the MIS system (SAMS). In order to record aggregately, provide a detailed explanation which described why it is not practical to register consumers; SDA approval is required. Provide a chart or narrative which outlines the FTE staff positions dedicated to this waiver.

Public education will help inform the region of the availability of NFCSP. Large scale billboards, print and/or radio will be used to communicate the message. SWCAA also uses its Advisory Council and frequent community service presentations and in-services to inform aging network providers of the NFCSP and CRSP programs. Services will be provided by SWCAA's Caregiver Team. The team includes 1 FTE Associate Care Manager, responsible for case management, counseling and some Information and Assistance; .5 FTE Information Specialist, responsible for I & A and coordinating supplemental services; and .25 administrative professional to support all data collection and coordinate large scale media events. Most referrals will come from calls to the CHOICES 800 line or the Agency's care manager's referrals of clients and caregivers pending enrollment in a Medicaid waiver program who would benefit from immediate support. The calls and referrals will be triaged by the Information Specialist with counseling, case management and more lengthy contacts referred to the Associate Care Manager.

Services will be reported in SAMS using the information recorded from the Form 5 with One Person Session for Caregiver Counseling; one hour for Case Management; one activity for Public Education; and a combination of individually and aggregately reported Information and Assistance based on whether the contact results in application assistance and/or the substantial manner of the contact. Either the Associate Care Manager, Information Specialist or Administrative Professional will enter all contacts in SAMs.

3. **Client Satisfaction:** Describe how the service staff will determine client satisfaction and make improvements if problems are identified. Provide a copy of the survey tool specific to this program.

Clients will receive a survey (attached) at the end of the first contact. Participants in large-scale educational events will also be encouraged to complete a client satisfaction survey to inform our presentations. The Program Department supervisor will review the responses and incorporate the feedback in department meetings.

4. **Sub-Contracts:** Describe plans for sub-contracting services components.

Supplemental and Respite Services will be sub-contracted to Agencies enrolled and credentialed through the Connecticut Medical Assistance Program. Clients will always have choice when selecting a Provider. If no choice is indicated, the care manager will rotate through existing Providers or select a Provider based on the special needs of the client, i.e. Spanish-speaking, expertise with dementia, etc.

**B. BUDGET:** Attach the line item budgets using the Caregiver and Grandparent budget forms, as provided by SDA.

We the undersigned approve and submit the attached service description for Title III Waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

_________________________________________________________________________

We the undersigned approve and submit the attached service description for Title III Waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

Signature of Area Agency Director __________________________________________ Date ____________

Instructions: Provide information detailing how the agency coordinates activities with local and State emergency response agencies, relief organizations, local and State governments, and other institutions that have responsibilities for disaster relief service delivery. Provide a copy of the agency’s long-range emergency preparedness plan. The plan should address communication protocols for after hours and weekends. At a minimum, the Emergency Preparedness Plan must include a designation of a Disaster Communications Officer and:

1. Communication Plan: How does Agency communicate with staff, local and state government and local community?

2. Public Information Plan: How will information be relayed to the Public?

3. Outreach and Assistance: How will clients, especially at-risk, vulnerable clients, be contacted and provided assistance?

4. Emergency Operations Procedures: What preparation is in place for the provision of services before, during and after the emergency and the staff assigned?

5. Situation Reporting: How will updates be provided to the State Unit on Aging and any other stakeholders deemed necessary by the Area Agency on Aging?
Emergency Preparedness Plan

1. Communication Plan
The Agency communicates with staff via a multi-pronged approach including:
   a. Email sent by the Executive Director to all staff using Virtual Server technology;
   b. Message is placed on a dedicated phone line that staff call to hear new and ongoing
      messages throughout an emergency period;
   c. A text-tree begins when the executive director sends a text to all directors and
      supervisors.

The State Department on Aging has developed a comprehensive procedure of contact in the
case of emergency which includes designating two staff members from each Area Agency on
Aging, sharing home phone and cellular numbers, a required response time to confirm receipt
of messages and a designated State Department on Aging contact person. Local communities
and governments are contacted via our Advisory Council and Community Focal Point
Partners, which represent all cities and towns served. We have designated point of contact
information and we would offer assistance, confirm needs and communicate issues from the
local communities to the Emergency Management Department of the State via the State
Department on Aging.

   Disaster Communications Officer: Marie Allen, Executive Director
   Back up: Pat Knebel, Grants Manager

2. Public Information Plan
   SWCAA would communicate information to the public via its website and through
   telephonic messages left with our answering service. The answering service is located in
   Florida which reduces the potential for both the Agency and the Service to have an outage.
   Sharing information through the Agency’s Advisory Council and Community Focal Point
   Partners will also allow information to be publicly posted through partner websites and
   communications.

3. Contacting and providing assistance to clients
   SWCAA works with local communities to add vulnerable clients to the emergency
   management lists of local towns and cities. The Agency pre-emptively identifies and
   documents elders in need of electricity, oxygen, unable to transfer or ambulate, without
   family or community supports and cognitively at-risk. This list is shared with the local
   community so that emergency managers realize the risks faced by these clients in the event
   of an outage or weather-related emergency lasting more than 24 hours. SWCAA’s database
   includes a field to recognize vulnerable seniors so that we can print and maintain this list for
   contact if re-entry to the physical location is not possible. Cell phones would be used to
   respond to clients calling via the Agency’s answering service.

4. Emergency Operations Procedures
   SWCAA initiates an “Are you okay?” phone call for clients and caregivers prior to any
   emergent event that we are aware of, usually 24 hours prior to the event. SWCAA’s Grants
   Manager is responsible for communication with meal providers to ensure the delivery of
   shelf stable meals or the pre-emptive delivery of meals if we have warning of a storm.
During an emergent event, SWCAA’s answering service would continue to field calls to managers providing cellular access is available.

5. **Situation reporting**
   The State Department on Aging has developed a comprehensive procedure of contact in the case of emergency which includes designating two staff members from each Area Agency on Aging, sharing home phone and cellular numbers, a required response time to confirm receipt of messages and a designated State Department on Aging contact person. Communication will include updates regarding the delivery of meals, the risk to clients in communities without power, the actions and interactions with local communities, the need for assistance and periodic updates to any of the aforementioned issues.
EXHIBIT I-10 Description of Area Agency on Aging Target Setting and Data Collection

Instructions:

1. a) Describe how the Area Agency sets targets for services using Census and American Community Survey data.
   
b) Describe how the Area Agency determines if the targets were met.

2. a) Describe how the Area Agency collects data.
   
   b) Describe how the Area Agency enters the data collected into the SAMS system within the timeframes set by SDA.
   
   c) Describe how the Area Agency monitors data entry to address missing or incomplete data and the plan to ensure corrections within the established timeframes.
Description of Area Agency on Aging Target Setting and Data Collection

1. a) Describe how the Area Agency sets targets for services using Census and American Community Survey data.
   Each year the AGid Special Census Tabulation prepared by the US Census Bureau (AGid Special Census Tabulation, 2009-2013) is accessed by SWCAA to update available demographic data concerning older adults age 60 and above living in the 14 Towns of the SWCAA area. Grantees are expected to serve poverty-level, minority, and low income minority older adults, at a minimum, in proportion to their representation in the older adult population. During the allocations process, for each application, proposed percentages of clients in these categories are compared with their proportion in the older adult population. For returning grantees, proposed percentages are also compared to their current services. The ability to serve target population older adults is a major factor considered in the SWCAA allocations process. In addition, the allocations committee attempts to distribute grant funding between the Greater Bridgeport, Greater Norwalk, and Greater Stamford regions based on the numbers of older adults and target population older adults in each region. Targets in SWCAA waivers are also based on this population data. In some cases waiver targets may be designed to reach target populations in geographic or demographic areas not sufficiently served by grant projects.

b) Describe how the Area Agency determines if the targets were met.
   SWCAA has developed a spreadsheet which includes the target units and clients for each grantee. Each month, after entering grantee MIS into SAMS, the MIS and Grants Assistant records the monthly unit and client data for each grantee in the spreadsheet. At any time during the year, this spreadsheet provides a snapshot of how the grantee is progressing toward meeting their targets. This spreadsheet is reviewed by the Grants Manager periodically throughout the year. If further detail is needed, the grantee’s SAMS CT Monthly Performance Report can be compared to the target section of the application. This data is reviewed and discussed with each grantee during mid-year site visits. If the grantee applies for a grant for the following year, this data is also scrutinized during the allocations process. In their year-end report, grantees are asked to explain any circumstances that resulted in over-reaching or under-reaching their targets.

SWCAA staff responsible for waiver projects and their supervisor monitor progress on waiver targets on a regular basis.

2. a) Describe how the Area Agency collects data.
   Grantees are required to submit MIS data by the 15th of each month to report on services provided in the previous month. At the beginning of each grant year, the MIS and Grants Assistant provides each grantee with updated instructions and forms, including Form 5, cover sheet, and an aggregate reporting form if needed. E-mail and telephone reminders are utilized for any grantees who are late in reporting. The Grants Manager or the MIS and Grants Assistant are always available to provide training or answer questions to assist grantee staff to understand the MIS reporting requirements.
SWCAA Title III E, Bridgeport Outreach, and Nutrition Assessor waiver and Alzheimer’s Respite staff generate Form 5s and service data for their programs.

b) Describe how the Area Agency enters the data collected into the SAMS system within the timeframes set by SDA.
The MIS and Grants Assistant enters all grantee submitted MIS data—roster units and new Form 5 demographic, ADL, IADL, and service units—for the month as the data is received. After each grantee’s monthly MIS is entered into SAMS, a CT Monthly Performance Report is prepared to be sure all services were entered correctly. A copy of the report is sent to the provider for their records. Data from the report is recorded in the target spreadsheet. Aggregate services, which cannot be entered into SAMS, are tracked on a separate spreadsheet.

SWCAA staff responsible for waiver projects and the Program Administrative Assistant regularly enter MIS data for the Title III E, Bridgeport Outreach, Alzheimer’s Respite and Nutrition Assessor waiver programs.

c) Describe how the Area Agency monitors data entry to address missing or incomplete data and the plan to ensure corrections within the established timeframes.
The MIS and Grants Assistant maintains e-mail and/or telephone contact with any grantees who may have submitted incomplete data, numbers that do not match their cover sheet, illegible data, demographic data in conflict with data already in SAMS, or other problems to obtain and record the best information available. At least once or twice a month the MIS and Grant Assistant and the Program Administrative Assistant run the following SAMS reports to double check for errors, missing information, or duplicate consumers: Napis Consumer Listing Report, Agency Summary Report, and SAMS Consumer Provider Service Report. All irregularities are researched and corrected. Details on any duplicate clients found in SAMS are forwarded to the CT Associate Research Analyst for merger and records of such clients are maintained at SWCAA for future reference. At least quarterly, Title III E Respite and Supplemental SAMS reports are compared to a SWCAA Finance Department report of Title III E Respite and Supplemental services paid to ensure accuracy.
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EXHIBIT II-1 Area Agency Mission Statement

MISSION STATEMENT

Instructions: Explain your agency’s mission and role within the communities you serve. Describe how the 4 Year Plan relates to the mission, how the two will be integrated to meet your stated goals and outcomes, and how these will be implemented to ensure compliance with the intent and purpose of the Older Americans Act.
The Agency’s Mission Statement

The mission of the Southwestern CT Agency on Aging, Inc. (SWCAA) is to provide leadership and resources to meet the needs of the rapidly growing older adult population and to maintain and improve the quality of life and independence of older persons. In recent years, SWCAA has broadened its organizational mission to include any person wishing to maintain maximum independence and forego nursing facility or hospital-based institutional care. In 2009, we added “Independent Living” to our title to solidify our commitment to any person, of any age, with any disability, seeking to maximize his or her independence. We have spent the last five years working in collaboration with disability resources to hone our skills and increase support to persons with disabilities and their caregivers.

SWCAA plays an integral role as a liaison between the community and state and federal resources in southwestern Connecticut. SWCAA provides information on best practices in the field of aging and community living; informs communities of collaborative opportunities to more efficiently deliver services; advocates for seniors, particularly seniors in the target populations; and enhances local resources to meet the demands for long-term care services and supports. SWCAA’s Advisory Council brings representatives from each local community to discuss best practices, challenges and creative solutions. Collaborative monthly meetings bring information from the community to SWCAA which is then shared with the community. During site visits to local grantees, members of the Board and Advisory Council look for opportunities to support the local efforts of grantees based on the needs identified in the Area Plan. SWCAA routinely convenes in-services, technical support and presentations to inform and update the community on essential programs. The SWCAA website supports service providers and community residents by providing information and streamlined access to applications on many local, State and Federal resources.

SWCAA’s mission to support maximum independence is demonstrated by grant allocations to help older adults’ access to transportation, nutrition, in-home care, information, referrals and caregiver respite. Bilingual information specialists support the diversity of the community by providing education, information and assistance for non-English speaking residents. Strategic outreach is provided in communities traditionally underserved due to language and socioeconomic barriers.

SWCAA is aligned in mission with the Older Americans Act. The 2018-2021 Area Plan prioritizes assistance to older adults designed to: (a) ensure access to programs and services that will enhance economic security of older adults; (b) ensure access to community based long-term services and supports to maximize independence of older adults; (c) ensure access to proven health promotion, wellness, and disease prevention programs for older adults and caregivers.

SWCAA’s broad, strategic priorities as presented in the Area Plan include access to services; economic security; access to physical and mental health services. The foundation for the SWCAA goals and objectives can be found in the principles of the Older Americans Act which support consumer information for long-term care planning, evidence-based prevention programs, and community-based services to older individuals at risk of institutionalization. The implementation of SWCAA’s objectives include allocation of federal and state funds to support local programs enhancing access, economic security and health services for older adults. Efforts
include increasing the diversity and education of community-based volunteers to help magnify efforts and bring more capacity to the target communities. The Area Plan prioritizes long term care services and supports using information gleaned through participation in Connecticut’s Money Follows the Person Program and findings from the Medical Assistance Program Oversight Council. Collaborations with hospitals and medical centers along with the funding of evidence-based programs will enhance the health of the region’s older adults. The Agency hopes to utilize ACL’s learning collaborative to help sustain evidenced-based programs. An emphasis on funding for community senior centers and strengthening focal points will ensure that each community has an unbiased, informed source of information to assist older adults and persons with disabilities. SWCAA will continue to coordinate social and nutritional services for older individuals and their caregivers in the southwestern region of the state.

Regional administration of Money Follows the Person and the Medicaid waivers cement SWCAA’s commitment to all persons, regardless of age requiring assistance in their efforts to maintain independence. These programs also connect SWCAA to the important work done under the umbrella of the Medical Assistance Unit, funded by Medicaid dollars and essential to the State’s efforts to promote better health outcomes and independence.
EXHIBIT II-2  The Agency’s Vision for Older People

Instructions: Explain what the agency’s vision is for older people. How did the agency arrive at this vision?
The Agency's Vision for Older People

SWCAA's vision for older adults is to promote dignity and independence through the aging spectrum and to offer assistance so that every individual can live in the least restrictive environment of their choice. The SWCAA vision for older adults includes: (1) promoting economic security and stability for older adults so that they have the financial resources to meet their needs and live with maximum independence; (2) providing older adults with access to information, assistance and long-term services and supports designed to maximize independence; and (3) ensuring access and opportunities to proven health interventions and preventive disease programs designed to maximize their independence and dignity. This vision is clearly aligned to the three goals identified in the Area Plan. SWCAA will advocate for the rights of older adults and promote a safe, nurturing environment by supporting home & community services through person-centered care plans. The organization will respond swiftly and effectively to the needs of older adults by maintaining a flat structure where employee input is valued and a competent management team balances administrative work with direct service. Training will ensure cultural competence and an inclusive environment for all prospective clients and caregivers.
EXHIBIT II-3 The Agency’s Core Values

Instructions: What are the agency’s core values? Explain how the agency in its ongoing management of programs and its strategic planning process is guided by core values. How do the agency’s core values define the Area Agency’s organizational culture?
The Agency’s Core Values

SWCAA’s core values form the foundation on which we work and conduct ourselves both internally and externally. The Agency’s core values were developed through an intensive review of current goals and future objectives and represent the best practices of our highly trained and committed staff. The core values were integrated into the strategic planning process which is an ongoing rather than a “point in time” process including members of the Agency’s Board of Directors.

**SWCAA Core Values:**

1. Promote maximum independence and dignity for the clients we serve
2. Develop person-centered plans of care keeping the client at the center of all goals
3. Build community capacity through education, resources and assistance provided to aging network partners
4. Uphold maximum transparency when working with contractors, funders, Board leadership and stakeholders
5. Treat all clients with the utmost dignity and respect
6. Treat all employees with the utmost dignity and respect
7. Evaluate people and programs by outcome rather than tasks completed
8. Utilize the most efficient and effective methods of service delivery
9. Meet and routinely exceed the expectations of state and federal contracts, funders and clients

The Agency's organizational culture is based on honesty, transparency and respect. The Core Values described above guide the management/employee, funder/Agency relationships and also guide the employee/client relationship. Transparency and exceeding expectations are at the root of all contractual engagements. Clients are supported through collaboration and efficient service delivery. This can be demonstrated through the process of monitoring and building capacity in our Title III grantees and subcontractors, creating a true safety net for vulnerable seniors. SWCAA's interdepartmental communication provides seamless transition for the client between all programs administered by the Agency. SWCAA actively researches best-practices and innovative solutions to the challenges of aging by participating in quality training and learning experiences; reviewing the work of other Agencies on Aging across the nation; and working collaboratively with universities, hospitals, ACL, CMS and the State Department on Aging.
EXHIBIT II-4  Review of Area Agency’s Accomplishments

Instructions: Describe the primary accomplishments of the Agency in terms of the organization and as a planning, advocacy and funding entity during the previous four years. Identify organizational strengths and strategies used to accomplish the goals that were attained. Please note areas needing improvement, how they were identified and any actions taken or plans you may have made to achieve a higher degree of successful outcomes for these areas.
Review of the Agency’s Accomplishments

As an organization, the Southwestern CT Agency on Aging (SWCAA) has excelled in procuring social service contracts that provide an economy of scale. This economy of scale strengthens the financial position of the Agency while adding to the inclusive nature of programs and populations served. SWCAA has broadened its mission to include persons with disabilities and in 2009, added “& Independent Living” to its title. SWCAA now serves individuals 18 – 64 years of age through the Personal Care Assistance Waiver and the Acquired Brain Injury Waiver. SWCAA has strong Personnel Policies that hold staff accountable for outcomes rather than counting tasks. Staff are empowered with decision-making abilities that help streamline assistance and services to both clients and community partner agencies. Cross training and deep understanding of eligibility criteria for numerous entitlement and social service programs provide SWCAA clients with highly effective referrals and the right intervention at the right time. The staff pride themselves on relationships with community partners and was awarded, “Healthcare Agency of the Year” by the Greater Bridgeport Business Council. Advisory Council meetings provide innovative, informative discussion that help all municipalities by brainstorming and sharing strategies to improve the quality of life for older adults. For example, the Council recently invited UBER to discuss transportation options for older adults. On another occasion, the Council facilitated a meeting that helped SWCAA prioritize its goals and objectives in anticipation of the Area Plan.

SWCAA has increased its commitment to continuous planning through the development of the Board’s Steering Committee. This Committee is designed to routinely monitor the strengths and weaknesses of the Agency while helping to set the strategic course. The Committee serves as a planning committee to align the Agency’s activities with the mission and to look for opportunities to strengthen and sustain key programs.

SWCAA works closely with sister Agencies through the CT Association of Area Agencies on Aging. For example, the implementation of the Veterans’ Directed Home and Community Based Services Program allowed Western, Eastern and North Central Agencies on Aging to participate in the project by having SWCAA act as the billing agent. This Program has proven beneficial from a budgetary standpoint while solidifying the Agencies as core partners with the Veterans Administration Medical Center. This has led to further collaboration including a Veterans Administration award winning pilot to identify and support Veterans with depressive and/or suicidal tendencies. Acting as the lead agency, SWCAA recently gained entrance to the Administration of Community Living’s Learning Collaborative to procure a Medicare Tax ID in an effort to enhance the sustainability of the Chronic Disease and Diabetes Self Management programs.

Advocacy has always been a priority for SWCAA. SWCAA develops legislative agendas each year in concert with the CT Association of Area Agencies on Aging. This agenda is a good cross section of the State’s elder needs and priorities. SWCAA’s Executive Director has presented testimony on all legislative priorities as the representative for the Association. In addition, SWCAA meets with the Aging Partner Councils: the Greater Bridgeport Elder Service Council, the Norwalk Senior Umbrella, the Westport Aging Partnership and Stamford’s Partnership for Elderly Services (PIES). An agenda is developed based on the issues facing the local providers. SWCAA provides sample testimony and advice on the most effective advocacy measures.
SWCAA hosts Legislative Breakfast in three regions to present the agenda and strategize an advocacy plan. Updates are distributed to all aging partners throughout the budget session. SWCAA’s website includes advocacy and instruction to help individuals get their thoughts to elected officials. Senator Kevin Kelly is an Emeritus Board Director and has been very helpful in providing a sounding board for older adults.

Underlining the importance of communication, SWCAA developed a PowerPoint to explain the funding and program requirements of the Title III C program. Through meetings with the Nutrition Projects, host sites and city leadership, SWCAA was able to increase the community’s understanding of the program’s limitations and develop a roadmap to maximize meals. The plan was shared with all State representatives and Senators and effectively avoided potential miscommunication as fewer meals were available in the community.

Funding efforts have flourished under the leadership of Grants Manager Pat Knebel. With twenty years of Older Americans’ Act experience in funding and monitoring programs, Pat has worked closely with the Board leadership to develop the most streamlined, fair and equitable grant award and review process. Applicants have found the application process user friendly and some have commented on how the application helps them focus their project ideas. Expert Technical Assistance helped SWCAA identify new prospective grantees and provide a path to funding even for business offices with little experience. The lessons learned regarding cost allocation and target development help grantees write award winning applications to other funders. The Grants office distributes announcements about new or renewable funding opportunities in an effort to assist grantees in sustaining vital programs.

SWCAA was a lead Agency along with Senior Resources in the development of the Elderly Nutrition Program Request for Proposals. The new application outlined assurances which required a sign-off and allowed the prospective providers to focus the application on how the Provider would meet and/or exceed the seniors’ preferences and program objectives. The application followed the contractor guidance presented by Department of Administrative Services (DAS). The budget package requires applicants to include all expense and revenue and effectively prevents the redundant allocation of expenses.

The Finance Committee of the Board reviews and comments on each applicants’ audit to ensure that funds are awarded to capable grantees. A strategic process of grantee review is led by the Allocations Chair of the Board. This process includes a review of the target units, clients and spending. Policies and requirements such as donation policies and grievance methods are reviewed at the site visits. Meetings often result in brainstorming to help the grantees identify other resources or connect to other successful agencies in the region. The information gleaned at these visits is included in the evaluation of any returning grantees to ensure that funds are reaching community agencies with the best chance to meet client needs.

SWCAA believes in continuous improvement and always strives to find effective methods to deliver services and information to older adults and their caregivers. Marketing is an area targeted for improvement. SWCAA is working with the Steering Committee to redesign the website and enter into social media with the goal of raising awareness around issues of long term services and supports. Along with the marketing efforts, SWCAA will continue to engage volunteers with meaningful activities through the Chronic Disease programs and CHOICES.
This extrapolated effort created by identifying aging leadership in each community served will help SWCAA present support and options to people in need.
EXHIBIT II-5 Description of the Planning Process

**Instructions:** Describe the process used to assess the needs of older adults in its Planning and Service Area and to establish priorities. Outline the steps, procedures, instruments used, type of analysis and committees as applicable to your agency.
Description of the Planning Process

In the planning process for the 2018-2021 Area Plan, SWCAA used a variety of sources to assess the needs of older adults and to establish priorities. These included demographic data, relevant global, national and local literature, local surveys and focus groups with older adults and with local senior service providers.

Demographic Data – A number of demographic reports provided relevant population characteristics. Some are available at the county and town level and others provided a broader statewide or national perspective. Most provide data for those age 65 and older. The Aging Integrated Database (AGid Special Census Tabulation, 2009-2013) does provide data for the Older Americans Act populations of age 60 and above. Other sources consulted include: A Profile of Older Americans: 2016 (A Profile of Older Americans: 2016, 2016), Fairfield County Community Wellbeing Index 2016 (Abraham & Buchanan, 2016), Alzheimer’s Statistics Connecticut (Alzheimer’s Statistics Connecticut, 2016), Projections of the Size and Composition of the U.S. Population 2014-2060 (Colby, 2015), Connecticut State Innovation Model State Health Profile: Data Packet (Connecticut State Innovation Model State Health Profile: Data Packet, 2016), 2016 Disability Statistics Annual Report (Kraus, 2017), Living Below the Line: Economic Insecurity and Older Americans Insecurity in the States 2016 (Mutchler, Li, & Xu, 2016), Mortality Among Centenarians in the United States 2000-2014 (Xu, 2016), Title III Target Population Workbook for Setting Area Agency on Aging Service Goals (Cho & Bratesman,, 2012) and others.


Local Needs Assessment – An extensive recent Fairfield County needs assessment, Fairfield County Community Wellbeing Index 2016 (Abraham & Buchanan, 2016), was recently published based on demographic analysis, thousands of direct telephone interviews, and focus groups. In addition, a number of local towns, organizations, and senior centers shared the results of recent surveys. SWCAA conducted a recent survey with meal site participants and gathered information at focus groups with service providers and seniors. A brainstorming session with the SWCAA Advisory Council based on a review of data gathered provided ideas for the direction of future programming.
EXHIBIT II-6 Status and Needs of Area’s Older Adults

**Instructions:** Outline (1) the current needs [identified in priority order] among the area’s older adults and, (2) the needs of the area’s older adults projected over the planning period. Use information gathered through demographic data, needs assessment, survey instruments, community meetings/hearings, documented reports of unmet need and other sources relevant to your planning process and planning and service area. Use an organized format (such as numbers, letters, outline) so that needs may be easily referenced in the rationales and sources are cited. Include how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older adults during the ten-year period following the fiscal year for which the plan is submitted. Tell us the projected change in the number of older individuals in the planning and service area. An analysis of how the programs, policies, and services provided by the area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older adults.
Status and Needs of Area’s Older Adults

1. Current Needs of Area’s Older Adults
A review of the calls received by SWCAA’s Information & Assistance specialists over the past three years (not including CHOICES/Health Insurance calls) reveals that the information most commonly requested were in the areas of: (1) financial assistance, (2) in-home services, (3) health, (4) nutrition, and (5) housing. These areas are very similar to the top national areas reported by the Eldercare Locator: transportation, housing options, and in-home services. (Innovative Routes in Transportation Services, 2016) They are also similar to the older adult health issues reported by the Connecticut Community Health Needs Assessment of 2016: transportation, availability/affordability of senior assisted housing, social support systems, engagement in medical decision-making, repair/maintenance of their own homes, and burden of chronic diseases. (Connecticut State Innovation Model State Health Profile, 2016) The 2015 White House Conference on Aging Policy Briefs also highlighted similar themes: retirement security, healthy aging, long-term services and supports, and elder justice. (Final Report, 2015) Globally, the World Health Organization found “the most important basic needs identified by older people, beyond health care and long-term care, are personal and financial security, and adequate housing.” (World Report on Ageing and Health, 2015)

2. Projected Needs of Area’s Older Adults for FFY 2018-2021
Focus groups with service providers in southwestern Connecticut and with SWCAA’s Advisory Council members revealed that seniors they know or serve also share these same needs. But, in addition, providers and seniors active in their communities also overwhelmingly identified the additional need of identifying ways to reach isolated and un-connected older adults or their families with information—information about: services that are available, health and nutrition, how to avoid scams, financial resources--anything that will help an older adult age in community.

The themes that emerged from SWCAA’s needs assessment can be summed up as needs for information about and access to:

a. Economic Security
“Lack of financial security in older age is a major obstacle to Healthy Ageing and to reducing health inequity.” (World Report on Ageing and Health, 2015) Americans are living longer and those in Fairfield County struggle to age in community in an area where the cost of living is high and income inequality is the highest in the country. People are also living longer with chronic illnesses and various forms of dementia, increasing their need for costly services. Assistance locating and applying for

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benefits that may help make ends meet is much needed. Financial assistance generated the highest number of SWCAA I&A calls over the past three years.

b. **Community-Based Long-Term Services and Supports**
Community-based services and supports help older adults accomplish everyday tasks, provide respite for caregivers, allow older adults to remain independent in the community, and prevent expensive hospital and nursing costs. (Atkins, Tumlinson, & Dawson, Financing for Long-Term Services and Supports, 2016) The need for long-term services and supports will be a fact of life for more than half of those retiring today. (Mann, Raphael, Anthony, & Nevitt, 2016) In-Home Services generated the second most SWCAA I&A calls over the past three years.

c. **Health and Wellness Services**
The World Health Organization “defines Healthy Ageing as the process of developing and maintaining the functional ability that enables well-being in older age.” (World Report on Ageing and Health, 2015) “These components—purpose, social engagement, healthy diet, mobility, exercise—become especially important as determinants of health in old age.” (Lock & Belza, 2016) Fostering active, healthy living maximizes Americans’ quality of life and their contributions to society. (Lock & Belza, 2016) Health & wellness services can include: exercise, good nutrition, recommended health screenings, oral health, health education, management of chronic conditions, mental and cognitive health, health insurance navigation, opportunities to interact with others and contribute to society, support for caregivers, and prevention of elder abuse. Health concerns and nutrition generated the third and fourth most SWCAA I&A calls over the past three years.

d. **Needs are Inter-related.** Global, national and local research on older adult needs repeatedly discuss how these needs are inter-related. Attempts to prioritize one need above another are ineffective as increased needs in one area may result from a lack of services in another area. Proposed improvements in one area are dependent on solving multiple additional needs. For example:

- “Fairfield County’s large and growing population of senior citizens will present new opportunities and challenges for the region’s families and communities in the coming years. With many adults living substantially longer than they are able to drive on their own, this population will need social support, civic engagement, medical care, transportation, and housing options that are tailored to their needs.” (Abraham & Buchanan, 2016)

- “A lack of access to appropriate transportation has consequences on the health and well-being on the older adult, restricts opportunity for engaging in health behaviors and access to social services, restricts social engagement and places considerable burden on caregivers and family members on their effort to provide transportation.” (Assessing the Intersection Between Health & Transportation: Literature Review, 2016)

- A wide range of non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically-ill individuals. Older adults who require, but do not receive, reliable community-based social services in order to remain out of crisis will be at high risk of multiple hospital readmissions. This is likely to become increasingly difficult for hospitals to manage. (Montgomery & Blair, 2016)

- Food insecurity is a strong predictor of chronic disease and emotional distress, particularly depression. Chronic conditions can reduce a person’s ability to care for themselves. Health, functional and income limitations may lead to eating less food or
making tradeoffs between buying food and medications or seeing the doctor. Poor health outcomes may increase healthcare expenditures and the risk of nursing home placement. (Lloyd, 2017)

- “health-care providers are acknowledging that social determinants of health—including housing—are major contributors to the physical and mental well-being of the individuals they care for” (Stone, 2016)

e. **Advocacy, Information, and Assistance.** Many of the older adult needs that are repeatedly identified are needs that can not be directly addressed by the programs included in the Area Plan. No SWCAA contractual services are available to build or operate affordable senior housing, to control the costs and reimbursement rates of long-term services and supports or to operate a multi-town, multi-level-of-service transportation system. These areas, however, are among the older adult needs for which SWCAA can represent older adults by advocating for improved laws, regulations, and services at the federal, state, and local levels and for which we can provide up-to-date information about the services that are available and assistance accessing these services.

The Older Americans Act requires Agencies on Aging to “serve as the advocate and focal point for older individuals within the community” (Older Americans Act of 1965 As Amended [Public Law 89-73], 2016), monitoring and commenting on policies or programs that affect older individuals. In this capacity Agencies on Aging are in a position to voice the concerns, needs, and stories of older adults we serve to policy makers at all levels of government. We are also able to monitor proposed new laws and regulations and offer information to providers, older adults, and their families so they may be able to advocate for themselves.

There is a need to bridge the information gap for those approaching or newly in need of services, target population older adults, isolated older adults, and younger family members. The Commission on Long-Term Care reports that only half of people ages 40 and older even know where to go for information. (Report to the Congress, 2013) Older adults and their family members are entering a new chapter of life and are looking for guidance about services that are available, the new systems they will need to navigate and how they work, and the hazards and pitfalls to beware of. Older adults and their family members need clear, user-friendly information to get them started and, sometimes, guidance or assistance to navigate systems. In addition, local community providers report that they depend on SWCAA to provide updates and training on new information, advocacy needs, and back-up assistance with complex cases.

3. **Demographic Projections**
   a. **National Data** - One rarely finds an article or research report about older adults that does not include information about the recent and projected future large increases in the older adult population. “Over 10,000 baby boomers are turning 65 every day” is an often quoted statement. (Final Report, 2015) In addition to the large numbers of people turning 65, today’s elders are living longer than ever before—the average life expectancy continues to rise steadily along with the number of people age 100 or older. (Xu, 2016) In 2015 about one in seven, or 14.9% of the population, is an older American. (A Profile of Older Americans: 2016, 2016)
Census Bureau data and projections for those age 65 and over as a percentage of the total US population indicate:

- in 2014 (the beginning of the current Area Plan period): 15% of the population
- in 2021 (the end of the proposed Area Plan period): 17%
- in 2030 (9 years after the end of the proposed Area Plan period): 21%
- (Colby, 2015)

b. **Local Data** - According to the Fairfield County Community Wellbeing Index 2016\(^2\), “Since 1990, the county population increased by 13 percent, at a rate faster than Connecticut’s population overall.” “Over the next decade, older adults (ages 65 and over) are projected to be the only group to increase significantly in size.” (Abraham & Buchanan, 2016) Data presented in that report predicts that the age 65 and over population in Fairfield County will increase by over 36% from 2014 through 2025. (Abraham & Buchanan, 2016)

Census Bureau data accessed by SWCAA for the 14 towns in the southwestern Connecticut area indicate the following increases in the portion of (the now larger) population that is age 60 and above during just the four years of the current Area Plan period:

- 60 and over as a percentage of the entire population: 18.75% in 2012 increased to 19.04% in 2015
- 60 and over minority population as a percentage of the 60 and over population: 20.53% in 2012 increased to 21.6% in 2015
- 60 and over at or below poverty level as a percentage of the 60 and over population: 6.21% in 2012 increased to 7.36% in 2015.
- (AGid Special Census Tabulation, 2009-2013) and (Cho & Bratesman,, 2012)

An additional demographic factor, as important as population growth, is the income inequality in southwestern Connecticut and the gap between the cost of living and income for many. The Bridgeport-Stamford-Norwalk metro area ranks first of the 100 largest U.S. metro areas in income inequality. (Holmes & Berube, 2016) “The county population living in an extreme-income neighborhood (very rich or very poor) has steadily increased, at the expense of “middle-income” neighborhoods.” “Income segregation results in unequal access to community resources.” (Abraham & Buchanan, 2016) The Health & Human Services Poverty Guidelines issued in January 2017 consider those with an income of $12,060 or less as at or below the poverty level. (ASPE Poverty Guidelines, 2017) These guidelines are used to determine eligibility for many assistance programs. However, the Elder Index, which measures how much income a retired older adult requires to meet his or her basic needs without public or private assistance, estimates that an elder living in Fairfield County would require an income of $28,656 to $43,716 to meet their basic needs (Mutcher, Li, & Xu, 2016), leaving many in the gap between eligibility for assistance and adequate resources to meet basic needs.

c. **Funding Levels** - Despite the actual and projected continuing increases in the numbers of older adults eligible for Older Americans Act and other older adult programs, the level of funding available for these programs has remained stagnant and it is difficult to predict funding levels for the next four years. A report by the National Academy of Social Insurance

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\(^2\) The SWCAA Area includes 14 of the 22 towns in Fairfield County. Three of the 4 largest cities in Fairfield County are in the SWCAA Area.
states “Because OAA dollars have been on a declining trajectory in purchasing power as compared to the needs of a rising population of older Americans for a decade, the cumulative services gaps created by chronic underfunding are on track to create more substantial problems in the future as the population of homebound seniors grows, creating a new underclass of older adults with no meaningful access to the most basic of services and shifting costs to communities, charities and health care.” (Montgomery & Blair, 2016)

Locally, the chart on the right illustrates the Older Americans Act and matching State funds available to SWCAA from FFY 2008 through FFY 2017 (top line) in comparison to the rise in the Connecticut older adult population (bars). A continuation of this trend will cause continuing reductions in Older Americans Act services available in the community as the older adult population continues to grow.

4. How Resources May Be Utilized For FFY 2018-2021
SWCAA’s decision-making process for the distribution of Older Americans Act related grant and waiver projects and State Alzheimer’s Aide grants is designed to: fairly and consistently evaluate projects; emphasize meaningful outcomes; include new program applicants; and require competence from its providers.

In order to prioritize the distribution of the funds that may be available each year, the members of the allocations committees (Board and Advisory members representing all of SWCAA’s 14 towns) make funding decisions based on the following criteria: clients to be served, particularly low income and minority clients; community need for service to be provided; demonstrated quality of program; cost effectiveness; administrative competence; and past performance. (Policy and Procedure Manual Title III Grants, 2016) This allows the current needs and service gaps for various populations and towns to be considered each year in relation to the projected funds available as difficult funding and program decisions are made.

In addition, SWCAA solicits the input of a variety of community partners, as needed, to assist in prioritizing specific current needs. This could include, for example, Advisory Council members, community outreach workers, CHOICES volunteers, senior center directors or municipal agents. To work on the difficult FFY 2017 nutrition shortfalls, SWCAA convened an ad hoc committee of Board of Directors members, Advisory Council members, and Elderly Nutrition Provider staff to brain storm, analyze, and debate possible options. Once likely options were prioritized, meal site partners were also brought into the discussions. Quarterly meetings are continuing throughout the contract period to ensure serving levels are remaining on target. Similar processes will be utilized during the FFY 2018-2021 Area Plan years to make allocation and program decisions based on current needs and available resources.
EXHIBIT II-7 Summary of Area Plan Goals & Objectives with goals in priority order

Instructions: List goals in order of importance, with objectives listed under each goal, as appropriate.
## Summary of Area Plan Goals & Objectives

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
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<tbody>
<tr>
<td>1. Ensure access to programs and services that will enhance economic security of older adults.</td>
<td>1.1 Support the capacity of community services with resources and information</td>
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<td>1.2 Increase the awareness of available services and supports</td>
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<td>1.3 Assist older adults and their family members to access and receive services and to navigate systems</td>
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<tr>
<td>2. Ensure access to community based long-term services and supports to maximize independence of older adults.</td>
<td>2.1 Support the capacity of community services with resources and information</td>
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<td></td>
<td>2.2 Increase the awareness of available services and supports</td>
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<td>2.3 Assist older adults and their family members to access and receive services and to navigate systems</td>
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<tr>
<td>3. Ensure access to proven health promotion, wellness, and disease prevention programs for older adults and caregivers.</td>
<td>3.1 Support the capacity of community services with resources and information</td>
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<td></td>
<td>3.2 Increase the awareness of available services and supports</td>
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EXHIBIT II-8  Area Plan in Detail: Statement of Goals, Objectives and Strategies

Instructions for Completing the Area Plan in Detail

Instructions: The Area Agency is asked to provide the State Unit on Aging (State Department on Aging – SDA) with its Four Year Goals, Objectives and Strategies. This section should reflect the needs identified in Exhibit II-6. All objectives listed in Exhibit II-7 should be addressed. Please use a separate page for each objective.
GOAL 1

Ensure access to programs and services that will enhance economic security of older adults.

Rationale:
“Lack of financial security in older age is a major obstacle to Healthy Ageing and to reducing health inequity.” (World Report on Ageing and Health, 2015) Americans are living longer and those in Fairfield County struggle to age in community in an area where the cost of living is high and income inequality is the highest in the country. People are also living longer with chronic illnesses and various forms of dementia, increasing their need for costly services. Assistance locating and applying for benefits that may help make ends meet is much needed. Financial assistance generated the highest number of SWCAA I&A calls over the past three years.

Objective 1.1: Support the capacity of community services with resources and information

Strategies:
1. Distribute grant funds, as available, utilizing a broadly publicized request for proposals process with extensive input from Advisory Council and Board of Directors to review, prioritize, and distribute funds to support a wide range of community services, especially in the areas of information & assistance, outreach, and legal services, prioritizing grantees serving OAA target population older adults through the use of a weighted scoring tool. (See also objectives 2.1 and 3.1) annually
2. Require focal points to reach out to, and raise awareness of their services among older adults in OAA target population groups. (See also objectives 2.1 and 3.1) ongoing
3. Routinely distribute information about available grant announcements and local grant writing training opportunities to community providers. (See also objectives 2.1 and 3.1) ongoing
4. Visit all grant funded programs for oversight, support and to help facilitate collaboration between grantees. (See also objectives 2.1 and 3.1) ongoing
5. Utilize Advisory Council as a forum for discussion and development of needed community services; to share information with the community including emergent issues, innovative solutions and new services; and to foster collaboration among municipalities and service providers. (See also objectives 2.1 and 3.1) 6-7 times a year
6. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and ongoing
applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.2, 2.1, 2.2, 3.1, and 3.2)

7. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

8. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

9. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year

10. Provide support to the active Bridgeport neighborhood senior centers through scheduled visits from the Title III B Outreach Worker. (Title III B waiver) (See related strategies in objectives 2.1, and 3.1) annually

11. Advocate for coordination between Federal, State and local agencies in an effort to streamline eligibility determination. (See also objectives 2.1 and 3.1) ongoing

12. Explore new community partners/opportunities, with emphasis on providing I&A services to Older Americans Act target populations. (See also objectives 1.2, 2.1, 2.2, 3.1, and 3.2) ongoing

13. Maintain and promote a link to DSS ConneCT application portal, ASCEND and Respite programs to support community partners with the ability to check the status of client applications. (See also objectives 1.2, 1.3, and 3.1) ongoing

14. Explore the use of HIPPA compliant data transfer to streamline the Form 5 reporting requirements for grantees and nutrition providers. (See also objectives 2.1 and 3.1) 2018

15. Develop and present an annual presentation to update the community of changes to programs that assist with economic security and long term services and supports. (See also objectives 1.2, 2.1, 2.2, 3.1, and 3.2) annually

16. Host annual provider meeting to inform community of Title III and community focal point services, and make them aware of the CHOICES and SMP programs and how they can help clients. (See also objectives 2.1 and 3.1) annually

17. Work on a community-wide legislative priorities agenda which advocates for funds and resources to support home & community-based services that can improve economic security. (See related strategies in objectives 2.1 and 3.1) annually
GOAL 1: Ensure access to programs and services that will enhance economic security of older adults.

Objective 1.2: Increase the awareness of available services and supports.

Strategies:

1. Provide grant funding, as available, to projects that will provide information & assistance and outreach services with a focus on OAA target population older adults throughout the Area. (See related strategies in objectives 1.3, 2.2, 2.3, 3.2, and 3.3) annually

2. Require all grantees to provide referrals for any participants in need of additional services. (See also objectives 2.2 and 3.2) annually

3. Share information about available services through Advisory Council meeting discussions and collaborations between Advisory Council members. (See also objectives 2.2 and 3.2) 6-7 times a year

4. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.1, 2.1, 2.2, 3.1, and 3.2) ongoing

5. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

6. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

7. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year

8. Provide support to City of Bridgeport residents at Senior Centers or housing communities to assure all information is provided to individuals with limited English proficiency in their preferred manner of communication (by phone, email, in-person etc.) (Title III B Waiver) (See also objectives 2.2, and 3.2) annually

9. Present information at local senior centers and advisory councils, radio and other public education events about support for clients and caregivers. (target numbers of clients and units as approved in the waiver) (TIII E Waiver) (See also objectives 2.2 and 3.2) annually

10. Explore new community partners/opportunities, with emphasis on providing I&A services to Older Americans Act target populations. (See also objectives 1.2, 2.1, 2.2, 3.1, and 3.2) ongoing

11. Utilize Focal Points to raise awareness of availability of Senior Housing Assistance Fund (SHAF). ongoing
12. Increase and strengthen the community capacity as evidenced by a 2% increased recruitment annually and 85% retention of CHOICES and SMP volunteers. (See also objectives 1.3, 3.2, and 3.3)  
ongoing
13. Explore the possibility of local volunteer agencies to promote coordination of recruitment and training of CHOICES volunteers to build capacity. (See also objectives 1.3, 3.2, and 3.3)  
annually
14. Enhance and refine SWCAA’s system for volunteer processes, including improving and integrating volunteer engagement & retention planning, policy development, alignment and evaluation within the framework of the VRPM. (See also objectives 1.3, 3.2, and 3.3)  
2018
15. Solicit engagement and involvement from current CHOICES volunteer core to implement VRPM framework. (See also objectives 1.3, 3.2, and 3.3)  
2018
16. As funds allow, build the capacity of volunteers to communicate effectively about topics related to Medicare, Medicare Savings Program, Preventative Services, especially with identified Title III populations. (MIPPA) (See also objectives 1.3, 3.2, and 3.3)  
ongoing
17. Provide information about health benefit programs utilizing public events presented by CHOICES counselors and marketing materials. (See also objective 3.2)  
ongoing
18. Provide free and confidential appointments with certified CHOICES counselors in person at local sites or over the phone, which ever is most convenient for the individual, in all 14 municipalities throughout the SWCAA area, striving to consistently meet SHIP performance measures. (See also objectives 1.3, 3.2, and 3.3)  
ongoing
19. Help will be provided in resolving specific health insurance problems or facilitating the appeal process as needed. (See also objectives 1.3, 3.2, and 3.3)  
ongoing
20. Maintain and promote a link to DSS ConneCT application portal, ASCEND and Respite programs to support community partners to be able to provide information to individuals applying for benefits or check the status of an existing application. (See also objectives 1.1, 1.3, and 3.1)  
ongoing
21. Send semiannual article for distribution in Senior Center newsletters to inform public of Medicare and other important deadlines, changes, issues and legislative priorities. (See also objectives 2.2 and 3.2)  
semiannually
22. Develop and present an annual presentation to update the community of changes to programs that assist with economic security and long term services and supports. (See also objectives 1.1, 2.1, 2.2, 3.1, and 3.2)  
annually
23. Present information on services and supports with focus on economic stability at Senior Commissions, Councils, Focal Points, and Livable Communities. (See related strategy in objective 2.2)  
annually
GOAL 1: Ensure access to programs and services that will enhance economic security of older adults.

Objective 1.3: Assist older adults and their family members to access and receive services and to navigate systems.

Strategies:

1. Provide grant funding, as available, to projects that will assist OAA target population older adults and their families to locate and apply for appropriate services. (See related strategies in objectives 1.2, 2.2, 2.3, 3.2, and 3.3) annually
2. Provide grant funding, as available, for legal services to assist older adults and their families to understand and exercise their legal rights and prioritize resources to meet the needs of exploited or abused senior adults. (See related strategies in objectives, 2.3, and 3.3) annually
3. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing
4. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing
5. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year
6. Older adults will be offered eligibility screening for available programs and, as requested, assistance will be available throughout an application process. (See also objectives 2.3 and 3.3) ongoing
7. Assist and/or enroll Bridgeport residents in access programs and services (target number of clients and units as approved in waiver). This includes on-site visits, hours at local senior centers, and home visits, assisting individuals with limited English proficiency in their preferred manner of communication. (Title III B waiver) (See also objectives 2.3 and 3.3) annually
8. Assist older adults access important services, entitlements and programs (target clients and units as approved in waiver) by providing information & assistance via the CHOICES 800 number and public presentations, aging network meetings, etc. (Title III B Waiver) (See also objectives 2.3 and 3.3) annually
9. Provide nutrition education/materials and referrals to nutrition counseling to target number of clients approved in the waiver. (Title III C waiver) (See also objectives 2.3 and 3.3) annually
10. Increased access/options for approximately 26 older adults who fall below 200% of the FPL and at risk of homelessness to secure or remain in affordable housing through The Senior Housing annually
Assistance Fund (SHAF) interest free loans for security deposits, moving expenses, utilities, and other housing needs.

11. Increase and strengthen community capacity as evidenced by a 2% increased recruitment annually and 85% retention of CHOICES and SMP volunteers. (See also objectives 1.2, 3.2, and 3.3)

12. Explore the possibility of local volunteer agencies to promote coordination of recruitment and training of CHOICES volunteers to build capacity. (See also objectives 1.2, 3.2, and 3.3)

13. Enhance and refine SWCAA’s system for volunteer processes, including improving and integrating volunteer engagement & retention planning, policy development, alignment and evaluation within the framework of the VRPM. (See also objectives 1.2, 3.2, and 3.3)

14. Solicit engagement and involvement from current CHOICES volunteer core to implement VRPM framework. (See also objectives 1.2, 3.2, and 3.3)

15. As funds allow, build the capacity of volunteers to outreach and assist effectively about topics related to Medicare, Medicare Savings Program, Preventative Services, especially with identified Title III populations. (MIPPA) (See also objectives 1.2, 3.2, and 3.3)

16. Provide free and confidential appointments with certified CHOICES counselors in person at local sites or over the phone, which ever is most convenient for the individual, in all 14 municipalities throughout the SWCAA area, striving to consistently meet SHIP performance measures. (See also objectives 1.2, 3.2, and 3.3)

17. Help will be provided in resolving specific health insurance problems or facilitating the appeal process as needed. (See also objectives 1.2, 3.2, and 3.3)

18. Maintain and promote a link to DSS ConnecCT application portal, ASCEND and Respite programs to support community partners to be able to assist individuals applying for benefits or check the status of an existing application. (See also objectives 1.1, 1.2, and 3.1)
GOAL 2

Ensure access to community based long-term services and supports to maximize independence of older adults.

Rationale:
Community-based services and supports help older adults accomplish everyday tasks, provide respite for caregivers, allow older adults to remain independent in the community, and prevent expensive hospital and nursing costs. (Atkin, Tumlinson, & Dawson, Financing for Long-Term Services and Supports, 2016) The need for long-term services and supports will be a fact of life for more than half of those retiring today. (Mann, Raphael, Anthony, & Nevitt, 2016) In-Home Services generated the second most SWCAA I&A calls over the past three years.

Objective 2.1: Support the capacity of community services with resources and information.

Strategies:

1. Distribute grant funds, as available utilizing a broadly publicized request for proposals process with extensive input from Advisory Council and Board of Directors to review, prioritize, and distribute funds to support a wide range of community services, prioritizing grantees serving OAA target population older adults through the use of a weighted scoring tool. (See also objectives 1.1 and 3.1) annually

2. Require focal points to reach out to, and raise awareness of their services among older adults in OAA target population groups. (See also objectives 1.1 and 3.1) ongoing

3. Routinely distribute information about available grant announcements and local grant writing training opportunities to community providers. (See also objectives 1.1 and 3.1) ongoing

4. Visit all grant funded programs for oversight, support and to help facilitate collaboration between grantees. (See also objectives 1.1 and 3.1) ongoing

5. Utilize Advisory Council as a forum for discussion and development of needed community services; to share information with the community including emergent issues, innovative solutions and new services; and to foster collaboration among municipalities and service providers. (See also objectives 1.1 and 3.1) 6-7 times a year

6. Provide at least one leader training for CDSMP. (See also objective 3.1) annually

7. Provide at least one leader training for DSMP. (See also objective 3.1) annually

8. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.1, 1.2, 2.2, 3.1, and 3.2) ongoing

9. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and ongoing
assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives)

10. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives)

11. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives)

12. Provide community based long-term services and supports information at the active Bridgeport neighborhood senior centers through scheduled visits from the Title III B Outreach Worker. (Title III B waiver) (See related strategies in objectives 1.1, and 3.1)

13. Advocate for coordination between Federal, State and local agencies in an effort to streamline eligibility determination. (See also objectives 1.1 and 3.1)

14. Explore new community partners/opportunities, with emphasis on providing I & A services to Older Americans Act target populations. (See also objectives 1.1, 1.2, 2.2, 3.1, and 3.2)

15. Community-driven planning and development meetings with groups such as: Municipal Agents, Senior Center Directors, or Focal Points to reflect their expressed needs, preferences, and expectations.

16. Information regarding services, programs and benefits will be exchanged and updated through participation in and presentations at senior focused organizations such as Senior Umbrella, Westport Coordinating Council, Greater Bridgeport Elder Service Council, etc.

17. Explore the use of HIPPA compliant data transfer to streamline the Form 5 reporting requirements for grantees and nutrition providers. (See also objectives 1.1 and 3.1)

18. Develop and present an annual presentation to update the community of changes to programs that assist with economic security and long term services and supports. (See also objectives 1.1, 1.2, 2.2, 3.1, and 3.2)

19. Host annual provider meeting to inform community of Title III and community focal point services, and make them aware of the CHOICES and SMP programs and how they can help clients. (See also objectives 1.1 and 3.1)

20. Work on a community-wide legislative priorities agenda which advocates for funds and resources to support community based long-term services and supports. (See related strategies in objectives 1.1 and 3.1)

21. Assist Connecticut Legal Services in:
   a. identifying gaps in legal advocacy for older adults and developing a plan to meet the identified needs as evidenced by the Title III contract deliverables per the Model Approaches to State Legal Assistance Systems Phase II. (See also objective 2.3)


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GOAL 2: Ensure access to community based long-term services and supports to maximize independence of older adults.

Objective 2.2: Increase the awareness of available services and supports.

Strategies:

1. Provide grant funding, as available, to projects that will provide information & assistance, and outreach services with a focus on OAA target population older adults throughout the Area. (See related strategies in objectives 1.2, 1.3, 2.3, 3.2, and 3.3) annually

2. Require all grantees to provide referrals for any participants in need of additional services. (See also objectives 1.2 and 3.2) annually

3. Share information about available services through Advisory Council meeting discussions and collaborations between Advisory Council members. (See also objectives a.2 and 3.2) 6-7 times a year

4. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.1, 1.2, 2.1, 3.1, and 3.2) ongoing

5. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives.) ongoing

6. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives.) ongoing

7. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives.) at least once a year

8. Provide support to City of Bridgeport residents at Senior Centers or housing communities to assure all information is provided to individuals with limited English proficiency in their preferred manner of communication (by phone, email, in-person etc.) (Title III B Waiver) (See also objectives 1.2 and 3.2) annually

9. Present information at local senior centers and advisory councils, radio and other public education events about support for clients and caregivers. (target numbers of clients and units as approved in the waiver) (TIII E Waiver) (See also objectives 1.2 and 3.2) annually

10. Explore new community partners/opportunities, with emphasis on providing I & A services to Older Americans Act target populations. (See also objectives 1.1, 1.2, 2.1, 3.1, and 3.2) ongoing

11. Send semiannual articles for distribution in Senior Center newsletters to inform public of Medicare and other important semiannually
12. Develop and present an annual presentation to update the community of changes to programs that assist with economic security and long term services and supports. (See also objectives 1.1, 1.2, 2.1, 3.1, and 3.2)

13. Present information on Long Term Services and Supports at Senior Commissions, Councils, Livable Communities, Municipal Agents, and focal points. (See related strategy in objective 1.2)
GOAL 2: Ensure access to community based long-term services and supports to maximize independence of older adults.

Objective 2.3: Assist older adults and their family members to access and receive services and to navigate systems.

Strategies:

1. Provide grant funding, as available, to projects that will provide one-on-one counseling, social support services, support groups, or other types of services that will assist older adults and their families, with a focus on OAA target population older adults, to locate and apply for appropriate services. (See related strategies in objectives 1.2, 1.3, 2.2, 3.2, and 3.3) annually

2. Provide grant funding, as available, for legal services to assist older adults and their families to understand and exercise their legal rights. (See related strategies in objectives 1.3, and 3.3) annually

3. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

4. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

5. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year

6. Older adults will be offered eligibility screening for available programs and, as requested, assistance will be available throughout an application process. (See also objectives 1.3 and 3.3) ongoing

7. Assist and/or enroll Bridgeport residents in access programs and services (target number of clients and units as approved in waiver). This includes on-site visits, hours at local senior centers, and home visits, assisting individuals with limited English proficiency in their preferred manner of communication. (Title III B waiver) (See also objectives 1.3 and 3.3) annually

8. Assist older adults access important services, entitlements and programs (target clients and units as approved in waiver) by providing information & assistance via the CHOICES 800 number and public presentations, aging network meetings, etc. (Title III B Waiver) (See also objectives 1.3 and 3.3) annually

9. Provide nutrition education/materials and referrals to nutrition counseling to target number of clients as approved in the waiver. (Title III C waiver) (See also objectives 1.3 and 3.3) annually

10. Enroll participants in respite programs or supplemental services as funds permit. (See related strategy in objective 3.3) annually
11. Assist Connecticut Legal Services in:
   a. identifying gaps in legal advocacy for older adults and 2018
   b. developing a plan to meet the identified needs 2019
as evidenced by the Title III contract deliverables per the Model Approaches to State Legal Assistance Systems Phase II. (See also objective 2.2)
GOAL 3

Ensure access to proven health promotion, wellness, and disease prevention programs for older adults and caregivers.

Rationale:
The World Health Organization “defines Healthy Ageing as the process of developing and maintaining the functional ability that enables well-being in older age.” (World Report on Ageing and Health, 2015) “These components—purpose, social engagement, healthy diet, mobility, exercise—become especially important as determinants of health in old age.” (Lock & Belza, 2016) Fostering active, healthy living maximizes Americans’ quality of life and their contributions to society. (Lock & Belza, 2016) Health & wellness services can include: exercise, good nutrition, recommended health screenings, oral health, health education, management of chronic conditions, mental and cognitive health, health insurance navigation, opportunities to interact with others and contribute to society, support for caregivers, and prevention of elder abuse. Health concerns and nutrition generated the third and fourth most SWCAA I&A calls over the past three years.

Objective 3.1: Support the capacity of community services with resources and information

Strategies:

1. Distribute available grant funds utilizing a broadly publicized annually request for proposals process with extensive input from Advisory Council and Board of Directors to review, prioritize, and distribute funds to support a wide range of community services including nutrition, health and wellness services, behavioral health services, evidence-based health promotion services and elder abuse prevention, prioritizing grantees serving OAA target population older adults through the use of a weighted scoring tool. (See also objectives 1.1 and 2.1)

2. Require focal points to reach out to, and raise awareness of their ongoing services among older adults in OAA target population groups. (See also objectives 1.1 and 2.1)

3. Routinely distribute information about available grant ongoing announcements and local grant writing training opportunities to community providers. (See also objectives 1.1 and 2.1)

4. Visit all grant funded programs for oversight, support and to help ongoing facilitate collaboration between grantees. (See also objectives 1.1 and 2.1)

5. Utilize Advisory Council as a forum for discussion and development of needed community services; to share information with the community including emergent issues, innovative solutions and new services; and to foster collaboration among municipalities and service providers. (See also objectives 1.1 and 2.1)

6. Convene a minimum of 2 meetings yearly with Elderly Nutrition Providers and meal site partners to work together on appropriate utilization of available nutrition funds. minimum of 2 times a year

7. Provide at least one leader training for CDSMP. (See also objective annually 2.1)
8. Provide at least one leader training for DSMP. (See also objective 2.1) annually

9. Identify new, non-traditional host sites and community partners, such as local companies who provide employee wellness programs, in order to implement the CDSMP and expand services. ongoing

10. Implement the HBAI/DSMT Learning Collaborative with a focus on seeking HBAI Medicare Reimbursement in order to sustain the CDSMP. 2018

11. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.1, 1.2, 2.1, 2.2, and 3.2) ongoing

12. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

13. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

14. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year

15. Provide support to the active Bridgeport neighborhood senior centers through scheduled visits from the Title III B Outreach Worker to assist with health insurance and access to other wellness programs. (Title III B waiver) (See related strategies in objectives 1.1, and 2.1) annually

16. Advocate for coordination between Federal, State and local agencies in an effort to streamline eligibility determination. (See also objectives 1.1 and 2.1) ongoing

17. Explore new community partners/opportunities, with emphasis on collaboration, cross training, and provision of I&A services to Older Americans Act target populations. (See also objectives 1.1, 1.2, 2.1, 2.2, and 3.2) ongoing

18. Maintain and promote a link to DSS ConneCT application portal, ASCEND and Respite programs to support community partners with the ability to check the status of client applications. (See also objectives 1.1, 1.2, and 1.3) ongoing

19. Utilization of the DSS Escalation Unit to investigate and rectify errors or links to available programs; SNAP, MSP, Husky. ongoing

20. Maintain distribution lists of Municipal Agents, Senior Center Directors, Advisory Board, Resident Service Coordinators, Aging Partnership Associations, and Religious Organizations for purposes of updating the community on aging issues at least 4 times a year. quarterly
21. Communicate “dementia awareness” in collaboration with the regional Alzheimer’s Association chapter through presentations/events to the Aging network. annually

22. Through participation in CAPE (Coalition for Abuse Prevention of the Elderly) meetings, identify and develop at least 1 strategy to alert and inform the community of emergent elder justice issues ongoing

23. Increased access/options for the caregiver and care recipient through exploration and promotion of new models related to caregiver support. ongoing

24. Explore the use of HIPPA compliant data transfer to streamline the Form 5 reporting requirements for grantees and nutrition providers. (See also objectives 1.1 and 2.1) 2018

25. Develop and present an annual presentation to update the community of changes to programs that assist with health, wellness, and long term services and supports. (See also objectives 1.1, 1.2, 2.1., 2.2, and 3.2) annually

26. Host annual provider meeting to inform community of Title III and community focal point services, and make them aware of the CHOICES and SMP programs and how they can help clients. (See also objectives 1.1 and 2.1) annually

27. Work on a community-wide legislative priorities agenda which advocates for funds and resources to support health and wellness services for older adults. (See also objectives 1.1 and 2.1) annually

28. Support the capacity of regional Agencies on Aging to participate in the Veterans’ Directed Home and Community-based Services program by acting as a “billing hub” for Eastern, North Central and Western regions. ongoing

29. Coordinate high quality care management support to Veterans referred to the Veterans’ Directed Home and Community-based Services program in compliance with all program guidelines. ongoing
GOAL 3: Ensure access to proven health promotion, wellness, and disease prevention programs for older adults and caregivers.

Objective 3.2: Increase the awareness of available services and supports.

Strategies:

1. Provide grant funding, as available, to projects that will provide information & assistance, and outreach services to OAA target population older adults throughout the Area. (See related strategies in objectives 1.2, 1.3, 2.2, 2.3, and 3.3) annually

2. Require all grantees to provide referrals for any participants in need of additional services. (See also objectives 1.2 and 2.2) annually

3. Share information about available services through Advisory Council meeting discussions and collaborations between Advisory Council members. (See also objectives 1.2 and 2.2) 6-7 times a year

4. Expand CDSMP outreach by providing new host sites with CDSMP workshop opportunities in order to increase their services. ongoing

5. Maintain a web resource directory to allow optimal utilization by older adults, their caregivers, community providers and persons of all ages, to effortlessly and quickly find information and applications on programs and services, such as rent rebate, MSP, CDSMP, nutrition, and Medicare. (See also objectives 1.1, 1.2, 2.1, 2.2, and 3.1) ongoing

6. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

7. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

8. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) at least once a year

9. Provide support to City of Bridgeport residents at Senior Centers or housing communities to assure all information is provided to individuals with limited English proficiency in their preferred manner of communication (by phone, email, in-person, etc.) (Title III B Waiver) (See also objectives 1.2 and 2.2) annually

10. Present information at local senior centers and advisory councils, radio and other public education events about support for clients and caregivers. (target numbers of clients and units as approved in the waiver) (TIII E Waiver) (See also objectives 1.2 and 2.2) annually

11. Explore new community partners/opportunities, with emphasis on providing I&A services to Older Americans Act target populations. (See also objectives 1.1, 1.2, 2.1, 2.2, and 3.1) ongoing
12. Participate in health and wellness fairs/events promoting and educating the public about community health and wellness services.

13. Provide in-home respite services to clients, as funds permit. (Title III E waiver and State Alzheimer’s Respite) (See related strategy in objective 2.3)

14. Increase and strengthen the community capacity as evidenced by a 2% increased recruitment annually and 85% retention of CHOICES and SMP volunteers. (See also objectives 1.2, 1.3, and 3.3)

15. Explore the possibility of local volunteer agencies to promote coordination of recruitment and training of CHOICES volunteers to build capacity. (See also objectives 1.2, 1.3, and 3.3)

16. Enhance and refine SWCAA’s system for volunteer processes, including improving and integrating volunteer engagement & retention planning, policy development, alignment and evaluation within the framework of the VRPM. (See also objectives 1.2, 1.3, and 3.3)

17. Solicit engagement and involvement from current CHOICES volunteer core to implement VRPM framework. (See also objectives 1.2, 1.3, and 3.3)

18. As funds allow, build the capacity of volunteers to communicate effectively about topics related to Medicare, Medicare Savings Program, Preventative Services, especially with identified Title III populations. (MIPPA) (See also objectives 1.2, 1.3, and 3.3)

19. Provide information about health benefit programs utilizing public events presented by CHOICES counselors and marketing materials. (See also objective 1.2)

20. Provide free and confidential appointments with certified CHOICES counselors in person at local sites or over the phone, which ever is most convenient for the individual, in all 14 municipalities throughout the SWCAA area, striving to consistently meet SHIP performance measures. (See also objectives 1.2, 1.3, and 3.3)

21. Help will be provided in resolving specific health insurance problems or facilitating the appeal process as needed. (See also objectives 1.2, 1.3, and 3.3)

22. CHOICES Counselors will identify Veterans through an I&A checklist and script designed by the VA Healthcare, to assess for potential risk of suicide and to connect them to the local VA Suicide Prevention Coordinator and additional applicable services. (See also objective 3.3)

23. Provide 10 educational outreach events or activities to help prevent fraud and abuse within the Medicare system.

24. Provide public presentations & events in collaboration with the Coalition for Abuse Prevention of the Elderly (CAPE) on topics of elder abuse, scams, and frauds.

25. Heighten the awareness of elder abuse through outreach and education activities for older adults and their caregivers.

26. Send semiannual article for distribution in Senior Center newsletters to inform public of Medicare and other important
deadlines, changes, issues and of legislative priorities. (See also objectives 1.2 and 2.2)

27. Develop and present an annual presentation to update the community of changes to programs that assist with health, wellness, and long term services and supports. (See also objectives 1.1, 1.2, 2.1, 2.2, and 3.1)

28. Work with members from the CT Older Adult Collaboration for Health (COACH), to inform providers of available senior services and supports to inform the provider’s referrals to senior patients. (See also objective 3.3)

annually

CY 2018 and ongoing if the grant is renewed
GOAL 3: Ensure access to proven health promotion, wellness, and disease prevention programs for older adults and caregivers.

Objective 3.3: Assist older adults and their family members to access and receive services and to navigate systems.

Strategies:

1. Provide grant funding, as available, to projects that will provide one-on-one counseling, social support services, support groups, or other types of services that will assist an OAA target population older adults and their families to locate and apply for appropriate services. (See related strategies in objectives 1.2, 1.3, 2.2, 2.3, and 3.2) annually

2. Provide grant funding, as available, for legal services to assist older adults and their families to understand and exercise their legal rights. (See related strategies in objectives 1.2, 1.3, 2.2, 2.3, and 3.2) annually

3. Provide Chronic Disease Self Management workshops to older adult participants. (Target numbers of participants and units as approved in the Title III D waiver) annually

4. Provide Diabetes Self Management workshops to older adult participants. (Target numbers of participants and units as approved in the Title III D waiver) annually

5. Maintain the maximum number of highly trained I&A staff that available resources will allow. Staff will be knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on programs and services which can assist them in living independently in their community. (See also all other objectives) ongoing

6. Provide information and services to limited English proficiency older adults and their families utilizing tools such as bilingual staff, Language Line, CLAS standards, or I Read cards. (See also all other objectives) ongoing

7. Participate in annual cultural awareness programs (i.e. LGBTQ) promoting inclusion, cultural acceptance and intercultural cooperation. (See also all other objectives) At least 1 time per year

8. Older adults will be offered eligibility screening for available programs and, as requested, assistance will be available throughout an application process. (See also objectives 1.3 and 2.3) ongoing

9. Assist and/or enroll Bridgeport residents in access programs and services (target number of clients and units as approved in waiver). This includes on-site visits, hours at local senior centers, and home visits, assisting individuals with limited English proficiency in their preferred manner of communication. (Title III B waiver) (See also objectives 1.3 and 2.3) annually

10. Assist older adults access important services, entitlements and programs (target clients and units as approved in waiver) by providing information & assistance via the CHOICES 800 number and public presentations, aging network meetings, etc. (Title III B Waiver) (See also objectives 1.3 and 2.3) annually
11. Provide nutrition education/materials and referrals to nutrition counseling to target number of clients as approved in the waiver. (Title III C waiver) (See also objectives 1.3 and 2.3) 

annually

12. Increase the ability of SWCAA and their community partners to share information quickly as to create a “no wrong door” providing service directly to residents in their time of need.

ongoing

13. Increase and strengthen the community capacity as evidenced by a 2% increased recruitment and 85% retention of CHOICES and SMP volunteers. (See also objectives 1.2, 1.3, and 3.2)

ongoing

14. Explore the possibility of local volunteer agencies to promote coordination of recruitment and training of CHOICES volunteers to build capacity. (See also objectives 1.2, 1.3, and 3.2)

ongoing

15. Enhance and refine SWCAA’s system for volunteer processes, including improving and integrating volunteer engagement & retention planning, policy development, alignment and evaluation within the framework of the VRPM. (See also objectives 1.2, 1.3, and 3.2)

2018

16. Solicit engagement and involvement from current CHOICES volunteer core to implement VRPM framework. (See also objectives 1.2, 1.3, and 3.2)

2018

17. As funding allows, build the capacity of volunteers to outreach and assist effectively about topics related to Medicare, Medicare Savings Program, Preventative Services, especially with identified Title III populations. (MIPPA) (See also objectives 1.2, 1.3, and 3.2)

ongoing

18. Provide free and confidential appointments with certified CHOICES counselors in person at local sites or over the phone, which ever is most convenient for the individual, in all 14 municipalities throughout the SWCAA area, striving to consistently meet SHIP performance measures. (See also objectives 1.2, 1.3, and 3.2)

ongoing

19. Help will be provided in resolving specific health insurance problems or facilitating the appeal process as needed. (See also objectives 1.2, 1.3, and 3.2)

ongoing

20. CHOICES Counselors will identify Veterans through an I&A checklist and script designed by the VA Healthcare, to assess for potential risk of suicide and connection to the local VA Suicide Prevention Coordinator and additional applicable services. (See also objective 3.2)

ongoing

21. Work with members from the CT Older Adult Collaboration for Health (COACH), to increase awareness for all healthcare practitioners of promising interventions and strategies when working with an older cohort. (See also objective 3.2)

CY 2018 and ongoing if the grant is renewed
EXHIBIT II-9  Summary of Public Comment on Area Plan

**Instructions**: Include the following: Publicity date(s), location(s) of hearing(s), number in attendance, briefly describe proceedings, and note number of people giving verbal and written testimony. Summarize main points/focus of testimony noting significance (i.e. number of times mentioned)
Summary of Public Comment on Area Plan
Appendix 1

Works Cited


https://aspe.hhs.gov/poverty-guidelines


**Title III E Cost Sharing Policy**

**The National Family Caregiver Support Program**

The **National Family Caregiver Support Program** (NFCSP) is funded by the Administration For Community Living, and is operated in partnership with the State of Connecticut Department on Aging and the Connecticut Area Agencies on Aging. **This program requests a cost share contribution toward the cost of services received based on the care recipient’s monthly income as listed below, donations are accepted for care recipients under 100% of the poverty level:**

<table>
<thead>
<tr>
<th>Based on 2017 US Poverty Guidelines Income Range (% of FPL)</th>
<th>Individual’s Monthly Income</th>
<th>Cost Share Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100%</td>
<td>0 to $1,005</td>
<td>donations accepted</td>
</tr>
<tr>
<td>150%</td>
<td>$1,006-$1,508</td>
<td>5%</td>
</tr>
<tr>
<td>200%</td>
<td>$1,509-$2,010</td>
<td>10%</td>
</tr>
<tr>
<td>250%</td>
<td>$2,011-$2,513</td>
<td>20%</td>
</tr>
<tr>
<td>300%</td>
<td>$2,514-$3,015</td>
<td>40%</td>
</tr>
<tr>
<td>350%</td>
<td>$3,016-$3,518</td>
<td>60%</td>
</tr>
<tr>
<td>400%</td>
<td>$3,519-$4,020</td>
<td>80%</td>
</tr>
<tr>
<td>Over 400%</td>
<td>$4,021+</td>
<td>100%</td>
</tr>
</tbody>
</table>

To be eligible, the **CAREGIVER** must:
- be over 18 and caring for a person aged 60 years or older, OR
- be a relative caregiver age 55 or older, who is not a parent, and is caring full-time for an adult age 19-59 with disabilities.

To be eligible, the **CARE RECIPIENT** must:
- need assistance with at least two activities of daily living (ADLs). ADLs include bathing, dressing, toileting, eating, walking without substantial human assistance, OR
- have a cognitive or other mental impairment that requires substantial supervision.

Priority will be given to older individuals with the greatest social and economic need, with particular attention to low-income older adults; or older individuals providing full-time care and support to adults with severe disabilities.
This Program Instruction (PI) provides procedures for soliciting service contributions from recipients of Title III-E services only that are provided under the Older Americans Act.

In 2000, amendments to the Older Americans Act (OAA) allowed states to implement cost sharing for certain OAA services. The Reauthorization of the Older Americans Act of 2006 retains the cost sharing options for specified Title III services first enacted with the 2000 amendments in Section 315, Consumer Contributions. Cost sharing policies shall be established by each Area Agency on Aging based solely on care recipient income (or the income of a relative caregiver for a child 18 or younger) and the cost of services being provided. Care recipients at or below 200% of the Federal Poverty Level (FPL) will be excluded from consideration. However, those individuals with incomes at or below 200% of the FPL may make voluntary contributions for services received. Cost sharing policies developed by the AAA’s shall be designed to ensure that participation of low-income individuals will not decrease. Each AAA shall inform new and recertified clients of cost sharing requirements for the Program. Pursuant to Section 315, (a), (2) of the Older Americans Act cost sharing will be implemented for Title III-E services funded by the OAA, with the exception of information and assistance, outreach, benefits counseling, case management services, ombudsman, elder abuse prevention, legal assistance, consumer protection services, congregate and home delivered meals, and those services delivered through tribal organizations. Cost sharing will be implemented for Title III-E respite and supplemental services only.

1) The cost-sharing policies developed by each AAA must ensure that the AAA shall:

- protect the privacy and confidentiality of each older individual with respect to the declaration or nondeclaration of individual income and to any share of costs paid or unpaid by an individual;
- establish appropriate procedures to safeguard and account for cost share payments;
- use each collected cost share payment to expand the service for which such payment was given;
not consider assets, savings, or other property owned by an older individual in determining whether cost sharing is permitted;

not deny any service for which funds are received under this Act for an older individual due to the income of such individual or such individual’s failure to make a cost sharing payment;

determine the eligibility of older individuals to cost share solely by a confidential declaration of income and with no requirement for verification; and

widely distribute written materials in languages reflecting the reading abilities of older individuals that describe the criteria for cost sharing, the State’s sliding fee schedule and that services will not be denied individuals as mandated under subparagraph 5 above.

Reporting on cost share procedures will be at the discretion of the Department’s State Unit on Aging. Area Agencies on Aging must submit initial cost sharing policies for SUA approval no later than 8/1/11. Review and approval of each AAA’s policy shall be completed at least 30 days prior to the start of the Federal Fiscal Year. Any changes to AAA cost sharing policies will require approval by the SUA prior to implementation.

2) Area Agencies on Aging must ensure that fees generated from cost sharing on all fund sources

are used to serve eligible individuals currently on waiting lists;

are utilized to expand service availability to regions of the planning and service area in which services have not been available;

utilize cost sharing funds to expand program services only within the category for which services were provided. Collected cost share payments for respite services shall be utilized for Title III-E respite services only and for supplemental services shall be utilized for Title III-E supplemental services only; and

shall be based on the actual cost of services delivered up to the maximum benefit allowed for respite ($3,500) and supplemental ($750) services.

3) The cost-sharing policies developed by the AAAs shall utilize the following sliding fee scale based on a declaration of income to determine the amount of cost share and to provide guidance to consumers in making voluntary contributions:

<table>
<thead>
<tr>
<th>Income Range (% of FPL)</th>
<th>Individual’s Monthly Income</th>
<th>Couple’s Monthly Income</th>
<th>Cost Share Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 200%</td>
<td>$0 to $1,806</td>
<td>$0 to $2,430</td>
<td>0%</td>
</tr>
<tr>
<td>201 – 250%</td>
<td>$1,807 to $2,258</td>
<td>$2,431 to $3,038</td>
<td>20%</td>
</tr>
<tr>
<td>251 – 300%</td>
<td>$2,259 to $2,709</td>
<td>$3,039 to $3,645</td>
<td>40%</td>
</tr>
<tr>
<td>301 – 350%</td>
<td>$2,710 to $3,159</td>
<td>$3,646 to $4,250</td>
<td>60%</td>
</tr>
<tr>
<td>351 – 400%</td>
<td>$3,160 to $3,612</td>
<td>$4,251 to $4,860</td>
<td>80%</td>
</tr>
<tr>
<td>401 and above</td>
<td>$3,613 and over</td>
<td>$4,861 and over</td>
<td>100%</td>
</tr>
</tbody>
</table>