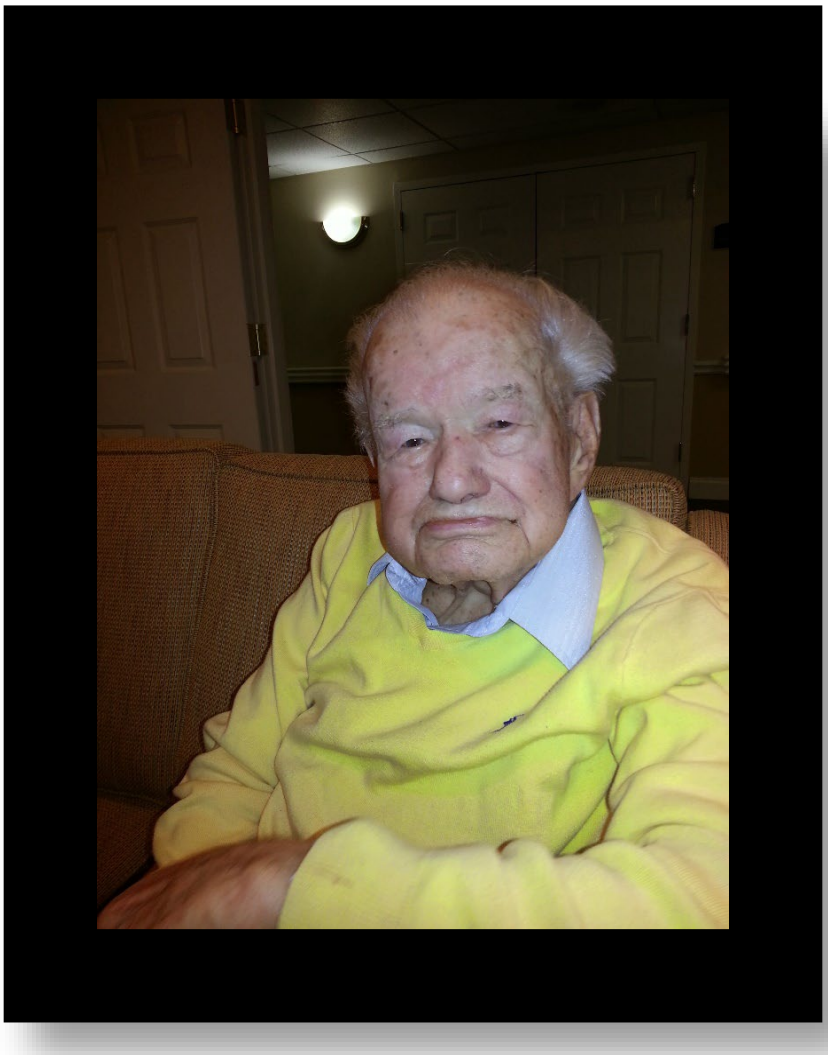
The Southwestern Connecticut Agency on Aging, Inc.

Area Plan October 1, 2025 - September 30, 2028

Access to Information & Supportive Services

Guidance through Person-Centered Care Management

Enhancing Resources and Training for the Aging Network



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Verification of Intent

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Acronyms

AAA Area Agency on Aging
ACL Administration for Community Living
ADRC Aging and Disability Resource Centers
ADRD Alzheimer's Disease and Related Dementias
ADS Aging and Disability Services
APS Adult Protective Services
ARPA American Rescue Plan Act
BOA Bureau of Aging
CDSME Chronic Disease Self-Management Education
CEJC Coalition for Elder Justice in Connecticut
CHOICES Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening
CHSP Congregate Housing Services Program
CIL Center for Independent Living
CMS Center for Medicare and Medicaid Services
CSRP CT Statewide Respite Program
DDS Disability Determination Services
DSS Department of Social Services
ENP Elderly Nutrition Program/Provider
FFY Federal Fiscal Year
FPL Federal Poverty Leve
HCBS Home and Community Based Services
IFF Intrastate Funding Formula
I&R/A Information and Referral/Assistance
LGBTQ+ Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning
LTC Long Term Care
LTCOP Long Term Care Ombudsman Program
LTSS Long Term Services and Supports
MIPPA Medicare Improvements for Patients and Providers Act
MIS Management Information System(s) NCAAA North Central Area Agency on Aging
NFCSP National Family Caregiver Support Program
NSIP Nutrition Services Incentive Program
NWD No Wrong Door
OAA Older Americans Act
PSA Planning and Service Area
PSE Protective Services for the Elderly
SFY State Fiscal Year SHIP State Health Insurance Program
SMP Senior Medicare Patrol

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Executive Summary

The Southwestern Connecticut Agency on Aging (SWCAA) is an Area Agency on Aging serving older adults and people with disabilities. The mission defines SWCAA as the trusted source of advocacy, information, and access to care for older and vulnerable adults. SWCAA provides resources to strengthen the regional aging and disability network. We are proud to be part of a dedicated network of aging and disability partners who improve the lives of older and vulnerable adults. This Area Plan defines the goals, objectives and outcomes that guide our efforts for the next three years.

SWCAA's overarching goals align with those of the Connecticut Bureau of Aging's Statewide Plan. SWCAA's regional efforts will concentrate on the goals of,1) Home & Community Based Services (HCBS) by empowering older adults to reside in the community setting of their choice; 2) Healthy Aging by providing older adults with prevention and wellness opportunities; and 3) Elder Rights and the prevention of elder abuse, fraud, neglect, and exploitation by increasing awareness and avoidance of the stressors that could lead to neglect and abuse.

SWCAA began the Area Plan process three years ago by analyzing call data and documenting meeting summaries with key constituencies. The 2025-2028 Area Plan began with a rigorous assessment of need. Southwestern Connecticut is the most economically and culturally diverse region in Connecticut. As such, it is critical to get input from multiple stakeholders. We analyzed the most pressing regional needs using data from thousands of calls to SWCAA. This three-year review of more than 30,000 contacts offers an accurate analysis of the most pressing challenges for older and vulnerable adults. These data were confirmed through multiple focus groups including legislative priority setting and local needs assessment.

Together with our sister Area Agencies from across the State, we present a clear vision of the opportunities that will lead to, 1) streamlined client experience when accessing services and supports; 2) healthier adult and disabled populations; and 3) reductions in elder abuse, neglect, fraud and exploitation. Funding decisions are made through the lens of equitable access and support for caregivers. SWCAA is powered by the strength

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of its dedicated Board of Directors and guidance from our Advisory Council. These governing and advisory bodies help the Agency monitor activities and outcomes that improve the quality of life for older adults, people with disabilities, and the people who love and care for them.

The growth in the older population, coupled with stagnant funding levels, motivates SWCAA to be more strategic, creative, and collaborative when developing interventions and support for aging services. SWCAA is most excited to continue the work towards a robust, *No Wrong Door* system of access. Working in step with the Department of Aging and Disability Services, we will continue to decrease service fragmentation and increase support of person-centered planning.

The Area Plan includes an outline of emergency procedures, assurances that SWCAA will comply with all State and Federal requirements and proof of State and Federal audit compliance. Waivers are requested to support over 10,000 clients and caregivers with information, assistance, public education, translation, and nutrition education at a total of fourteen (14) percent of the Federal Title III award. Federal awards totaling $3 million are administered and allocated to community partners at a ten (10) percent administration expense.

At the center of all activities, funding decisions, and outcomes are the clients, caregivers and community partners. The proposed outcomes and measures demonstrate SWCAA's commitment to meeting and exceeding contractual benchmarks. SWCAA's success is the direct result of managing resources and effort through the eyes of our stakeholders.

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Context: Overview of the AAA

Mission Statement

SWCAA lives by its mission as the trusted source of advocacy, information, and access to care for older and vulnerable adults that provides resources to strengthen the regional aging network. The mission aligns with the three overarching goals present in the Area Plan by providing streamlined access and information to support an elder's health, independence, preferences and well-being. In recent years, SWCAA has broadened its organizational mission to include vulnerable adults wishing to forego nursing facility or hospital-based institutional care. In 2009, we added "Independent Living" to our tagline to solidify our commitment to any adult, with any disability, seeking to receive their services in the setting of their choice. We work in collaboration with partners from the aging and disability networks to foster a "no wrong door" concept that meets the needs of our region.

Health access, equitable distribution of resources, and social service access for clients and caregivers are at the foundation of our work. The Area Plan presents a roadmap to support the staff and community stakeholders as we weave a strong network of services that maximize the opportunities for older residents, persons with disabilities and the caregivers who love them.

SWCAA Core Values

1. Promote maximum independence and dignity for older adults and persons with disabilities.
2. Raise awareness and understanding of Home & Community-Based Services to maximize access.
3. Build aging and disability network capacity through training, financial resources, and an inclusive spirit of collaboration.
4. Uphold maximum transparency and accountability when communicating with employees, contractors, funders, leadership, and other stakeholders
5. Incorporate efficiency in all aspects of service delivery; maximize the use of administrative technology to increase time for direct client interactions.

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SWCAA is deeply committed to fostering a culture of integrity, collaboration, and innovation, particularly when it comes to supporting vulnerable seniors and facilitating the complex processes surrounding aging services. The focus on values like honesty, transparency, and respect is especially crucial in creating trust and accountability in relationships with both clients and partners.

The “no wrong door” approach is a thoughtful way to ensure that clients have seamless access to services, which can often be a maze and difficult to navigate. SWCAA is not only focused on its own work but is constantly engaging with a wide range of stakeholders to improve and innovate overall services to vulnerable adults. SWCAA demonstrates a commitment to continuous improvement, shared leadership through the Board and Advisory Council and to learning from others in the field.

SWCAA actively researches the best practices and innovative solutions to meet the challenges of aging by participating in quality training and learning experiences. We do so by sharing and learning from the work of other Agencies on Aging across the state and nation. We are committed to working collaboratively with universities, hospitals, Administration of Community Living, Center for Medicare & Medicaid Services and the Department of Aging and Disability Services.

Accomplishments and Challenges

SWCAA achieved success in *supportive services* by empowering older residents to maintain independence and receive their services in the setting of their choice. Such services include but are not limited to, access services including transportation and information & referral, in-home care services, legal assistance, case management, adult day care, support groups, and senior centers. American Recovery Plan Act funds allowed us to serve a greater number of residents from 2020 –2024 and provided opportunities to meet with community leaders to solidify plans in support of older and disabled residents. We joined advocacy and service groups dedicated to housing, mental health, disability, homelessness, and health care, including disease specific groups for Alzheimer’s disease and Parkinson’s disease. SWCAA’s community connections with the leadership from the mayor’s office through the local Municipal

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Agent and Senior Center Director strengthened our ability to assess the local needs and respond with supportive services. Connection to the Adult Day Centers and senior centers helped identify caregivers in need of support. We looked at access through the lens of greatest need by focusing funding to the areas with the highest percentage of adults meeting the target populations set by the Older Americans Act. Innovative solutions were identified, and three new grants were implemented. The 2024-2026 State ARPA award, *Programs for the Elderly,* added capacity to economic security with support for home energy assistance and security deposits. SWCAA was selected to join the ACL Care Transition Learning Collaborative. This learning opened the door to a partnership with Yale New Haven Health System to assist older Medicare beneficiaries as they transition from hospital to home. OAA in-home support is essential in helping older residents receive the care they need in their community.

Nutrition Services and Nutrition Services Incentive Program (NSIP) provide meals, nutrition education and counseling, and socialization opportunities for the aging population both in congregate settings and within their own homes. Thanks to the Title III C2 nutrition waiver, we have forged meaningful relationships with the region's two Elderly Nutrition Providers. Additional ARPA funds significantly increased the administrative work required to manage the Elderly Nutrition Program. The nutrition waiver was essential in managing waitlists, implementing safe dining solutions during the pandemic, developing a restaurant program, and mitigating concerns between the Providers and their host sites. SWCAA served as a statewide taskforce member to enhance the legislators' understanding of the complexities in elderly nutrition funding and delivery. SWCAA's technology, Grantee Gateway, was recognized as instrumental in streamlining reporting, confirming accuracy & identifying funding sources of nutrition units while expediting payment to the nutrition providers.

Evidence-Based Disease Prevention and Health Promotion Programs promote healthy lifestyles among older adults to prevent or delay the effects of chronic conditions. SWCAA has struggled to maintain leaders and participants for the Chronic Disease Self-Management Programs (CDSME). There is a level of disease-fatigue as adults have spent years worrying about the health effects of COVID-19. Small group

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sessions over six weeks seem to be an overwhelming commitment for some. SWCAA's evidence-based health coordinator has worked to offer virtual, hybrid, and in-person sessions.

The National Family Caregiver Support Program connects family caregivers to a variety of supportive services. The past three years, SWCAA achieved meaningful improvements in the no wrong door system. Working in concert with our sister agencies, AgingCT (the association of the five Area Agencies on Aging) developed Aging Answers. Building on the Focal Point concept, Aging Answers provides highly visible entry points designed to triage the needs of the client and help them navigate to the most appropriate resource. From each of our regional websites, we offer access to the local Community Focal Points and our care networks. Working with the five AAAs, we created a single website that can help Connecticut residents and caregivers identify their regional resources. Service Navigators are available to offer person-centered planning that helps the family unit develop plans for current and future needs based on the preferences of the older adult.

SWCAA raises awareness, provides resources and collaborates with Connecticut Ombudsman's office and Adult Protective Services. We co-host multidisciplinary case conferences with Mozaic's Center for Elder Abuse Prevention. SWCAA uses private philanthropic funds to support emergency placement if a client is at risk of abuse and/or neglect. Challenges related to self-neglect, particularly for those residents experiencing mental health issues, can result in risks to housing, health and well-being. SWCAA takes a pre-emptive approach to empower victims through early support and services, including NFCSP and CSRP.

In addition to the specific challenges affecting the Area Plan and OAA programs, the Providers and Area Agencies will face the challenge of reduced funding levels resulting from the conclusion of ARPA programs. SWCAA plans to meet this challenge in a strategic way so that we continue to support individuals with the greatest social and economic need. Conversations with our community are particularly important given this challenge.

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SWCAA's role is evolving as we enhance the connection with the community. SWCAA's strong relationships and advisory council will support this effort. We plan to elevate the use of Community Focal Points by shining a light on the CFP at the local level, through local media, and via our website. Access starts with information. Regular communication with and through the CFPs will guide the community to the services they need. SWCAA is effective in working with local councils on aging, first selectman and community leaders. By breaking down complex aging services like Medicare and Medicaid, SWCAA can help navigate the challenges of aging. As we work with our sister agencies throughout the state, the next three years will see greater coordination, less fragmentation and further development of a true *no wrong door* system.

Needs and Targets

Needs Assessment

The needs assessment is a three-year, accumulative analysis of white papers, research, surveys, focus groups and census data related to older adults from national, statewide, and Fairfield County data. The Agency's needs assessment looks at global themes and challenges affecting older adults through publications by the American Society on Aging, the Journal on Aging and Health, the Centers for Disease Control and Prevention and the American Geriatric Society. Statewide review includes *"Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut"* as required by Section 17b-337 of the Connecticut General Statutes. This document provides real-time data on efforts to offer community-based care options. Reports from the Medicaid Advisory Council provide gap analysis on issues ranging from transportation to capitated payment models for long term care. Information on Connecticut health and economic status was gleaned from *Economic Circumstances of Older Adults in Connecticut and Links to Health and Well-Being, research from Dr. Richard Fortinsky, UCONN,* November 19, 2024. Locally, SWCAA hosts monthly Advisory Council meetings. Gaps and challenges are documented by representatives from each community within our region. Our Nutrition Coordinator (C2 Waiver) uses surveys from the nutrition program participants to help guide innovations and caterer

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evaluation. Local senior centers, hospital community health assessments and program surveys are instrumental in completing the gap analysis.

SWCAA drew on the success of the previous Area Plan by using data from the 800# number and calls to the Aging Answers Department. This department houses the State Health Insurance Program (CHOICES), Senior Medicare Patrol (SMP), Medicare Improvements for Patients and Providers (MIPPA), Information Specialists' waivers (general & caregiver), NFCSP, and Connecticut Alzheimer's Respite care managers and Service Navigators. Utilizing call data provides a statistically significant sample and inclusive data set more reliable than the data collected through typical focus groups or surveys. This analysis was completed and reviewed during the May 14, 2025, Advisory Council meeting.

The call data covers the three-year Area Plan period beginning October 1, 2022, through present. Using data identifying the topics of importance as determined by the issues presented by callers to the Aging Answers department provides evidence of the most pressing needs and challenges faced by older adults.
Additional Consumer Engagement/Focus Groups:

- Lunch and Learn at the Stamford Senior Center- all senior center members June 6, 2024, 24 participants,
- Trumbull Senior Center- Senior Council on Aging on November 22, 2024, 12 participants
- Advisory Council strategic needs assessment- December 16, 2024, 11 participants
- Legislative Breakfasts – Fairfield on 1/15/25, 41 attendees; and Darien 1/24/25, 52 attendees
- Greenwich Library on 11/7/2024, 58 attendees
- Housing Collaborative Care Team in Bridgeport, 12/11/2024, Caregiver audience of 30
- Mozaic Senior Living, Fairfield, 12/18/2024, Caregivers audience of 18

Current and Projected Needs

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In parts of the state where economic conditions for older adults are poorer, health and well-being indicators also tend to be poorer. Areas of the state most likely to show poorer economic and poorer health-related indicators include Hartford, New Haven, Bridgeport, the rural northeast region, and for several indicators the Naugatuck Valley westward to the New York state line. These urban and rural areas are high-risk for poor health outcomes associated with poorer economic conditions among older adults. (*Economic Circumstances of Older Adults in Connecticut and Links to Health and Well-Being, Dr. Richard Fortinsky,* November 19, 2024)

Fairfield County's older population is expanding, while its residents are becoming more racially and ethnically diverse. Six of Connecticut's wealthiest towns (Westport, Wilton, Weston, New Canaan, Darien, and Greenwich) sit juxtaposed to Connecticut's poorest city, Bridgeport. 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). Income inequality helps SWCAA align resources from the OAA to serve the low-income and typically underserved population targets. However, it does challenge the allocation of resources when pockets of need exist in wealthy communities. According to the *Tuft's Healthy Aging Report,* Fairfield County has a more diverse population with the highest number of immigrants and non-English speakers in the State.

The needs assessment from Area Plan 2022 - 2025 cites the most pressing needs as, 1) economic security; 2) access to support and services; and 3) access to healthcare. Statewide assessments from this period identify the need for transportation, affordable housing, social support systems, and assistance with routine household tasks. A more detailed investigation is needed to separate the numbers between economic security, eligibility, healthcare and in-home care access. Housing concerns were a close fourth.

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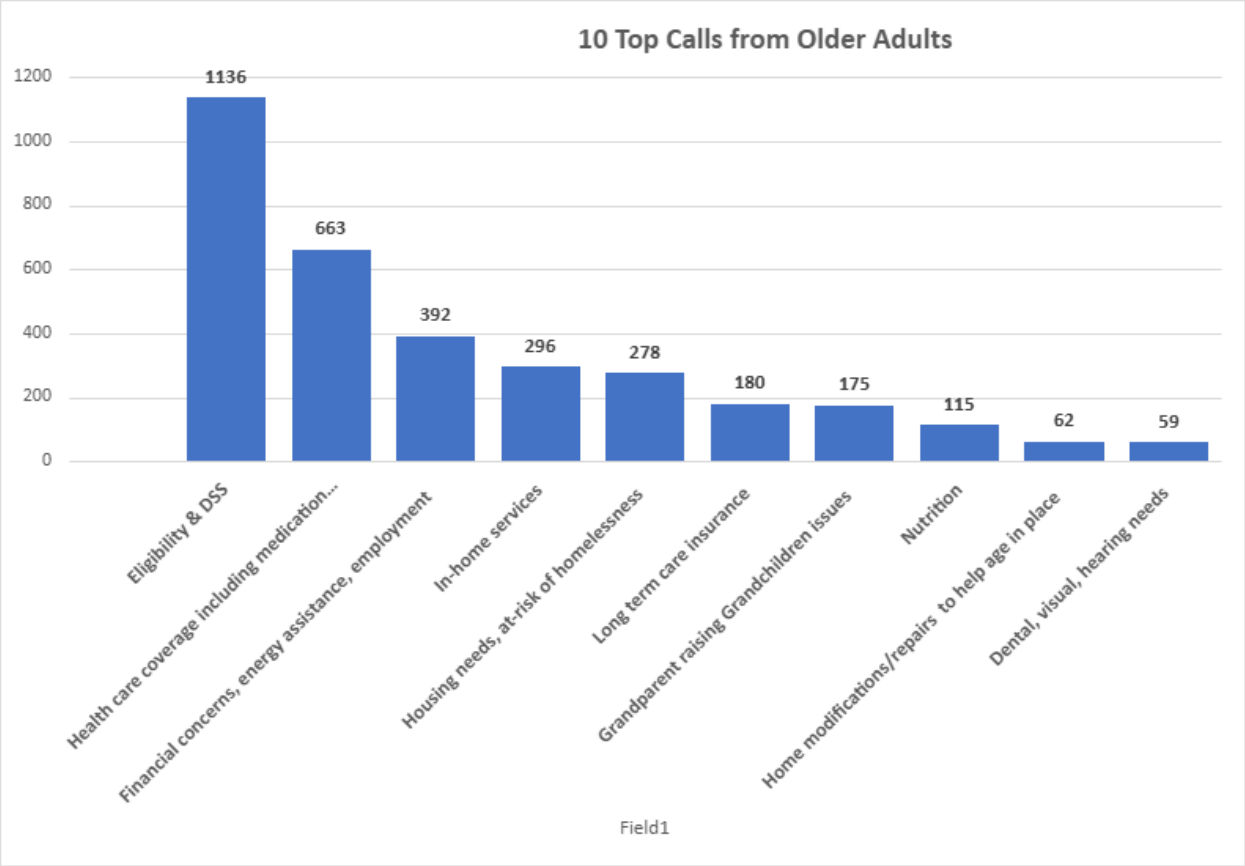
CHART 1



As demonstrated in Chart 1, SWCAA assisted 1,475 adults in need of assistance with 6,553 concerns. Calls regarding DSS eligibility are characterized as economic security and the need for access. Callers often experience the inability to pay for food, medication or assistance because their Title 19 benefits are stalled or discontinued. Rounding off the other requests for assistance are housing, general disability questions, transportation needs/complaints, Social Security information, Nursing Home issues or information, technology, caregiver stress/resources/support groups, elder abuse/Protective Services for the Elderly, Legal services, Veterans' assistance, and Behavioral Health information. These findings, along with the information gleaned from the focus groups, confirm targeting resources for access to home & community-based services, economic support programs, and health & wellness. As previously stated, none of these concerns exist in a vacuum. The benefit of the triage approach employed by all Connecticut Agencies on Aging allows support for multiple interventions in a person-centered environment by the staff best suited to support the individual.

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A similar review of caregiver calls gives SWCAA data to understand the most pressing needs of caregivers.

CHART 2

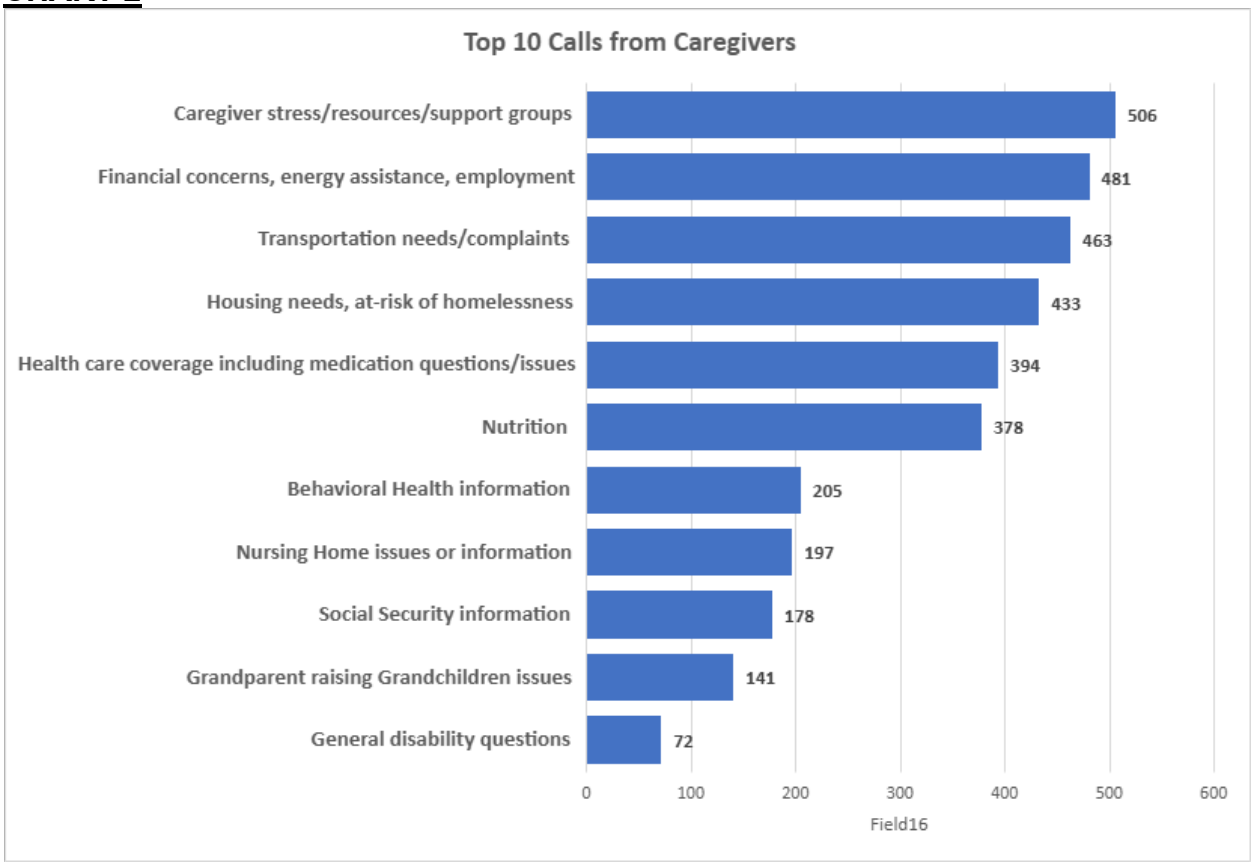

Chart 2 presents the call topics from callers identifying as caregivers. In FY 2024, SWCAA assisted 1,743 caregiver callers with 11,451 concerns. This goes to the nature of caregivers who often want to learn about a variety of services available for aging loved ones. Focus groups with caregivers from Mozaic Adult Day Center and Bridgeport Housing Collaborative confirmed the identification of the needs to help SWCAA target the most pressing concerns. Caregiver burden, financial assistance, and transportation round out the top three priorities, followed closely by housing, healthcare and nutrition.

Projected Change

Connecticut has nine counties, with Fairfield County being the largest and the only one experiencing growth, increasing by 2.66% since 2010 to 943,823 residents (26.42% of

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the state's population). One rarely finds an article or research report about older adults that does not include information about the recent and projected increases in the older adult population. "Over 10,000 baby boomers are turning 65 every day" is an often-quoted statement. (Final Report, 2015) Connecticut's largest population cohort is 55-59 indicating a large influx to the 60+ population over the three-year area plan. People aged 65 years and older represented 18.09% of the population in 2023 but are expected to grow to 21.8% of the population by 2030.

Data from the 2020 census is limited. Over the next decade, older adults (aged 65 and over) are projected to be the only group in Fairfield County to increase significantly in size. From 2025 to 2030, the regional population will grow by approximately 3.71% over the *five-year period.* The population of 60+ is expected to increase by 3.4% *annually* over the three-year Area Plan. (https://www.ctpublic.org/news/2023-07-10/connecticuts-baby-boomers-are-aging-into-retirement-heres-what-that-means-for-the-economy)

Given the projected increase, funds will probably not keep pace with demand. SWCAA will attempt to improve the efficiency of grant-funded projects by offering streamlined administrative and data collection so the award targets services rather than the administration. Advocacy for sustainable funding through the Older Americans Act is crucial. Allocations Committee members award applicants based on the greatest need aligned with the priority cohorts described in the Older Americans Act. In conjunction with the Bureau on Aging and Connecticut's Agencies on Aging, a nutrition priority scale will be developed using Form 5 intake data to ensure nutrition is delivered to those most in need.

Provider Information

Southwestern Connecticut is home to a host of capable and caring providers. Each town boasts dedicated Municipal Agents, Senior Center Directors and Human Service professionals. There are five extraordinary Adult Day Centers in the region and over 240 skilled and custodial care companies. Nonprofit aging services exist in each city and town. In some communities, the Departments of Public Health and Recreation support senior health and wellness programs. Over ten years ago, SWCAA identified a

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gap in support for the City of Bridgeport residents. High levels of poverty, non-English speakers, and a greater number of socially disadvantaged residents warranted more assistance than what was available. SWCAA's Title III B, I & A waiver provides additional capacity to existing City systems through enrollment assistance, I & R/A and translation. The other towns and cities within our Planning Service Area (PSA) receive added capacity during high volume times including Medicare Open Enrollment, energy assistance and Title 19 redetermination. Other challenges include Connecticut's low reimbursement rate for Medicaid services as compared to Medicare or private services. OAA in-home care services use the Medicaid schedule to reimburse OAA providers. Many Providers refuse Medicaid reimbursement, which makes it increasingly difficult to fill service orders for participants in the National Family Caregivers Support Programs.

Despite efforts to recruit new bidders in the Elderly Nutrition Program (Title III C1 and C2), there have been two nutrition providers in southwestern CT. Each bidder targets a different geographic territory (greater Bridgeport or lower Fairfield County). The lack of competition limits alternatives for host sites (C1) or meal selection for home delivered (C2). This situation presents challenges when negotiating for improvements in the program. The Providers face financial difficulties due to legislated increases in minimum wage, and increased food and fuel costs. To counter these challenges, SWCAA implemented an annual host site/ENP meeting to review the terms of a Memo of Understanding. This memo outlines the deliverables for each party- host site, ENP and SWCAA. It is an opportunity to voice concerns and make course corrections. We have also established quarterly meetings between SWCAA and the ENP Provider to ensure compliance with OAA and state requirements and to problem-solve any issues of quality, customer service, or capacity.

Target Populations

Target Setting

SWCAA's target setting process is designed to fairly and consistently allocate funds to the population cohorts prioritized in the Older Americans Act. Prioritized populations include, low income, minority, at-risk of institutionalization, Alzheimer's or related disorders, non-English speaking, rural and severely disabled populations. Census data

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and the AGid Special Census Tab are used to inform staff and allocations committee members of the percentage of priority groups living in each town. Allocations are made based on a project's ability to serve individuals at a rate that is at least equal to the percentage of the prioritized cohort residing in the town they are serving. 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 weighted criteria including, priority clients to be served; community need for service to be provided; demonstrated quality of program; cost effectiveness; administrative competence; and past performance.

Strategies for Targeting

The SWCAA Title III allocations process requires applicants to project the number of clients to be served 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 underserved and low-income older adults. Applicants are informed that the percentage must be representative of the community served.

Staff of SWCAA's nutrition education waiver and I & A/R waiver work in the community identifying older individuals who have economic or social need or are low-income minorities and assist them in accessing available community services. SWCAA is the trusted leader relative to all aging issues in the planning and service area of southwestern Connecticut. This translates into proactive execution, under the leadership and direction of the Board and Advisory Council, of a wide range of resources related to older adults, such as health insurance, home & community-based services, housing, and in-home care. These systems are designed to assist, maintain, and improve the quality of life and independence of older people regardless of cognitive or mobility challenges, income, language preference, ethnic background, sexual identification, or religious affiliation. SWCAA Information Specialists work diligently to

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break down barriers to services through community presentations, one-to-one counseling events, enrollment events, health and wellness fairs, hosting community forums (Senior Centers/Municipal Agent) and content at targeted media outlets (Facebook, electronic publications, radio, TV, billboards, newsletters).

Individuals aged 60 years and older at risk for institutional placement:
Title III grantees are required to have a system in place to advise participants of additional services that may be helpful when accessing services. When a client responds to required demographic questions (as presented on the Form 5 intake) or interactions between grantee staff and participants indicate that a participant may be at risk in the community, the grantee staff can aid or refer the participant to staff who can provide additional access to services. Some grant projects include outreach workers or social workers who can assist these participants; others may make referrals to the SWCAA Programs/Community Supports staff or other aging network partners. Service Navigators provide second-tier support. Staff of SWCAA's nutrition education waiver and Bridgeport outreach waiver are in the community available to older individuals who are at risk for institutional placement and assist them in accessing available community services.

SWCAA continues to develop and maintain effective referral partnerships with organizations and providers who have dementia expertise, including the Alzheimer's Association and the Adult Day Centers Association. We engage services that use a 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 information.

SWCAA promotes referrals from agency to agency through its advisory council, senior center forums, and Facebook announcements. These communications 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 to foster a No Wrong Door approach.

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Individuals with limited English proficiency:

The majority of SWCAA's Title III grantees employ staff who are bilingual and many of them also provide materials in languages other than English. SWCAA supports senior centers in Bridgeport, Norwalk, and Stamford with bilingual services for non-English speaking older adults. SWCAA's Bridgeport outreach worker is bilingual and works predominantly with minority and low-income older adults in Bridgeport. BoostLingo provides telephonic translation support for languages not available on-site.

SWCAA's Information Specialists provide callers with limited English proficiency the option of using the translation service through BoostLingo. Within the Community Services Department, there are staff members who are proficient in Spanish and assist individuals who prefer to communicate in Spanish. The SWCAA website also has a language feature which will translate all webpages into more than one hundred languages.

Individuals with Alzheimer's disease, related disorders, or older individuals living with severe disabilities:

Using the triage methodology, staff target referrals to one of the Medicaid waiver programs or to the Statewide Alzheimer's Respite Program or the National Family Caregiver Program. These programs provide case management services that help the family caregiver, the 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 support. State Alzheimer's Aide grant recipients can provide services to Individuals with Alzheimer's and related dementias, as diagnosed by a physician to include Frontotemporal disorders, Lewy Body Dementia, Vascular Dementia/Vascular Cognitive Impairment, or Mixed Dementias. SWCAA provides both grant funds and scholarship dollars to support Adult Day Centers.

Efforts to reach people with disabilities are made through partnerships, collaborations, or presentations with Behavioral Health agencies. NAMI, Access Independence, Kennedy Center, and Bridges are examples of SWCAA's partnerships. SWCAA Information Specialists provide relevant referrals from agency to agency to ensure that

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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 embracing the No Wrong Door philosophy. The Annual Aging Summit is developed in collaboration with the Centers for Independent Living with workshops designed to foster communication and partnership between the two disciplines.

Serving target populations

Strategies for serving older adults are similar to those described in targeting older adults. SWCAA's strategy includes raising its own visibility as a trusted resource for services and support of older adults. We ensure that callers are connected to the services available that will help them achieve their personal goals of health, wellness, independence and dignity. Our website and Facebook communications offer a full array of services and support options. We list programs with the State's 2-1-1 information directory, attend local senior center information sessions, participate in community health fairs, host enrollment events and submit informational articles to local senior center new publications.

We have analyzed demographics in each target group using the Census.gov quick facts for our PSA. CHART 3 interprets the data based on the seven targeted populations as presented in the Older Americans Act on a town and city level.

CHART 3 -Current Population 2024

	Residents	Minority	Non-English Speaking	Age 65+	Poverty	Age 75+	65+ w disability	75+ w disability
Stratford	52,355	23,948	3,453	9,947	3,508	4,686	2,903	1,695
Monroe	18,831	3,126	359	2,956	471	1,168	841	536
Bridgeport	140,028	104,181	45,929	18,624	31,506	7,562	7,453	4,150
Trumbull	37,269	8,572	8,609	6,410	2,273	3,168	1,627	1,201
Fairfield	63,433	8,500	10,149	9,959	2,981	4,821	2,427	1,684
Easton	7,636	970	794	1,298	588	695	406	313
Westport	27,470	5,000	4,148	5,109	989	1,868	1,066	674
Norwalk	98,458	48,934	36,725	16,147	9,944	6,400	3,386	2,132
Darien	22,020	3,457	2,532	3,083	1,321	1,233	521	387
New Canaan	20,862	2,796	3,129	3,275	688	1,398	687	441
Weston	10,344	1,934	1,800	1,572	207	455	290	179

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Wilton	18,400	4,416	4,269	3,018	460	1,104	615	411
Stamford	136,226	69,339	56,261	21,660	12,941	8,991	5,696	3,875
Greenwich	63,574	16,529	15,194	11,316	3,433	4,704	2,003	1,396
	CT Residents 60 and over have been diagnosed with HIV - 3,419							

Chart data-
https://www.census.gov/quickfacts/fact/table/newcanaantownwesternconnecticutplanningregionconnecticut,bridgeportcityconnecticut,stratfordtowngreaterbrideportplanningregionconnecticut/PST045223

SWCAA has been successful in serving the OAA target populations. Challenges exist due to the income inequality of the region. Fairfield County has the dubious distinction of the highest national income inequality. Although strong proposals are received from some of the wealthier towns within the PSA, the proposals are not successful in targeting minority, low-income and disadvantaged residents. We mitigate these challenges by offering more support for information, access to state and federal programs and complex navigation through the service navigators in towns that may not receive grants. Strong focal points exist in these towns. Financial awards are concentrated in the three urban centers- Stamford, Norwalk and Bridgeport. These cities have a much higher than average percentage of residents who meet the OAA target population criteria. Support adds capacity to towns whose applications may not score well due to a lack of target populations.

Data Collection

SWCAA developed and implemented a HIPPA compliant data portal, Grantee Gateway, which provides an electronic system for managing all Title III grants and data. Through this password protected system, Grantees and SWCAA staff can track units of service, clients, award dollars and much more in real time. Grantees are also able to submit invoices for services and track all utilization and payments.

Another feature of Grantee Gateway provides Grantees with the ability to submit Form 5 intakes through the data portal. This was a major improvement from mailing and scanning paper intakes which created several challenges in the past including a gap in time from mailing to receiving forms, difficulty reading handwriting, and incomplete data. The new system is cost effective, improves accuracy, and maintains the integrity of data. The system uses File Transfer Protocol to transmit data into the Wellsky

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database. Most importantly, the system allows staff to spend less time on data entry and more time with clients.

SWCAA has been able to accurately monitor grantee submission and make timely payments. Grantees of the Agency appreciate the ease of the system and the timelines for payment. Technology makes it possible for Grantees to continue submitting Form 5 in real time and submit invoices for reimbursement no matter where they were working.

Following the WellSky report specifications, SWCAA is now able to upload units of services for all Title III B, C, D and E services. This eliminates the need for manual data entry, which can lead to errors and allows staff more time to focus on the provider community. Fund identifiers can be adjusted in mass rather than individual adjustments.

The Grants Department manages the data entry workflow and has a system in place to ensure timely data entry. Grantees are made aware of the timeline and receive helpful reminders and tips for managing their data throughout the year. When Form 5s are submitted with missing information such as the date of birth, the Grantee is prompted to submit the information, and the status of the Form 5 remains “unqualified” until the data is complete. The MIS staff manage the exceptions rather than touching every service unit submitted to the Agency.

Thanks to funding from the CT Office of Policy and Management, Grantee Gateway is currently under development for release 3 and will be shared with the other Agencies on Aging. In this next evolution of the software, coding will improve the data presentation for the State Performance Report, add functionality to reduce instances of duplication, and enhance reconciliation between fund identifiers for financial reporting. This will improve the accuracy and timeliness of reporting. Additional modules will address respite care management and waiver data updates.

Evaluation of Target Achievement

Grant criteria require the applicant to project its ability to serve the target population. We review the targets at the annual program review with the grant providers to ensure they

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are on course to achieve their projected targets. If there appears to be a challenge in any target area, adjustments to strategies are made. At the year-end, SWCAA totals the data from grantee reports to evaluate the target achievement. Target data are reported to our AAA field representative. These processes confirm SWCAA's commitment to serving the target population.

Quality Management

SWCAA has developed policies and procedures to enhance advocacy, evaluation and monitoring of subgrantees as they relate to quality assurance. Advocacy starts with regional legislative meetings with aging and disability networks to develop the advocacy agenda. Over the past three years, Medicaid reimbursement has been in the top three issues. Medicaid reimbursement is noted as a challenge in the "Provider Information" section of the Area Plan. Fair and equitable reimbursement was a crucial theme in the public testimony provided by SWCAA's director. The director also participated in two statewide taskforces- Nutrition, and Adult Day Centers- to identify solutions to improve access to these essential services.

Quality management begins with the review of the applicant's proposal. All applications are reviewed and scored by a committee consisting of a least twelve Board, Advisory Council and staff members. The evaluation looks at history, capacity, impact, targets, and budget. Each proposal is scored independently and then reviewed in subcommittee meetings where either consensus is reached, or the average of all evaluations is used to score the application. Audits are reviewed using a *Risk Assessment tool* as described in 2 CFR 200. Through informed decision-making, enhanced accountability, and supportive relationships with grantees, SWCAA maximizes funding impact, which contributes to quality management.

With guidance from SWCAA's Board of Directors, SWCAA developed an *annual program evaluation tool* to accompany the mid-year evaluation of sub-grantees. Each year, half of the grantees receive a face-to-face visits while the other half responds to the program evaluation in writing. New grants are always interviewed at their site. A team from the Board and Advisory Council accompanies the staff. The scoring tool

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presents evidence of the grantee's performance in meeting stated goals, targets and compliance.

Area Plan Development Process

The Area Plan process begins with literature reviews through the Administration on Community Living, and National Council on Aging, the Journal of the American Geriatric Society and the National Institute on Aging. Reviews of the Connecticut Healthy Aging Data Report and the research from UCONN's Pepper Center (Center on Aging) added statewide and regional context. Data Haven offered a high-level view of the regional communities served by SWCAA. Focus groups with diverse communities within the PSA confirmed alignment with national needs and concerns. Review of the call data in SWCAA's Aging Answers Department proved the requests for assistance were related to the greatest needs. Focus groups confirm the data gleaned from call data. Summarized data and citations are offered through the content presented in the plan. Goals are aligned with the State's Bureau of Aging State Plan. Staff meet to develop the goals for the waivers. The Board and advisory council review the Plan. A public hearing integrates comments from the community. The Plan is presented to the BoA for review and approval.

Goals, Objectives, Strategies and Measures

Home & Community Based Services (HCBS): empowering older adults to reside in the community setting of their choice

Objective 1	**Strengthen the aging network by providing timely, accurate and concise information that presents options for home & community-based (HCBS) care.**
Strategy 1	Utilize monthly advisory council meetings to present HCBS options, application processes and eligibility information. Advisory Council members share information with town leadership and aging services.
Strategy 2	Host regional community meetings with focal point leaders to present HCBS options, application processes and eligibility information.

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Strategy 3	Attending regional senior center meetings to present HCBS options, application processes and eligibility information.
Outcome	Municipalities have a greater understanding of OAA home & community services to help their residents access support.
Measure 1	Increased participation in HCBS and Medicaid waiver programs as demonstrated by a minimum of 200 enrollees in NFCSP and CSRP.
Measure 2	Greater support for community-based settings as adults access services in the community as demonstrated by number of enrollees in HCBS.
Objective 2	**Provide uniform, statewide information and navigation for HCBS.**
Strategy 2.1	Enhance education through certification in I R&A program (InformUSA) of at least one Information Specialist and Navigator in each regional Agency.
Strategy 2.2	Annual training on Medicaid waivers and pertinent eligibility information.
Strategy 2.3	Update and maintain accurate information on the AgingCT.org website to guide residents on how to access HCBS.
Strategy 2.4	Incorporate education and information on HCBS in the annual AgingCT Summit to share with the statewide aging and disability networks.
Measure1	Less fragmentation and enhanced comprehension on HCBS, LTSS and alternatives to nursing home placement.
Outcome	More residents will participate in HCBS as an alternative to nursing home placement as demonstrated by a minimum of 200 enrollees in NFCSP and CSRP.
Objective 3	**Enhance access to HCBS for disadvantaged populations targeted in the OAA.**
Strategy 3.1	Recruit and retain at least one Spanish-speaking Information Specialist. Utilize telephonic language services to support communication. Ensure communications meet literacy levels of participants.
Strategy 3.2	Include HCBS information during MIPPA presentations targeting disadvantaged groups.

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Strategy 3.3	Include information for self-directed and Adult Family Living options that allow family/friends and neighbors to provide HCBS care.
Outcome	More low income, minority, low-income minority and non-English speaking residents participate in NFCSP and CSRP.
Measure	Maintain or increase the number of disadvantaged residents choosing home and community options rather than nursing home placement as demonstrated by number of enrollees in HCBS.
Objective 4	**Utilize state-funded and Older Americans Act programs to support older adults waiting for eligibility in Medicaid home and community-based services.**
Strategy 4.1	Assess and enroll (as appropriate) in Title III National Family Caregiver Support Program including person-centered planning, care management, support groups and in-home services to relieve caregiver burden, reduce health & safety risks.
Strategy 4.2	Assess and enroll (as appropriate) in the CT Statewide Alzheimer's Program including person-centered planning, care management, supplemental support and in-home services.
Strategy 4.3	Introduce Title III nutrition services (congregate or home delivered as appropriate) to relieve caregiver burden, support healthy nutrition and access to food.
Strategy 4.4	Utilize the assistance of the Service Navigator to help guide individuals through the complex Medicaid enrollment process.
Outcome	Decrease in caregiver burden.
Measure	Maintain or increase the number of individuals receiving support from NFCSP and CSRCP and Medicaid waiver services. Monitor # of NFCSP & ARP transitioning to CHCP.
Objective 5	**Support for informal caregivers**
Strategy 5.1	Utilize in-home services including respite, nutrition, transportation and nursing care as needed.

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Strategy 5.2	Refer to support groups, focal points, disease associations (i.e. Alzheimer's Association) for additional support.
Measure	Family caregivers are able to maintain loved ones at home and forego nursing home placement.
Outcome	Maintain or increase the number of families choose HCBS rather than nursing home placement.
Objective 6	**Adopt common core competencies of Person-Centered Planning curriculums when discussing care options with adults seeking support**
Strategy 6.1	Establish a level of comfort and understanding of all HCBS options.
Strategy 6.2	Ensure the preferences of the individual and family are at the center of all decisions.
Measure	Individuals fully understand their options and their rights in self-determining their care setting.
Outcome	Greater satisfaction for the individual and family when pursuing long-term care options.

Healthy Aging: provide older adults with prevention and wellness opportunities

Strategic Goal #: ***Influence health and wellbeing of CT's Older Adults by addressing Social Health Care Needs***

Objective 1	**Improve access to health care and/or expand access to services that address chronic illnesses.**
Strategy 1.1	Fund or offer Chronic Disease Self-Management Programs to be delivered with a focus on OAA target populations.
Outcome	IIID Waivers and newly accredited programs reviewed annually
Measure	Consumers have access to a variety of evidence-based health programs.

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Strategy 1.2	Partner with disease-specific organizations to create opportunities for synergy and cross-sector collaboration with a focus on OAA target populations.
Outcome	Increased information sharing and cross referral between AAA and disease-specific organizations.
Measure	Monitor referrals to Alzheimer's Association, Parkinson's Disease and other organizations.
Strategy 1.3	Maximize use of Medicare covered services by offering *New to Medicare* presentations with focused outreach to OAA target populations.
Outcome	Medicare beneficiaries are aware of their preventive benefits, coverage options and important deadlines.
Measure	CHOICES contract deliverables are met or exceeded
Objective 2	**Address upstream factors contributing to the rising rates of homelessness among older adults.**
Strategy 2.1	Fund or provide pre-eviction housing assistance to older adults and individuals with disabilities with a focus on OAA target populations.
Outcome	Greater availability of information and advocacy offers more mitigation options before eviction.
Measure	Legal Services demonstrates success in offering eviction prevention support.
Strategy 2.2	Work with housing advocates to establish annual communication and training opportunities.
Strategy 2.3	Conduct benefits outreach to connect individuals with greatest economic and social need to public income support programs such as Supplemental Nutrition Assistance Program SNAP.
Outcome	Older adults and individuals with disabilities are identified for assistance earlier.
Measure	At least one housing-related activity is attended or provided by AAA staff annually.

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Objective 3	**Address food insecurity and malnutrition.**
Strategy 3.1	Boost participation in SNAP by assessing and enrolling clients during Nutrition education session.
Outcome	More individuals receiving home-delivered meals are introduced to SNAP with enrollment assistance as indicated.
Measure	Nutrition Coordinator monitors SNAP referrals.
Objective 4	**Improve continuity of care across state systems by Bridging Aging and Disability Services**
Strategy 4.1	Member(s) of AgingCT/AAAs will participate in Bridging Aging & Disability Community of Practice
Strategy 4.2	Members of AgingCT/AAAs will participate in advocacy discussions and activities around items of common concern.
Strategy 4.3	The annual AgingCT Summit Committee shall work collaboratively to build the agenda for the Summit.
Outcome	Greater communication and coordination opportunities between Aging & Disability networks allows creative ways to address unmet social health care needs and moves closer towards a “No Wrong Door” system.
Measure	Continued support for Medicare beneficiaries aged 18 - 59 years.

Elder Rights, to protect elder well-being, and prevent elder abuse, fraud, neglect, and exploitation

Objective 1	**Support the work of the Coalition for Elder Justice in Connecticut and other organizations.**
Strategy 1.1	Identify opportunities to increase participation by supporting the AgingCT designee.
Strategy 1.2	AAA director participates in CEJC Steering Committee and all other activities.
Outcome	Provide regional information related to elder rights and abuse prevention and share information from CEJC with the region.

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Measure	At least one annual web or social media post related to elder rights and/or the work of the CEJC. Continued education on the community's role as mandated reporters.
Objective 2	**Increase information and community awareness of elder rights while preventing abuse, fraud, neglect and exploitation**
Strategy 2.1	Present at least ten SMP Fraud programs to the regional aging network.
Outcome	Greater awareness of elder rights and how to prevent abuse, neglect, fraud and exploitation.
Measure	At least one hundred residents will participate in workshops that include information on the prevention of abuse, fraud, neglect and exploitation
Measure	Referrals to Protective Services are appropriate and timely.
Outcome	More older adults are supported when abuse, neglect, fraud or exploitation is suspected as indicated by referrals to PSE.
Strategy 2.2	Offer respite or relief to caregivers experiencing caregiver burn-out, exhaustion and stress.
Outcome	Decreased instances of caregiver neglect and/or abuse.
Measure	At least 200 family caregivers are supported by NFCSP and CSRP with in-home support to relieve the stress of caregiving. Surveys indicate a reduction in stress for caregiver.

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Attachment A -AREA PLAN ASSURANCES

The Area Agency on Aging assures that it will comply with the Older Americans Act, including Section 306 as described below.

Sec. 306. AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1).

Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and

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participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

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(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

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(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education,

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prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

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(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) provide assurance that -

(A) the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

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(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of 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 individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority

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older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;
(B) land use;
(C) housing;
(D) transportation;
(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness;
(K) protection from elder abuse, neglect, and exploitation;
(L) assistive technology devices and services; and
(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of

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transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Marie Allen, President/CEO Area Agency on Aging

6/15/2025

DATE

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Attachment B -Emergency Preparedness Plan

1. Coordination

SWCAA brings valuable information to the community regarding the challenges and needs of older adults and people with disabilities. We participate in Area 1, Department of Emergency Management and Health Services, led by Robert Kenny. The group meets monthly with representatives from each city/town in the region. SWCAA is asked to join when aging services is an agenda item. This is the best way to keep SWCAA informed of emergency protocols and resources in the event of a potentially dangerous situation. The State's largest city, Bridgeport, also has an active emergency command center. The executive director meets with Director Scott Appleby any time there is an emergent issue or concern regarding older adults. SWCAA has worked with the emergency command center to get food to residents during prolonged power outages and, more recently, throughout the pandemic.

2. Communication Strategy

The Bureau on Aging has developed a comprehensive procedure of contact in 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 Unit on Aging contact person. Marie Allen is the SWCAA Emergency Communications Officer, Gretchen James, Grants Manager provides back-up. SWCAA has up-to-date distribution lists for town leadership including municipal agents, senior center directors, and human services directors. We would share information via email, Facebook, and phone as best suited for the situation. SWCAA convenes Zoom meetings to bring groups together to brainstorm and solve problems during an emergency. 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. A Staff telephone tree allows SWCAA to communicate important information to staff before, during and after an emergency. The telephone tree will be used to request assistance for communities in need of human resources to assist older adults and people with disabilities. SWCAA has developed a small group of volunteers willing to make phone calls, deliver meals and support the needs of older adults. At the conclusion of an emergent event,

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SWCAA will communicate with all grantee partners and community focal points via email and via telephone for all nutrition vendors and clients served in care management (NFCSP & Respite Program & Veterans VDHCBS program) to ensure safety and address any special service needs/ concerns occurring as a result of the emergency. SWCAA will prioritize restoration of services that affect safety and then the quality of life for seniors. SWCAA has remote servers that use Cloud-based technology which maximizes alternative communication systems. In 2021, SWCAA will move to Microsoft Teams to support both video and telephonic communication using the most advanced Cloud technology. SWCAA is available 24/7 via on-call answering service. The answering service would continue to field calls to managers using cellular and traditional phone access. The Agency on-call can be accessed through its main number, (203) 333-9288.

3. Public Information Plan

SWCAA would communicate information to the public via its website, distribution lists via email and telephone trees. SWCAA's website has the capacity to place important information on the home page with links to important details and resources. 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. The communication will take before, during and after the emergency as systems allow.

4. Contact 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 is developing a single point of entry database that will include a field to recognizing 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.

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5. 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. Calls are made by staff and volunteers to ensure at-risk clients are planning for their safety. 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 emergency event, SWCAA’s answering service would continue to field calls to managers providing cellular access is available. Staff have a telephone tree that allows SWCAA to communicate important information to staff before, during and after an emergency. At the conclusion of an emergent event, SWCAA will communicate with all grantee partners and community focal points via email and via telephone for all nutrition vendors and clients served in care management (NFCSP & Respite Program & Veterans VDHCBS program) to ensure safety and address any special service needs/ concerns occurring as a result of the emergency. SWCAA will prioritize restoration of services that affect safety and then the quality of life for seniors. SWCAA will also confirm with each town via the advisory council to see if there are newly identified clients who may benefit from the programs and services.

6. Situation reporting

The State Unit on Aging has developed a comprehensive procedure of contact in 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 Unit on Aging contact person. Marie Allen is the SWCAA Emergency Communications Officer.

Communication will include updates regarding the delivery of meals, the risk to clients in communities without power, the actions and interactions with local communities and emergency services, the need for assistance and periodic updates. Communication will continue after the emergent event for as long as necessary to ensure the safety of clients and the efficacy of the programs. Communication will be both verbal and written as determined by the State Unit on Aging.

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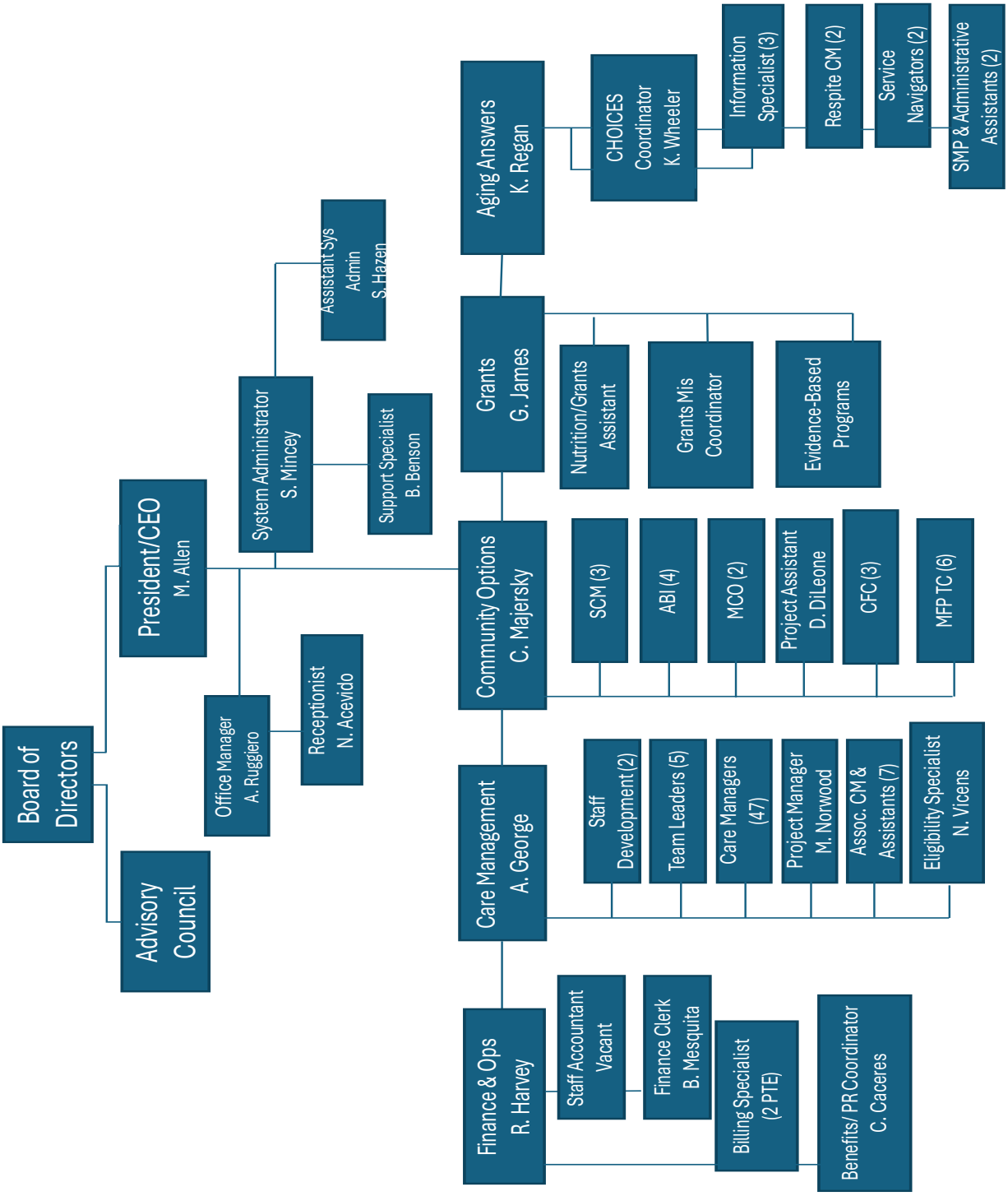
Attachment C – Organizational Chart



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Attachment D -Focal Points

Attachment E: Accomplishments

The Southwestern Connecticut Agency on Aging is proud of all the work accomplished over the three previous years. The following description focuses on OAA funded-programs and the related policies, processes, events and outreach contributing to a successful three-year planning period, FY 2022 – 2024.

1. *No Wrong Door* improved access- The five Agencies on Aging sought private funding from the Point 32 Foundation to compliment OAA funding in the development of a No Wrong Door system. The five AAAs, through the Association, AgingCT, recognized the importance of creating uniformity and connecting our own agencies to offer all Connecticut residents streamlined access to home & community-based services. We continue the efforts today, including weekly meetings, joint training of staff, work on a new statewide database and management system, and collaboration with aging and disability networks. These policies led to greater visibility of AAA programs & increased utilization of direct-support programs like NFCSP & Alzheimer's Respite.
2. Seamless support- Creating the Aging Answers Department offered callers a clear description of what they could achieve by calling SWCAA. Our tagline, "You have aging questions, we have aging answers," removes any question about what the caller will receive, *answers!* Incorporating the SHIP, SMP, MIPPA, I & R/A and NFCSP care management under one umbrella, Aging Answers can swiftly move clients through continuum that begins with basic I & R/A through short term case management, based on the needs of the individual. This process supports person-centered care by looking through the lens of the client, rather than the funder. You can see an improvement in the number of Title III B and E waiver specialist contacts and the improvements in customer service.
3. Internal call routing- In the past, call routing had been initiated based on funding source of the predominant issue described by the caller. After through process analysis, SWCAA developed a triage system that takes callers (caregivers and adults) through a series of intake questions that allow the client to move through the Aging Answers Department to the staff specialist based on their needs. In this holistic approach, callers are recognized for the many issues they may have related to economic, food, housing or transportation security. We find this to be best practice in support of improved client experience.
4. Enhanced Provider communication- There are two noteworthy accomplishments related to Provider/Sub-recipient communication. In the nutrition program, the Grants Manager and the Title III C2 nutrition educator (waiver-funded) instituted quarterly meetings with the region's two Elderly Nutrition Providers and one

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meeting between each C1 host site and ENP. These meetings have helped establish the roles and responsibilities for all parties, including SWCAA. They are an opportunity to explore utilization, outreach survey responses and any other challenges. The meetings have been very successful in helping the community to understand the importance of confidential & voluntary contributions, following local, state and federal food policies and improving the overall quality of the food and experience of the participants. This best practice led to a new restaurant option in one of our more rural towns, Monroe.

The annual program review gives staff, Board and Advisory Council members the experience of visiting many of the sub-recipient grantees and exploring the benefits of their funded programs. We take the grantees through an evaluation that reviews their progress on goals, targets and funding. Together, we make course corrections if necessary. Board and Advisory members share ideas and offer partnerships to help realize goals. The data from our Grantee gateway data management system is shared for a transparent review of dollars awarded and spent. The number of clients, units and MIS services are on display for evaluators and grantees. This information is used to support any future application from the organization as past achievement is an indicator of future success.

5. Partnerships- SWCAA, along with Connecticut's other AAAs, joined forces with the CT Coalition to End Homelessness to share resources and train the network on the support available through the OAA programs. We stressed the important role the AAAs have in preventing homelessness through a person-centered review of economic security and other issues putting the individual at risk of homelessness. As a result, 32 members of the Coalition have received the training and AgingCT will present to a larger crowd at their annual conference. Other partnerships with the Adult Day Center and Alzheimer's Disease, Parkinson's Disease Associations help support the important role of caregivers and raise awareness of NFCSP and Alzheimer's Respite programs. Partnership with the disability community results in the annual Aging Summit where over 400 attendees join for a day of learning and fellowship to brainstorm innovative ways to serve the aging and disability communities. This event promotes the *No Wrong Door* concept from the grassroots up. It aligns with the Administration of Community Living and Bureau on Aging goal of access to HCBS, improved health & wellness and abuse prevention.

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Attachment F – Accounting Systems Certification

Please see the Agency's State Single Audit, previously submitted to the BoA.

Attachment G – Waiver Submission

Title III-B
Information and Referral/Assistance and Service Navigator (ADRC) Waiver Request

AAA Name:	**Southwestern Connecticut Agency on Aging**
Date Submitted:	**April 30, 2025**
Waiver Title:	**Information & Assistance**
Time Period of Waiver:	**FFY 2026 – 2028**
Geographic Area(s) Served:	**Southwestern Connecticut**

Refer to Program Instruction BOA-SPI-24-06 for additional guidance.

A. BOA Guidance and Requirements: Title IIIB waiver requests may be used to deliver Information and Referral/Assistance and Service Navigator programs (previously referred to as Aging and Disability Resource Center).

1. Information and Referral/Assistance (I&R/A) Specialists will provide Information and Referral/Assistance services as well as Public Education services.
    a. Information & Assistance is a service for older individuals that (A) provides them with current information on opportunities and services that are available to them in their communities, including information related to assistive technology; (B) assesses their programs and capacities; (C) links them to available opportunities and services and (D) to the maximum extent practicable, ensures that they receive needed services and are aware of available opportunities by establishing adequate follow-up procedures.
    b. Public Education includes activities undertaken to increase public awareness of the problems or concerns confronting older adults and recommended 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 for these activities is the general population.
2. Service Navigators will provide consumers and/or their caregivers with Application Assistance, Benefits Counseling, Case Consultation, and Options Counseling.

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a. Application Assistance is the completion and filing of application on behalf of consumers to address housing or other supports needed to divert individuals from unnecessary nursing home placement or to increase or maintain stability
b. Benefits Counseling helps in determining their consumers eligibility for public assistance, assist in processing or completing forms and teaches about local, state, and federal tax benefits and credits
c. Case Consultation is collaborating and providing information, guidance, and assistance to another professional or provider who is seeking to assist a consumer or caregiver with long-term care services and supports or benefits issues. Case Consultation may be a general consultation on service delivery in Connecticut or nationally.
d. Options Counseling is an interactive process where individuals are supported in deliberations to make informed choices about long-term services and supports in the context of the individual's preferences, strength, needed services, values, and individual circumstances
    1. The following four steps must occur in order to be considered Options Counseling
        a. Conduct a personal interview
        b. Develop a person-centered plan
        c. Facilitate streamlined access to public and/or private services and support
        d. Conduct ongoing follow-up and documentation

3. Program Requirements
    a. Maintain a phone line during business hours of the agency
    b. Ensure that all calls that go into voicemail or inquiries through email are returned within 3 business days.
    c. Maintain a language translation service for the purpose of offering multilingual services in order to respond to inquiries from consumers whose primary language is not English.
    d. For I & R/A Program: Provide two Public Education services quarterly to Senior Center, municipalities, community events, and community partners.
4. Staff Requirements:
    a. Receive Community Resource Specialist – Aging/Disabilities (CRS-A/D) Certification through Inform USA within 180 days of hire
    b. Complete and record a minimum of two hours of social service resource training (in-person or webinar) each month
    c. Additional staff requirements for Service Navigators
        1. Complete Person-Centered Counseling training, provided or approved by the BOA, within 90 days of hire
        2. Receive SHIP/CHOICES certification within 180 days of hire

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3. Attend and successfully complete at least one SHIP/CHOICES annual training each calendar year (Spring or Fall)

5. Reporting Requirements:
    a. I & A is to be reported in a format provided by the Department and submitted quarterly to the Department.
    b. Public Education is to be reported in a format provided by the Department and submitted quarterly to the Department
    c. Service Navigator services are entered into WellSky Aging & Disability (A&D) on a schedule in accordance with the federal contract.

B. AAA Narrative

1. **Program Waiver Justification:** In a brief paragraph, provide information regarding the need for the service(s) and need for the AAA to provide the service(s) directly. Include an explanation of how assurances in the Title III Waiver PI BOA-SPI-24-06 are met. *Address efforts made to identify community providers to provide the service.* Attach any relevant data to support or justify your need statements.

The need for the Title III B waiver *access to information and services* aligns with the State Plan on Aging by providing the necessary guidance and assistance to older and disabled residents to support home & community-based services, healthy aging, and elder rights. The SWCAA Area Plan relies on the two Information Specialists to meet many of the outcomes promised throughout the FFY 2025 – 2027 Area Plan. Data presented in CHART 1 of the Needs Assessment justifies the TIII B waiver need. Access to state systems like Impact and Ascend streamlines enrollment information not available to other community providers. This information is integral to correcting enrollment issues, updating information, and helping the client gain access to the services needed. Awarding an individual town or city the I & R/A funds would limit the provision of services for the town's residents. There is no nonprofit organization serving the entire region. With its holistic focus on aging and disability, SWCAA can provide economical and high-quality I & R/A by involving the aging network through education and referral and creating an economy of scale by cross training information specialists, care managers, service navigators and community health workers. Each year, SWCAA holds a comprehensive "Request for Proposals." Information and Assistance proposals are encouraged by community partners. There has never been a proposal for full regional I & R/A services. Attempts to recruit and maintain full–time Information and Enrollment Specialist in Bridgeport have not been successful. SWCAA's I & R/A waiver adds capacity for the needs of Connecticut's poorest and most diverse City.

2. **Narrative** (Provide separate narratives for each program – i.e. I &R/A & Service Navigator)

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a. **Service Description:** Provide a brief overview of each program to be provided in 1 paragraph. This should provide an overall picture of the program or services.

Information and Referral/Assistance (I&R/A) Specialists will provide Information and Referral/Assistance services as well as Public Education services. SWCAA assisted 1,475 adults in need of assistance with 6,553 concerns in FFY 2024. Two full-time equivalents will answer calls to the 800 and main telephone lines. They will respond to questions from the website and Facebook. The staff can accommodate walk-ins and schedule on-site counseling. Staff will host public education on topics including caregiving, Medicare, Medicaid, Medicare Savings Program, respite support and general aging topics. Enrollment events shall be available throughout the region. Bilingual staff will support Spanish speakers and Boost Lingo supports other languages. Staff will be located in the Aging Answers department. This department answered over 11,000 concerns in FY 2024. Staff can triage callers to experts in the areas of home care, options counseling, and respite support. This ensures the highest quality information is provided to every caller.

3. **Service Delivery:** Describe how the AAA will deliver the programs and associated service(s) in 4 paragraphs or fewer
    a. How will potential consumers be informed of and receive the service(s)?
    b. How will service(s) be coordinated with other Title III-B services, Title III-E Information services (Public Education) and Assistance services (I & A) or other OAA services?
    c. How will service(s) be targeted and tracked?
    d. Will the AAA require a new A&D provider or service be created?

Consumers are informed of I & R/A through SWCAA's community partnerships, advisory council, community presentations, website, Facebook, and senior center newsletters. Referrals come from United Way's 2-1-1, area hospitals, physicians, pharmacists, UniteUs and referrals from other state agencies including the Departments of Social Services, Aging & Disability Services, and Public Health. Services are received face-to-face, through community presentation and via phone and virtual platforms.

Services are coordinated with other Title III Older Americans Act services by working with local aging councils, senior center directors and Municipal Agents to the most relevant, non-duplicative information and complement local supports. Callers are asked to identify as caregivers, so client counts are not duplicated.

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows all contacts to be coordinated. Referrals to service navigators or Respite care managers require a Form 5 intake, which is initially entered into the Technology Hub. Technology Hub can present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging.

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Traditional I & R/A services will be recorded in aggregate. Clients requiring referrals to specialized areas such as respite or Service Navigators will be added to Wellsky using the Form 5 intake and tracking their units and types of services.

No additional A & D providers or services are required.

4. **Staff Positions:** Provide a chart which clearly outlines the individual staff positions dedicated to this waiver including specific duties performed and the portion of FTE. If staff position works on other Title III programs, specify which programs and portion of FTE assigned to those programs.

Information and Referral/Assistance

Staff Position	Specific Duties Performed	Portion FTE
Information Specialist	Responds to inquiries on all aging issues. Provides first contact with telephonic, in-person and web-based inquiries. Triages inquiries in need of specialized support. Responds to requests from community partners. Presents relevant information at community presentations and enrollment events (at least two per quarter). Attends health fairs and community events to raise awareness of services. Provides enrollment support and follow up as needed. Advocates for clients to minimize risks and support community-based service delivery. Completes all required training per Federal & State contracts.	1 FTE
Information Specialist	Same as above + bilingual (English/Spanish) requirement. Focus on Bridgeport community.	1 FTE

Service Navigator

Staff Position	Specific Duties Performed	Portion FTE

1.

Other

Staff Position	Specific Duties Performed	Portion FTE

5. **Client Satisfaction:** Describe how client satisfaction is measured and how improvements are made when problems are identified. Provide a copy of the survey tool by October 1, 2025.

Each client will be asked to participate in a three-question survey following contact with the Information Specialist. Questions include, 1) are you calling for yourself or are you a caregiver; 2) was your information specialist knowledgeable; and 3) will the information help you care for yourself or someone important to you?

6. **Sub-Contract(s) (if applicable):** Describe plans for sub-contracting service components and how program requirements are being met. If components are sub-contracted, explain why staff cannot fulfill component.

None requested.

C. Service Levels

1. Service Numbers

Information and Referral/Assistance

Service	# of Individuals Served	# of Units	Title III-B Funds
Information & Assistance	3500	9000	$140,368.18
Public Education*		56	$17,878.37

Service Navigator

Service	# of Individuals Served	# of Units	Title III-B Funds
Application Assistance			
Benefits Counseling			
Case Consultation			
Options Counseling			

1.

Other

Service	# of Individuals Served	# of Units	Title III-B Funds
Translation	250	340	$7,923.69

*****Denotes a permissible aggregate service. All other services require individual registration and reporting

D. Data collection and reporting: Describe how the AAA will collect and report data for each service related to the program.

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows for all contacts to be coordinated. Technology Hub can present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging. Traditional I & R/A services will be recorded in aggregate. Clients requiring referrals to specialized areas such as respite or Service Navigators will be added to Wellsky using the Form 5 intake and tracking their units and types of services.

E. Budget: Complete the following budget line-item in addition to the budget workbook. Complete the Budget workbook as provided by the BOA and submit to the BOA with the completed waiver request. The budget and budget narrative need to reflect the scope of the work. Include the staff position name and FTE equivalent in the budget narrative section of the workbook. *Include expenses related to staff requirements such as training or certifications.*

1. **Summary**

Information & Referral/Assistance	$166,170.23
Service Navigation	
Title III-B Total of Programs	
Match (at least 15%)	$29,324.00
Program Income	

1.

Total Program	
Other Resources	
Grand Total	$195,494.23

We, the undersigned, approve and submit the attached service description for Title III Direct Service 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

_____ _____
Signature of Authorized Official of Area Agency (Optional) Date

For ADS Use Only

_____ Waiver Request Approved

_____
Time Period of Approved Waiver

_____ Waiver Request Denied

_____
_____
Signature of Authorized Official, Aging and Disability Services Date

1.

Title III-C2 Waiver Request

AAA Name: **Southwestern Connecticut Agency on Aging**
Date Submitted: **April 30, 2025**
Waiver Title: **Information & Assistance**
Time Period of Waiver: **FFY 2026 – 2028**
Geographic Area(s) Served: **Southwestern Connecticut**

Refer to Program Instruction BOA-SPI-24-06 for additional guidance.

A. **BOA Guidance and Requirements**

1. The following services will be permitted under this waiver:

a. **Home Nutrition Education**: Nutrition education is provided to participants or caregivers in their place of residence. This is an intervention targeting eligible adults and caregivers that uses information dissemination, instruction, or training with the intent to support food, nutrition, and physical activity choices and behaviors (as they relate to nutritional status) to maintain or promote better health and address nutrition-related conditions. Nutrition Education can be delivered in-person, by a one-on-one phone call, conference call, or virtually by nutrition staff. Home nutrition education is overseen by a registered dietitian or individual of comparable expertise.

b. **Nutrition Counseling**: A standardized service as defined by the Academy of Nutrition and Dietetics and provides individualized guidance to participants who are at nutritional risk because of their health, nutritional history, dietary intake, chronic illnesses, or medication use or are caregivers of such persons. Nutrition education is provided one-on-one by a registered dietitian and addresses the options and methods from improving nutrition status with a measurable goal.

c. **Nutrition Assessment**: A nutrition assessment is the development of an individual profile of one's current nutritional status and the identification of nutritional deficiencies. This individualized profile includes but is not limited to, the nutritional risk score as identified on the Consumer Registration Form. A nutrition assessment is not required for all individuals; but is required to be conducted before a participant receives nutrition counseling. Nutrition assessments are completed for participants with a nutritional risk score of six or more in order to receive nutrition counseling. Nutrition assessments are completed for individuals where the approved nutrition education plan or currently approved nutrition waiver indicates prioritization of a different nutritional risk score or another identified factor. A nutrition assessment is completed by a registered dietitian or other health professionals in accordance with state law and policy.

*NOTE: A nutrition assessment is required before the provision of nutrition counseling, but is not tracked as a separate service. A unit of nutrition assessment recorded in WellSky A&D must have a corresponding unit of nutrition counseling recorded.

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*NOTE: **Nutrition intake services provided by the AAA will be phased out effective 10/1/26.** As of 10/1/26, these intake services should be provided by the Elderly Nutrition Providers (ENPs). The AAA will be required to submit a phase-out plan to the BOA by 10/1/25.

2. Program requirements

a. Nutrition Education and Nutrition Counseling through III-C2 must be provided, whether through waiver or by subcontractor, by licensed or approved individuals.

3. Staff requirements

a. Individuals providing Nutrition Counseling and Nutrition Education materials must be a registered dietitian or individual of comparable expertise including but not limited to a nutritionist, diabetic educator, or nurse, in accordance with state law.

b. Staff identified in this waiver request are required to attend all mandatory Bureau of Aging trainings.

4. **Reporting Requirements**

a. Annual Nutrition Education Plan(s) for upcoming the upcoming federal fiscal year must be submitted to the BOA Nutrition Consultant no later than September 1.

b. Quarterly Nutrition Education Workbooks outlining the nutrition education topics covered during each quarter must be submitted to the BOA Nutrition Consultant and are due:

1. January 15
2. April 15
3. July 15
4. October 15

c. Home Nutrition Education and Nutrition Counseling consumers and units must be entered into Well Sky within 45 days of the end of each quarter.

B. **AAA Narrative**

1. **Program Waiver Justification:** 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 BOA-SPI-24-06 are met. *Address efforts made to identify community providers to provide the service.* Attach any relevant data to support or justify your need statements.

The need for the Title III C2 waiver for nutrition education, assessment and counseling aligns with the State Plan on Aging by providing the necessary nutritional support to older and disabled residents. Nutrition education offers strategies to improve nutritional intake and manage complex and chronic diseases. The SWCAA Area Plan relies on the Nutrition Educator to meet many of the outcomes promised throughout the FFY 2025 – 2027 Area Plan. Data presented in CHART 1 of the Needs Assessment justifies the TIII C waiver need. Health and nutrition concerns rank as high priorities for older adults. Awarding an individual town or city or sub-region the funding would limit the educators reach and Elderly Nutrition Providers have said the cost of nutrition education is not sustainable. With a focus on health education, SWCAA can also use these visits to assess meal quality, customer satisfaction and suggest improvements to the ENP.

2. **Service Description:** Provide a brief overview of the program to be provided in 1 paragraph. This should provide an overall picture of the program and services.

1.

Nutrition education will be provided by the Nutrition Coordinator to a minimum of 500 home delivered meals clients. In addition, the coordinator will provide nutrition education at senior housing complexes, targeting apartment complexes in disadvantaged neighborhoods. This aligns the project goals with the strategies in the Area Plan. Nutrition education is developed by Alison Dvorak, RD. SWCAA's coordinator maintains fidelity with the lessons and utilizes her college level training in nutrition to deliver information. Educational sessions improve access to services as seniors will be aware of the locations of community cafes.

3. **Service Delivery:** Describe how the AAA will deliver the programs and associated service(s) in 4 paragraphs or fewer. Include the format of each service (in-home visit, phone call, handout, etc.)

a. How will potential consumers be informed of and receive the service(s)?
b. How will service(s) be coordinated with other Title III-C2 services or OAA services?
c. How will service(s) be targeted and tracked?
d. Will the AAA require a new A&D provider or service be created?

Consumers are informed of nutrition services through SWCAA's community partnerships, advisory council, community presentations, website, Facebook, and senior center newsletters. Referrals come from United Way's 2-1-1, area hospitals, physicians, pharmacists, UniteUs and referrals from other state agencies including the Departments of Social Services, Aging & Disability Services, and Public Health. Services are received face-to-face, through community presentation and via phone and virtual platforms. New home delivered clients are targeted as their Form 5 is entered into the data management system.

Services are coordinated with other Title III Older Americans Act services by working with local aging councils, senior center directors and Municipal Agents to the most relevant, non-duplicative information and complement local supports. Referrals for in-home support come from the ENP. Drivers are often made aware of concerns and share them with the ENP staff. ENP Staff call the Aging Answers department for follow-up. In addition, the Nutrition Coordinator shall make referrals to the SNAP program to support the nutritional intake and goals of participants.

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows all contacts to be coordinated. Referrals to the Elderly Nutrition Program require a Form 5 intake, which is initially entered into the Technology Hub by the ENP. Technology Hub can present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging. Units of nutrition education shall be added as presented to the client after the client's enrollment in the nutrition program.

No additional A & D providers or services are required.

1.

4. **Staff Positions:** Provide a chart which clearly outlines the individual staff positions dedicated to this waiver including specific duties performed and the portion of FTE. If staff position works on other Title III programs, specify which programs and portion of FTE assigned to those programs.

Home Nutrition Education & Nutrition Counseling

Staff Position	Specific Duties Performed	Portion FTE
Nutrition Coordinator	Nutrition Education for home delivered meal participants. Participates in all BoA trainings and statewide nutrition education planning meetings. Follows RD guidance and lesson plans. Communicates with ENP for improved quality. Tracks all participants in state-approved database.	.8

Nutrition Intake Assessment**

Staff Position	Specific Duties Performed	Portion FTE

**Service to be phased out effective 10/1/26

5. **Client Satisfaction:** Describe how client satisfaction is measured and how improvements are made when problems are identified. Include attachments, if applicable.

Most clients assess satisfaction based on the quality and taste of the food provided through the program. The coordinator will send or provide (if face-to-face) a three-question survey specific to nutritional education. Two additional questions will assess satisfaction with food quality and taste. This information will be shared with the ENPs as part of the quarterly quality assurance meetings. SWCAA will use the information to improve the educational presentation as indicated by survey responses.

6. **Sub-Contract(s) (if applicable):** Describe plans for sub-contracting service components and how program requirements are being met. If components are sub-contracted, explain why staff cannot fulfill component.

1.

The ENP will receive referrals for assessment and counseling under their contract with SWCAA. Referrals come from the client, caregiver or SWCAA nutrition coordinator. A registered dietician will provide this service. Units will be tracked via Technology Hub and entered via Wellsky each month.

7. **Service Levels**

a. **Service Numbers**

Service	**# of Individuals Served**	**# of Units**	**Title III-C2 Funds**
Home Nutrition Education*	640	640	
Nutrition Counseling			
Nutrition Intake**			

A Nutrition Assessment is required before the provision of Nutrition Counseling but is not tracked as a separate service.

*****Denotes a permissible aggregate service. All other services require individual registration and reporting

**Service to be phased out effective 10/1/26

b. **Data collection and reporting:** Describe how services will be tracked, data collected, and reporting done.

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows all contacts to be coordinated. Referrals to the Elderly Nutrition Program require a Form 5 intake, which is initially entered into the Technology Hub by the ENP. Technology Hub can present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging. Units of nutrition education shall be added as presented to the client after the client's enrollment in the nutrition program.

C. **Budget:** Complete the following budget line-item in addition to the budget workbook. Complete the Budget workbook as provided by the BOA and submit to the BOA with the completed waiver request. The budget and budget narrative need to reflect the scope of the work. Include the staff position name and FTE equivalent in the budget narrative section of the workbook. *Include expenses related to staff requirements such as trainings or certifications.*

1. **Summary**

NOTE: All Nutrition Education and Nutrition Counseling services are not to exceed 10% of the total C-2 allocation, whether performed by the AAA or a subcontractor.

Title III-C2 Nutrition Services	$79,508.51
Title III-C2 Total of Programs	

1.

Match (at least 15%)	$14,031.00
Program Income	
Total Program	
Other Resources	
Grand Total	$93,539.51

We, the undersigned, approve and submit the attached service description for Title III Direct Service 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

_____ _____
Signature of Authorized Official of Area Agency (Optional) Date

For ADS Use Only

_____ Waiver Request Approved _____
Time Period of Approved Waiver

_____ Waiver Request Denied

_____ _____
Signature of Authorized Official, Aging and Disability Services Date

1.

Title III-E Waiver Request

AAA Name:	**Southwestern Connecticut Agency on Aging**
Date Submitted:	**April 30, 2025**
Waiver Title:	**Information & Assistance**
Time Period of Waiver:	**FFY 2026 – 2028**
Geographic Area(s) Served:	**Southwestern Connecticut**

Refer to Program Instruction BOA-SPI-24-06 for additional guidance.

A. **BOA Guidance and Requirements**

1. The following services will be permitted under this waiver. Note that all services listed must be provided in the region, whether through a waiver, a subcontract, or a vendor. Information, Assistance, Respite and Supplemental Services must be provided throughout the entire region, whereas the other services are not required to be available region-wide. Services are divided into two sections:

a. Section 1: Non-Respite Care and Non-Supplemental Services

i. *Information*

A. Benefits Education: Educational programs offered through the NFCSP that are designed to increase caregivers' awareness of available government and non-government programs that assist them in meeting their needs and finding supports and solutions for challenges associated with caregiving. These programs provide detailed service information, including eligibility requirements and places where services are delivered.

B. Public Information Services: A public and media activity that provides caregivers, as a targeted audience, information that includes but is not limited to available services, issues related to caregiving and caregiver stress. Public activities may include in-person or virtual interactive presentations, booths/exhibits at fairs, conferences, public service announcements, distribution of pamphlets and newsletters, and radio, TV or web site events. This service is intended for large audiences and is not tailored to the needs of an individual like NFCSP Information and Assistance. *This service is recorded aggregately because collecting consumer registration forms is not feasible due to the large number of participants.* An estimated unduplicated number of caregivers receiving NFCSP Public Information Services must be provided. The audience provided should only be reported one time per medium per quarter. The year-to-date total should only reflect each audience one time. For example, a newsletter is mailed to the same 100 people every quarter. Each quarter one unit of service is reported for the newsletter and 100 consumers. The reported year-to-date total, however, would be 4 units of service and 100 consumers (NOT 400 consumers) since the same people received the newsletter each quarter.

1.

ii. *Assistance*: Assistance is a component of “Information and Assistance”. Assistance is a service for NFCSP caregivers that: (A) provides current information on opportunities and services that are available to caregivers and their care recipients in their communities, including information related to assistive technology; (B) assesses problems and capacities; (C) links to available opportunities and services; and (D) ensures, to the maximum extent practicable, that caregivers receive needed services and are aware of available opportunities by establishing adequate follow-up procedures. *This service should be recorded directly to the caregiver whenever possible. The service in A&D that Assistance is recorded to is: NFCSP Information and Assistance.*

iii. *Case Management*: NFCSP Case Management is a service provided to the caregiver, at the direction of the caregiver, by an individual who is trained or experienced in case management skills to assess needs and arrange, coordinate, and monitor a package of services that meets the caregiver’s needs. This service includes activities and coordination such as: 1) a comprehensive assessment of the caregiver, including physical, psychological and social needs, 2) develop, implement monitor and adjust a service plan in conjunction with the caregiver that uses formal services, including those from other plans, as well as informal services to meet the needs of the caregiver identified in the assessment, 3) coordinate and monitor service deliveries, 4) advocate on behalf of the caregiver for needed services or resources, 5) authorize payment for services and, 6) conduct an annual reassessment, as required. *NFCSP Case Management is recorded directly to the caregiver. Case Management is a required service for providing respite and supplemental services to ensure case plan goals are met for each caregiver.*

iv. *Caregiver Counseling*: A service designed to support caregivers and assist them in their decision-making and problem solving. Counselors have the capacity to work with older adults, families and caregivers and to understand and address the complex physical, behavioral and emotional problems related to caregiving. This includes counseling to individuals or in group sessions. Per Administration for Community Living guidance, counselors must be degreed and/or credentialed professionals licensed by the State of Connecticut and include: Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Therapists, Professional Counselors and Clinical Social Workers. *This service is recorded directly to the caregiver.*

v. *Organization of Support Groups*: Support groups are led by a trained individual, moderator, or professional, as designated by the BOA, who facilitates groups of NFCSP caregivers in discussing their common experiences and concerns and developing a mutual support system. These support groups can help participants cope with issues that include isolation, role reversal, depression, change in social supports, relationship changes, how to advocate for the care recipient, etc. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online. Caregiver Support Groups do not include “caregiver education groups,” “peer-to-peer support groups,” or other groups primarily aimed at teaching skills or meeting on an informal basis without a facilitator who possesses training and/or credentials as required by the BOA.

1.

Facilitators may include psychologists, licensed counselors, persons with a bachelor's or master's degree in social work. Facilitators can also include individuals who are certified through a BOA-approved, evidence-based practice program such as *Powerful Tools for Caregivers*, *Savvy Caregivers*, *REACH Community (Resources for Enhancing Alzheimer's Caregivers Health in the Community)*, and *Stress-Busting Program for Family Caregivers*. *This service is reported aggregately in the consumer group (Agency Name) NFCSP Caregiver Support Group*. This service records the number of caregiver support group sessions conducted by the provider and the number of consumers that attended such sessions for the report month.

vi. *Caregiver Training*: NFCSP Caregiver Training provides caregivers who participate in the NFCSP with information to improve knowledge and enhance specific skills related to caring for older individuals, children under age 18 and adult children between age 18 and 59 with a disability. Training sessions may include skills related to home emergency planning and preparedness, medication and financial management, health, and nutrition, including disease specific needs, communication with health care providers and other family members, and assistance with activities of daily living, such as bathing and dressing. Training may include the use of evidence-based programs; be conducted in person or on-line; and be provided in individual or group settings.

b. Section 2: Respite Care and Supplemental Services

vii. *Respite Care*: Respite provides temporary care to participants requiring person care assistance so that their primary caregiver (usually a family member) can have a break. This service can be provided in the home, in a long-term care facility, or a day care facility.

viii. *Supplemental Services*: Services delivered under the service category NFCSP Supplemental can only be provided to program participants on a temporary basis. In addition, supplemental funds must be the payer of last resort for these services. Supplemental funds must only be used when other programs and resources have denied payment for a service and when the service is approved by the BOA as a supplemental service.

2. Services are divided into two populations:

a. Caregivers:

i. The term "family caregiver" includes unmarried partners, friends, or neighbors who are caring for an older adult or a person of any age with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction (§ 1321.3). » The term "older relative caregiver" means a person who is at least 55 years old who lives with a child or a person with a disability for whom they are the primary caregiver and to whom they provide informal care.

b. Grandparents: The term "grandparents" is defined as: grandparent, other relatives, or close family friends who are raising children whose parents are unable to do so.

3. Program requirements

a. Maintain a phone line during business hours of your agency to respond to caregiver program needs.

1.

b. Ensure that all calls that go into voicemail or inquiries through email are returned within 3 business days.
c. Maintain a language translation service for the purpose of offering multilingual services in order to respond to inquiries from caregivers whose primary language is not English.

4. Staff requirements:

a. Title III-E staff providing one-on-one Assistance services must meet the following requirements:

i. Receive Community Resource Specialist – Aging/Disabilities (CRS-A/D) Certification through Inform USA within 180 days of hire
ii. Complete and record a minimum of two hours of social service resource training (in-person or webinar) each month

b. Title III-E staff providing Case Management services must meet the following requirements:

i. Complete Person-Centered Counseling training through a training provided or approved by the BOA, within 90 days of hire
ii. Complete and record a minimum of one hour of resource training (in-person or webinar) each month that relates to caregiver services
iii. Have prior experience providing case management services
iv. Participate in BOA hosted Care Manager meetings

c. Title III-E staff providing Counseling services must meet the following requirement:

i. Be a professional licensed by the State of Connecticut such as a Psychiatrist, Psychologist, Psychiatric Nurse Practitioner, Therapist, Professional Counselor or Clinical Social Worker.

5. **Reporting Requirement**s:

a. Information (Benefits Education and Public Information) and Assistance (I & R/A) are to be reported in a format provided by the Department and submitted quarterly to the Department
b. Case Management, Caregiver Training, Caregiver Counseling, Support Groups, Respite and Supplemental Services are entered into WellSky Aging & Disability (A&D) on a schedule in accordance with the federal contract.

B. **AAA Narrative**

1. **Program Waiver Justification:** 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 BOA-SPI-24-06 are met. *Address efforts made to identify community providers to provide the service.* Attach any relevant data to support or justify your need statements.

The need for the Title IIIE caregiver waiver aligns with the State Plan on Aging by providing the necessary guidance and assistance to caregivers to support home & community-based services, healthy aging, and elder rights. The SWCAA Area Plan relies on the Caregiver Information Specialists and Respite Care Manager to meet many of the outcomes promised throughout the FFY 2025 – 2027 Area Plan. Data presented in CHART 2 of the Needs Assessment justifies the TIII E waiver need.

1.

Access to state systems like Impact and Ascend streamlines enrollment information not available to other community providers. This information is integral to correcting enrollment issues, updating information, and helping the client gain access to the services needed. Awarding an individual town or city the Caregiver I & R/A funds would limit the provision of services to the town's residents. There is no nonprofit organization serving the entire region. With its holistic focus on aging and disability, SWCAA can provide economical and high-quality I & R/A by involving the aging network through education and referral and creating an economy of scale by cross training information specialists, care managers, service navigators and community health workers. Each year, SWCAA holds a comprehensive "Request for Proposals." Information and Assistance proposals are encouraged from community partners. There has never been a proposal for full regional Caregiver I & R/A services. Working in concert with the Adul Day Centers and in-home providers, SWCAA has successfully created a network of support, respite and information for caregivers and their loved ones.

2. **Service Description:** Provide a brief overview of each program to be provided in 1 paragraph. This should provide an overall picture of the program or services.

SWCAA will provide Benefits Education, Public Information, and Assistance as part of the I & R/A component of the Title III E waiver. One- and one-half full-time equivalents will answer calls to the 800 and main telephone lines. In FFY 2024, SWCAA assisted 1,743 caregiver callers with 11,451 concerns. They will respond to questions from the website and Facebook. The staff can accommodate walk-ins and schedule on-site counseling. Staff will host public information sessions on topics for caregivers including Medicare, Medicaid, Medicare Savings Program, in-home care, caregiver burn-out, respite support and general aging topics. Benefits education shall be available throughout the region. Bilingual staff will support Spanish speakers and Boost Lingo supports other languages. Staff will be located in the Aging Answers department. This department answered over 11,000 concerns in FY 2024. Information and Assistance staff will refer callers to experts in the Title III E Caregiver waiver. This ensures the highest quality information is provided to every caller.

3. **Service Delivery:** Describe how the AAA will deliver the programs and associated service(s) in 4 paragraphs or fewer

a. How will potential consumers be informed of and receive the service(s)?
b. How will service(s) be coordinated with other Title III-X services or OAA services?
c. How will service(s) be targeted and tracked?
d. Will the AAA require a new A&D provider or service be created?

Consumers are informed of I & R/A through SWCAA's community partnerships, advisory council, community presentations, website, Facebook, and senior center newsletters. Referrals come from Adult Day Centers, community support groups, United Way's 2-1-1, area hospitals, physicians, pharmacists, UniteUs and referrals from other state agencies including the Departments of Social Services, Aging & Disability Services, and Public Health. Services are received face-to-face, through community presentation and via phone and virtual platforms.

1.

Services are coordinated with other Title III Older Americans Act services by working with local aging councils, senior center directors and Municipal Agents to the most relevant, non-duplicative information and complement local supports. Presentations to caregivers are offered at convenient times, using the regional Adult Day Centers, support groups and grandparent support programs. Callers are asked to identify as caregivers seeking information for their loved ones, so client counts are not duplicated.

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows all contacts to be coordinated. Referrals to Respite care managers require a Form 5 intake, which is initially entered into the Technology Hub. Technology Hub can present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging. Traditional I & R/A services will be recorded in aggregate. Clients requiring referrals to specialized areas such as respite or Service Navigators will be added to Wellsky using the Form 5 intake and tracking their units and types of services.

No additional A & D providers or services are required.

4. **Staff Positions:** Provide a chart which clearly outlines the individual staff positions dedicated to this waiver including specific duties performed and the portion of FTE. If staff position works on other Title III programs, specify which programs and portion of FTE assigned to those programs.

Staff Position	**Specific Duties Performed**	**Portion FTE**
Caregiver I & A Specialist	NFCSP Information & Assistance	1 FTE
Care Manager	NFCSP Respite & Supplemental	1 FTE

5. **Client Satisfaction:** Describe how client satisfaction is measured and how improvements are made when problems are identified. Provide a copy of the survey tool by October 1, 2025.

Each client will be asked to participate in a three-question survey following contact with the Information Specialist. Questions include, 1) are you calling for yourself or are you a caregiver; 2) was your information specialist knowledgeable; and 3) will the information help you care for yourself or someone important to you?

6. **Sub-Contract(s) (if applicable):** Describe plans for sub-contracting service components and how program requirements are being met. If components are sub-contracted, explain why staff cannot fulfill component. If vendors are to be used for Respite or Supplemental Services, please specify.

1.

SWCAA plans to subcontract services through community, nonprofit organizations for support groups, grandparents' programs and caregiver counseling. These sub-contracts are dependent on receiving viable proposals from the community. The Grants Manager encourages submissions in these areas.

C. **Service Levels**

1. **Service Numbers:** When completing the charts below, provide information on the number of caregivers and grandparents expected to be served, the number of units provided to those individuals, and the amount of Title III-E funds by service. Base these targets on FFY 2024 data and demographics for your region.

Section 1: Non-Respite Care and Non-Respite Supplemental Services

Service	# of Caregivers Served	# of Units	Title III-E Funds - CG	# of Grandparents Served	# of Units	Title III-E Funds - GP
NFCSP Information*	5,000	8,000		20	25	
NFCSP Assistance	70	70				
NFCSP Case Management	50	350				
NFCSP Counseling	n/a					
NFCSP Support Groups	Sub-contract					
NFCSP Training	n/a					
NFCSP Public Education		24				

Section 2: Respite Care and Supplemental Services

Service	# of Caregivers Served	# of Units	Title III-E Funds - CG	# of Grandparents Served	# of Units	Title III-E Funds - GP
Respite	30	2500		5	5	
Supplemental Services	40	350				

*Denotes a permissible aggregate service. All other services require individual registration and reporting

E. Data collection and reporting: Describe how the AAA will collect and report data for each service related to the program, including aggregate services: Information (Public Education and Benefits Education)

Services will be targeted and tracked using Technology Hub, the Agency data management system that allows all contacts to be coordinated. Technology Hub can

1.

present data in Excel reports and seamlessly transfer information into Wellsky as required by the Bureau on Aging. Caregiver Information services will be recorded in aggregate. Clients requiring referrals to specialized areas such as respite or supplemental services will be added to Wellsky using the Form 5 intake and tracking their units and types of services.

F. **Budget**: Complete the following budget line-item in addition to the budget workbook. Complete the Budget workbook as provided by the BOA and submit to the BOA with the completed waiver request. The budget and budget narrative need to reflect the scope of the work. Include the staff position name and FTE equivalent in the budget narrative section of the workbook. *Include expenses related to staff requirements such as trainings or certifications.*
See attached workbook
1. Summary

Section 1 Total	$210,876.09
Section 2 Total	$95,000.00
Title III-E Total of Programs	$305,876.09
Match (at least 25%)	$101,959.00
Program Income	
Total Program	
Other Resources	
Grand Total	$407,835.09

We, the undersigned, approve and submit the attached service description for Title III Direct Service 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

_____ _____
Signature of Authorized Official of Area Agency (Optional) Date

1.

For ADS Use Only

_____ Waiver Request Approved _____

Time Period of Approved Waiver

_____ Waiver Request Denied

_____ _____

Signature of Authorized Official, Aging and Disability Services Date

1.

Attachment H -Cost Sharing Provisions

Subject : Cost Sharing Policy for the CT National Family Caregiver Support Program's Respite & Supplemental Services
Effective Date: October 1, 2011
Program: Title III – E, National Family Caregiver Support Program

Under the direction of The CT Dept. of Social Services, State Unit on Aging and pursuant to Section 315, (a), (2) of the Older Americans Act, cost sharing will be implemented under Title III–E services funded by OAA. The following protocol has been put in place by the Southwestern CT Area Agency on Aging with regards to cost sharing under the NFCSP specifically for respite & supplemental services. The following programs are NOT subject to cost sharing: Information & Assistance, outreach, benefits counseling, case management services, ombudsman, elder abuse prevention, legal assistance, home delivered and congregate meals.

Income Guidelines

I. Cost sharing for Respite & Supplemental Services will be based solely on the care recipient's self-declassed income. Assets are NOT included in determining cost sharing. For grandparent services, the caregiver's monthly income will be counted

II. To determine cost share, the following is considered income:
   a. Social security, SSI or SSDI
   b. Pensions
   c. Interest
   d. Dividends
   e. Veteran's benefits
   f. Wages
   g. Any other payments received on a one-time or recurring basis

III. For accounts held jointly, 50% of interest or dividends will be counted towards care recipient's income.

Sliding Fee Schedule

Income Range % of FPL	Individual's monthly income	Cost Share Amount
0 %– 100%	$0 - $1,041	Donations Accepted
150%	$1,042-$1,562	5%

1.

200%	$1,562-$2,082	10%
250%	$2,083-$2,603	20%
300%	$2,603- $3,123	40%
350%	$3,124-$3,644	60%
400%	$3,644-$4,164	80%
Over 400%	$4,165+	100%

IV. Determination of the income range will be determined by the confidential declaration of income by caregiver or care recipient. No verification or documentation of income will be requested by SWCAA.
V. Services will NOT be denied to anyone who fails to make a cost sharing payment.

Implementation:

I. All existing clients of the NFCSP will be sent a letter along with their re-certification paperwork beginning 07/01/2011 informing them of the new cost- sharing policy for Respite & Supplemental Services under Title III-E. (see sample letter labeled Attachment A).
II. Application packet for NFCSP Respite/ Supplemental Services will now include a paragraph on cost sharing. All new and re-certifying clients will be given the application packet.
III. At the time of home visit and assessment by Respite Care Manager, cost sharing policy will be discussed w/ care recipient and/or caregiver. Care Manager will show the income chart listed above to client and ask client to indicate what income bracket they fall into. Based on the income bracket that the client declares, the corresponding percentage of cost sharing will be assigned to plan of care.

Billing Procedures:

I. Upon start-up of services, the Care Manager will indicate in client's plan of care their appropriate percentage of cost share based on their self-declared income.
II. When the provider bills SWCAA for services rendered on behalf of the client, SWCAA's finance dept. will issue payment to the provider and then invoice the consumer for their percentage of the cost for the services rendered in that period.
III. All cost sharing revenue will go back into the appropriate account depending on whether it was for respite or supplemental services and those funds will

1.

be used to serve additional consumers who are on the waiting list within those respective categories.

IV. SWCAA will continue to conduct outreach and education to all 14 of our cities and towns to make them aware of the program in our efforts to reach those in our underserved towns.

1.