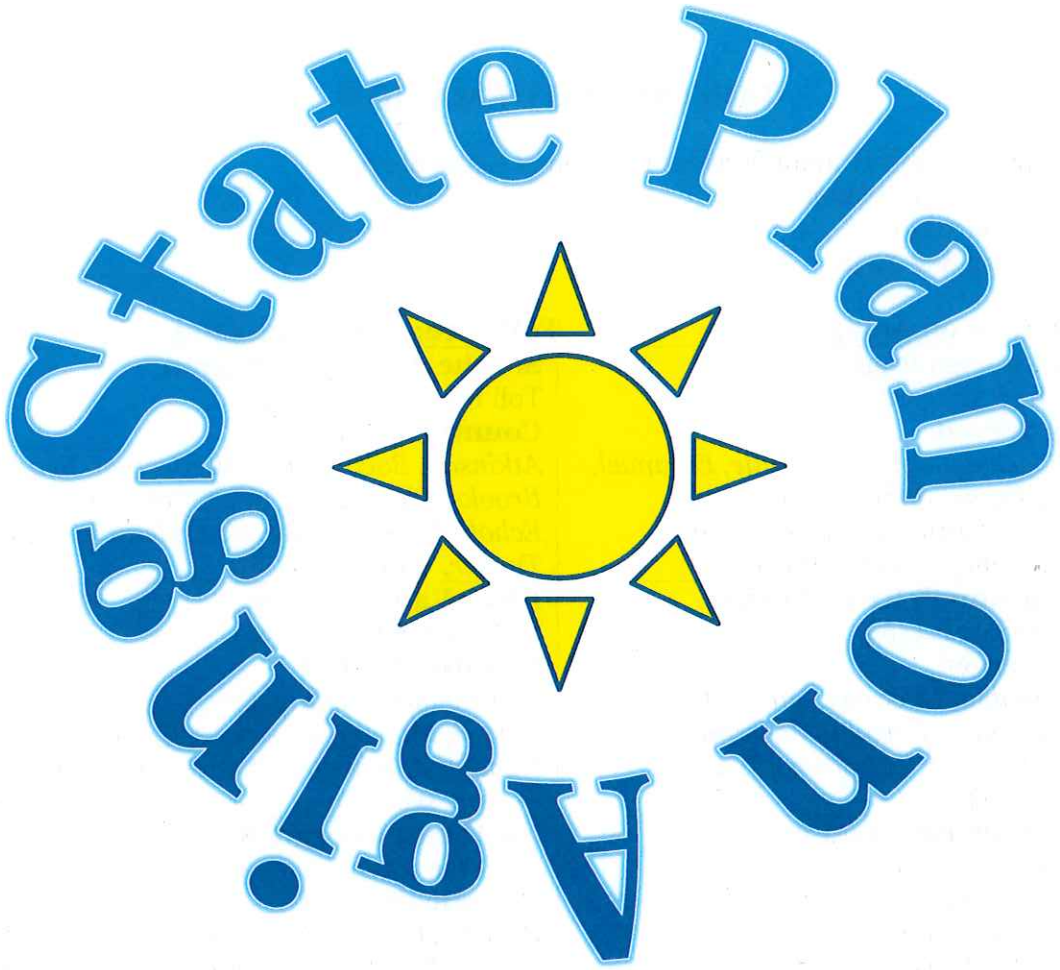


October 1, 2015 through
September 30, 2019

Georgia Department of Human Services
Division of Aging Services

Nathan Deal
Governor of Georgia

CONTACT INFORMATION

Georgia Department of Human Services Division of Aging Services
2 Peachtree Street, 33rd Floor
Atlanta, Georgia 30303
Telephone: 404-657-5252

Area Agencies on Aging **Toll Free: 1-866-552-4464**

Heart of Georgia Region Toll Free: 888.367.9913 **Counties Served** *Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox*	**Southern Georgia Region** Toll Free: 888.732.4464 **Counties Served** *Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charleton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware*
Central Savannah River Region Toll Free: 888.922.4464 **Counties Served** *Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes*	**River Valley Region** Toll Free: 800.615.4379 **Counties Served** *Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster*
Southwest Georgia Region Toll Free: 800.282.6612 **Counties Served** *Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth*	**Northeast Georgia Region** Toll Free: 800.474.7540 **Counties Served** *Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton*
Three Rivers Region Toll Free: 866.854.5652 **Counties Served** *Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson*	**Coastal Region** Phone: 912.262.2840 **Counties Served** *Bryan, Bullock, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh*
Georgia Mountains Region Toll Free: 800.845.5465 **Counties Served** *Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White*	**Northwest Georgia Region** Phone: 706.295.6485 **Counties Served** *Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield*
Middle Georgia Region Toll Free: 888.548.1456 **Counties Served** *Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson*	**Atlanta Region** Phone: 404.463.3333 **Counties Served** *Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale*

MISSION VISION AND VALUES

Mission Statement

The Georgia Department of Human Services (DHS) Division of Aging Services (DAS) supports the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives.

Vision

Living Longer, Living Safely, Living Well.

Values

A Strong Customer Focus
We are driven by customer – not organizational – need. We consider customer's input and preferences in all decision-making.

Accountability and Results
We are good stewards of the trust and resources placed with us. We base our decisions on data analysis and strive for quality improvement.

Teamwork
We do business through teamwork and collaboration. We practice shared decision-making and everyone's contribution is valued.

Open Communication
Our communication is open and responsive. We listen to our customers and partners and provide them accurate, timely information.

A Proactive Approach
We envision the future needs of our customers and the changing service network. We lead and advocate with innovation.

Dignity and Respect
We respect the rights and self-worth of all people.

Our Workforce
Our workforce, including volunteers, is our best asset. We maintain a learning environment with opportunities to increase professional growth, share knowledge and stimulate creative thinking.

Trust
Compassion and integrity drive what we do and who we are.

Diversity
We value a diverse workforce; it broadens our perspective and enables us to better serve our customers.

Empowerment
We support the right of our customers and workforce to make choices and assume responsibility for their decisions.

SIGNED VERIFICATION OF INTENT

The State Plan on Aging covers the period of October 1, 2015 through September 30, 2019. It includes all assurances and plans to be conducted by the Georgia Department of Human Services Division of Aging Services under the provisions of the Older Americans Act (OAA) (amended). The state agency named above has been authorized to develop and administer the State Plan on Aging in accordance with all requirements of the OAA, including the development of comprehensive and coordinated systems for the delivery of supportive services, such as multipurpose senior centers and nutrition services. DAS, under the guidance of DHS, serves as the State of Georgia's effective and visible advocate for older individuals, at-risk adults, and persons with disabilities. DAS also serves as an effective and visible advocate for the families and caregivers of those served.

The State Plan on Aging, developed in accordance with all Federal statutory and regulatory requirements and approved by the Governor is hereby submitted.

The State Plan's approval by the Governor constitutes authorization to proceed with activities under the State Plan upon approval by the Assistant Secretary on Aging.

6/22/15
(Date)

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services

12 Jun 15
(Date)

Keith Horton

Keith Horton, Commissioner
Georgia Department of Human Services

I hereby approve the State Plan on Aging and submit it to the Assistant Secretary for Aging.

22 June 2015
(Date)

Nathan Deal

Nathan Deal, Governor
State of Georgia

Georgia Department of Human Services
Division of Aging Services
State Plan Table of Contents

NARRATIVE

Executive Summary

The Georgia Department of Human Services Division of Aging Services' mission is to support the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives. In order to accomplish this mission, DAS works collaboratively with others within Georgia's Aging Services Network (Area Agencies on Aging (AAA), providers, older adults and advocates) and with key organizations serving individuals with disabilities. Moreover, DAS is committed to continually improving its person-centered, statewide comprehensive and coordinated system of programs and services. The programs and services are available to all eligible individuals. They provide seamless access to long-term supports and services needed for consumers to remain at home and in the community, safely, for as long as they desire.

The State Plan provides leadership and guidance in rebalancing the long-term care system and development of a comprehensive and coordinated infrastructure for home and community based services. The Plan documents the goals, objectives, and strategies outcomes planned and achieved, translating activities, data, and outcomes into proven best practices, and providing a blueprint that spells out the coordination and advocacy activities the state will undertake to meet the needs of older adults and persons with disabilities.

The Georgia State Plan on Aging reflects the focus areas outlined by the United States Department of Health and Human Services Administration for Community Living (ACL). The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. DAS will provide the leadership for accomplishing the goals in collaboration with the aging services network and other state agency partners. Specific objectives and strategies to achieve the goals along with metrics to measure performance in reaching the goals are specifically outlined in the Goals and Objectives section of this plan.

The goals set forth in this State Plan will continue to advance the service delivery system and allow for a higher quality of service and potentially increase the number of available services for Georgia's continually growing older adult population, disability population and their families and caregivers. DAS will continue to deploy innovative methodologies to efficiently and effectively expand capacity, foster collaborations, and drive cost efficiencies to deliver a comprehensive system of programs and services to assist Georgians in living longer, living safely and living well.

Introduction and Context

State Agency on Aging

The Georgia Department of Human Services Division of Aging Services, as the State Agency on Aging provides leadership to administer a statewide system of comprehensive and coordinated array of services for older adults and their families and caregivers. DAS administers federal and state funding to AAA, manages contract requirements with AAA and their governing bodies, and provides the policy framework for programmatic direction and operations, standards, and guidelines for service delivery systems, quality assurance and training. DAS continuously seeks to improve the effectiveness and efficiency of the services provided to older adults, people with disabilities and their families.

As Georgia's State Agency on Aging, DAS assures that preference will be given to the provision of services to older individuals with the greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals, individuals at risk for nursing home placement, older individuals living alone and older individuals living in rural areas. The Aging and Disability Resource Connection (ADRC) provides a "no wrong door" single entry point for adults who are aging and/or have a disability to access long-term care support services. The ADRC provides information, assistance, counseling, and referrals to community resources.

State Agencies on Aging administering funds under Titles III and VII of the OAA of 1965, as amended, are required to develop and submit to the Assistant Secretary on Aging a State plan for approval under Section 307 of the OAA. DAS has adopted a four-year State Plan on Aging for the period extending from October 1, 2015 through September 30, 2019.

The State Plan serves as roadmap to guide Georgia's twelve (12) AAA, designated under Section 305 of the OAA, in developing area plans. The AAAs will formulate their area plans using a uniform format developed by the State Agency in collaboration with the Area Agencies. The goal is to align area plans with this State Plan.

Area Agencies on Aging

In Georgia, DAS has designated twelve (12) Planning and Service Areas (PSAs) . All community-based services for older adults are coordinated through the AAAs. Ten of the Area Agencies are housed within Regional Commissions (RCs), which are the units of general-purpose local government. The remaining two agencies are freestanding, private non-profit organizations, both of which have 501(c) 3 status with the Internal Revenue Service.

The AAAs are responsible for:

- Assuring the availability of an adequate supply of high quality services through contractual arrangements with service providers, and for monitoring their performance;
- Local planning, program development and coordination, advocacy, monitoring;
- Developing the Area Plan on Aging and area plan administration, and resource development;
- Working with local business and community leaders, the private sector and local elected officials to develop a comprehensive coordinated service delivery system;
- Establishing and coordinating the activities of an advisory council, which will provide input on development, and implementation of the area plan; assist in conducting public hearings; review and comment on all community policies, programs and actions

affecting older persons in the area.

The State Plan encompasses a listing of Georgia's AAA. The map on the following page depicts the geographical boundaries of the AAAs within the State of Georgia.

Georgia Council on Aging

In 1977, the Georgia General Assembly created the Georgia Council on Aging (GCOA). The Governor, the Lieutenant Governor, the Speaker of the House and the Commissioner of the Department of Human Services appoint Council members. The Council has twenty members, including ten consumers at least 60 years of age and ten service providers. Members represent all older Georgians and ensure that minorities, low-income, rural, urban, public, and private organizations are included.

The Georgia Council on Aging's primary mission is to:

- Advocate with and on behalf of aging Georgians and their families to improve their quality of life;
- Educate, advise, inform and make recommendations concerning programs for the elderly in Georgia; and
- Serve in an advisory capacity on aging issues to the Governor, General Assembly, DHS and all other state agencies.

The Coalition of Advocates for Georgia's Elderly (CO-AGE) is led by the GCOA. The coalition is meant to be:

- a forum to identify and address concerns of older Georgians;
- a vehicle for bringing broad-based input on aging issues from across the state;
- a diverse group of organizations, individuals, consumers and providers interested in "aging specific" and intergenerational issues; and
- a unifying force communicating the importance of providing supportive communities and adequate services & programs for older Georgians.

Alzheimer's and Related Dementias Advisory Council

During the 2013 session of the Georgia General Assembly, legislators created the Georgia Alzheimer's and Related Dementias State Plan Task Force, a multidisciplinary group convened to improve dementia research, awareness, training, and care. Starting in June of that year, the six task force members and dozens of experts in diverse fields formed committees, conducted research, and made detailed recommendations.

The recommendations formed the core of the Georgia Alzheimer's and Related Dementias State Plan. The document described current demographics, prevalence statistics, and existing resources; analyzed the state's capacity to meet growing needs; and presented a roadmap to create a more dementia-capable Georgia.

In June 2014, Governor Nathan Deal signed the Georgia Alzheimer's and Related Dementias State Plan into action, and the Task Force became an Advisory Council.

Georgia's recommendations cover a range of topics, including research, services, policy, public safety, workforce development, and public education. And undergirding all of these areas is the

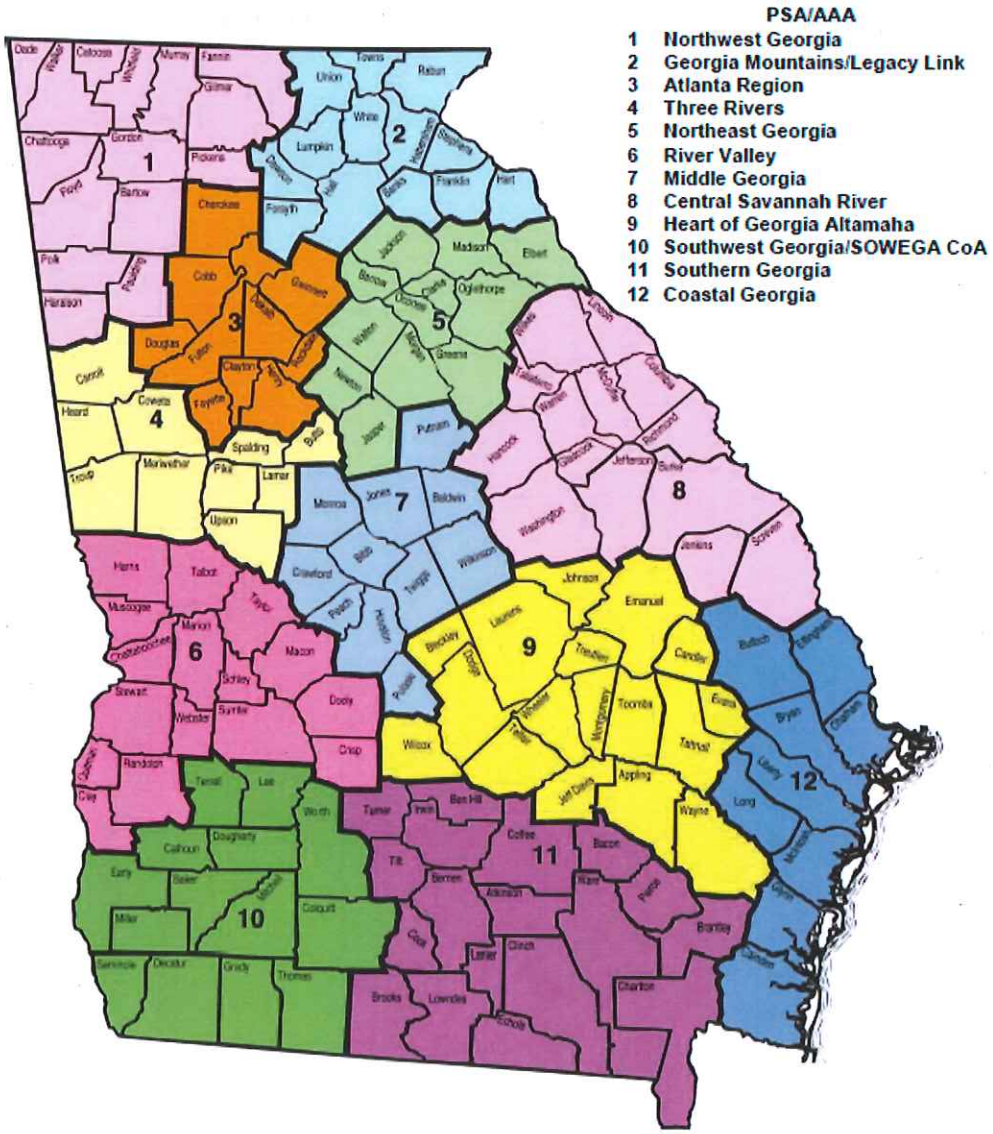
importance of partnerships – creating a deeply coordinated statewide team of agencies, nonprofits, businesses, and organizations.

The Georgia Alzheimer's and Related Dementias Advisory Council serves as a hub for cultivating new initiatives and improving communication about what Georgia is doing to address dementia needs.

The Georgia Alzheimer's and Related Dementias State Plan will undergo regular review to ensure that it reflects emerging priorities, shifts in resources, and evolving public- and private-sector roles. The Advisory Council will work with partner stakeholders, state agencies, and legislators to develop and file appropriate legislation and corresponding appropriations requests throughout the life of the Plan.

Planning and Service Areas Overview

DHS Division of Aging Services
Planning and Service Areas



Needs Assessment

In the fall of 2014, DAS collected public input through five statewide public hearings and an online survey. The primary objectives were to ascertain the perceived value of and barriers to DAS programs and services, obtain consumer suggestions for recommended improvements to the service delivery system and home and community based services, and ideas for new DAS initiatives. During the hearings, consumers praised DAS and the network for the positive differences that our supports and services provide. However, through the questions listed below, some opportunities for improvement were uncovered:

- which services were most needed by consumers to maximize their independence;
- which services were most needed by consumers to stay healthy or improve their health; and
- what could the State STOP, START or CHANGE to improve services.

Public hearing participants identified services most needed to maximize consumers' independence. The top three services, ranked in order of importance statewide were (1) transportation, (2) health care, and (3) housing. It is noteworthy that transportation was identified as the most needed service during the public hearings for the last State Plan development cycle in 2011. A recurring theme among many of the participants was a greater need for caregiver support programs.

In 2014, Public hearing participants also identified services most needed to stay healthy or improve their health. The top three services, ranked in order of importance statewide, were: (1) health care, (2) exercise nutrition, and (3) transportation.

The survey question "**What must we Start, Stop or Change"** was presented as an open-ended query during the public hearings; 333 respondents replied. Refer to Appendix C for a broadly categorized summary of results.

Goals and Objectives (Older Americans Act Core Programs)

State plans must include measurable objectives that address focus areas outlined by the United States Department of Health and Human Services Administration for Community Living. The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. A chart outlining goals developed by DAS for each focus area is below. DAS will directly accomplish some goals while the AAAs will accomplish others under DAS' oversight. Checkmarks in the tables below differentiate between AAA specific and DAS specific goals. Specific objectives and strategies to achieve the goals along with metrics to measure performance in reaching the goals are specifically outlined in this section of the plan.

Older Americans Act Core Program Goals

Goal	DAS	AAA	Goal	DAS	AAA
Focus on sustainability		☑	Advocate for person-centered long-term care facility resident access to less restrictive housing options	☑	
Focus on reaching underserved persons		☑	Increase the numbers of individuals served by GeorgiaCares from "targeted populations."		☑
Expand opportunities for transportation in underserved areas		☑	Increase the number of consumers reached that could benefit from assistance offered through the Medicare Improvements for Patients and Providers Act (MIPPA)		☑
Empower older adults to stay active and healthy	☑		Improve quality of services performed by the Community Care Services Program (CCSP)	☑	
Increase veterans enrollment and successful completion in Senior Community Services Employment Program (SCSEP)	☑		Ensure consumers receive services in their homes and communities	☑	
Increase enrollment of older adults with minimum English language proficiency in SCSEP	☑		Strengthen the Elderly Legal Assistance Program	☑	
Increase SCSEP participant placement in entrepreneurial ventures	☑		Exceed the expectations of our clients	☑	
Expand efforts to support individuals to remain in their desired residence as long as possible		☑	Improve the capacity of Georgia's aging and behavioral health networks to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness, and referrals	☑	

ACL Discretionary Grants Goals

Goal	DAS	AAA	Goal	DAS	AAA
Support older adults and people with disabilities to transition from an institutional setting to a setting of their choosing using a person centered approach through the Money Follows the Person grant and other means	☑		Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse	☑	

Participant Directed Person Centered Planning Goals

Goal	DAS	AAA	Goal	DAS	AAA
Utilize a person centered approach to service delivery designed to support older adults and individuals with disabilities living in the community	☑		Ensure maximum access and efficient delivery of Home and Community Based Services (HCBS) to older adults, persons with disabilities, and caregivers		☑
Develop and implement a person-centered approach to service mix		☑	Increase participation in and sustainability of evidence-based health and wellness programs		☑
Maximize the variety of approaches to support consumer control and choice		☑	Empower residents of facilities to fully participate in directing their care		☑
Increase the professional capacity of Georgia's Aging network to better meet the needs of family caregivers and at-risk adults		☑	Empower older people and people with disabilities, along with their support systems, to make informed decisions about community vs. institutional living based on their preferences, values, and strengths	☑	
Support grandparents and other relative caregivers to maximize family independence		☑			

Elder Justice Goals

Goal	DAS	AAA	Goal	DAS	AAA
Empower persons under guardianship through greater autonomy, independence, and self-determination	☑		Increase professional capacity to address abuse, neglect and exploitation of older adults and adults with disabilities	☑	
Decrease unnecessary removal of rights	☑		Increase collaboration among stakeholders to address abuse of older adults and adults with disabilities	☑	
Provide persons under guardianship with strong guardian-advocates	☑		Ensure the protection and rights of older and disabled individuals who are victims of abuse, neglect and exploitation	☑	
Protect residents of long-term care facilities from abuse, neglect and exploitation	☑		Increase understanding of "suspicious deaths" in older adults amongst medical examiners, coroners, medicolegal death investigators, and criminal justice professionals	☑	

Goal 1: Focus on sustainability to ensure programs and services remain available for those in need

Objective 1: Develop an aging network that is sustainable in all economic climates	
Strategies:	Expand fee-for-service program model (example: Evidence Based Programs, Case Management, Community Living Program, Senior Centers) by 2019
	Implement evidence-based hospital transition programs in all AAAs by 2019
	All AAAs have business plan with a regular review process by 2019
Performance Metrics:	100% of AAAs will receive business plan training by 2019
	100% of AAAs will implement business plans by 2019

	Develop a minimum of 3 new funds sources to support service provision by 2019
	Number of statewide hospital transition programs in operation will increase by 25% by 2019.
	Monitor dollar amount increase and percentage increase in funds (fee for service)

Goal 2: Create a statewide focus on reaching underserved persons

Objective 2.1: Develop an aging network that reaches underserved persons across the state	
Strategies:	Identify and prioritize potential underserved populations to be reached
	Develop partnerships that facilitate outreach for underserved populations such as veterans, those with limited English proficiency and those with other cultural barriers
	Develop service plan to address prioritized populations
	Focus network activity to address the needs of underserved populations (nutrition, social, etc.)
	Develop and implement training for community partners to aid in outreach and service provision to underserved populations
Performance Metrics:	Increase percentage of underserved individuals served by 10% after setting baseline in 2016
	Increase number of partner cooperatives by 10% after setting baseline in 2016
	Increase number of underserved populations for which service plans are developed
	Increase number of trainings
Objectives 2.2: Promote greater access to waiver services in underserved/rural parts of the state	
Strategies:	Develop effective ways to address potentially-eligible consumers' concerns related to cost-share and estate recovery
	Provide training for ADRC and case management staff to deliver consistent messages about cost share and estate recovery
	Partner with the DCH to explore opportunities for provider growth and/or partnerships in under-served/rural areas
	Develop a best-practice training geared towards providers serving under-served/rural parts of the state
Performance Metrics:	SFY 16: Identify the number and % of providers who visit the CCSP GIS Maps resource link after its launch in SFY 15
	SFY 17: Provide 2 best practice trainings geared towards the unique challenges and opportunities faced by providers delivering CCSP services in underserved/rural parts of the state
	SFY 18 to SFY19: Provide 1 refresher training session on cost-share and estate recovery for the ADRC

Goal 3: Expand the opportunities for transportation in underserved areas of Georgia

Objective 3: Increase community based transportation opportunities	
Strategies:	Develop county-based transportation cooperatives that work on local transportation options for older adults and persons living with disabilities
	Develop volunteer transportation programs in each AAA
	Build partnerships with transportation organizations (for-profit and nonprofit) to further develop transportation options for vulnerable populations
	Establish baseline data for number of cooperatives, number of volunteer programs and number of corporate partnerships by 2016.
Performance Metrics:	Measure number of cooperatives developed in each year of the plan after the 2016 baseline and increase number of cooperatives developed by 10% each year
	Measure number of volunteer programs developed after the 2016 baseline Increase number of volunteer programs by 10% each year.
	Measure number of corporate partnerships developed after the 2016 baseline. Increase number of corporate partnerships by 10% each year.

Goal 4: Empower older adults to stay active and healthy

Objective 4.1: Increase food security and access to healthy food options	
Strategies:	Increase the number served through congregate sites and home-delivered meals by increased efficiencies in all fund sources
	Connect older adults to local food systems (farmer's markets and community gardens)
	Strengthen partnerships with SNAP and senior centers
	Increase knowledge through nutrition education
	Develop a partner group to support and implement a State Senior Hunger Summit with the goal of illuminating the hunger issues in Georgia, where the need is greatest and potential strategies for stakeholders across the state. This would be a great opportunity to have the attendees complete a survey to aid in the next steps
Performance Metrics:	Increase food security for food insecure HDM clients and increase access to healthy foods for congregate clients
	Participation in Congregate and HDM programs will increase by 5% by 2019
	Increase number of community gardens with senior focus after 2016 baseline is established
	All senior centers will have a minimum of one SNAP sign-up day per quarter by 2019

	Form a partner group (CCSP, DPH, DFCS, G4A, Dollar General, Farmers Market Association, Grocers Association, The Food Policy Network, Food Bank Association, Wholesome Wave, Etc.). The partner group would be convened to plan and hold the summit and following the event; compile the survey results, develop at GA position statement, then begin work on a statewide plan with initial attention to identifying the policy barriers and identifying policy and planning strategies to fee a variety of food systems needs across the state.
	Convene State Senior Hunger Forum by 2019
Objective 4.2: Increase quality of life for community dwelling senior participants by providing opportunities for socialization, community involvement, health and wellness, civic engagement, and recreational activities	
Strategies:	Adapt a tool to capture QOL info
	Pilot the tool and establish baseline data
	Explore use of technology to increase socialization
	Explore the idea of an intergenerational wellness center system
Performance Metrics:	SFY16: Revise, Train and Implement the new survey on QOL
	SFY17-18: Use new survey with all senior center participants
	SFY 19-Evaluate effectiveness of tool
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to National Core Indicators – Aging and Disabilities (NCI –AD) consumer survey results question 48: "Are you able to do things you enjoy outside of your home when and with whom you want to?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 50: "Do you have transportation when you want to do things outside of your home, like visit a friend, go for entertainment, or do something for fun?"
Objective 4.3: Senior Centers will become an integrated focal point in the community for healthy, active aging and access to services to help older adults remain in the community of their choosing	
Strategies:	Each senior center will adopt and implement a wellness goal
	Increase community partnerships that support senior centers
	Increase community events that occur at senior centers
	Increase outreach to the community about senior center activities
	Explore center as an economic hub holding education and application sessions around support programs (SNAP, GA Cares, SSI Application, Etc. Monthly for each)
	Number of activities involving multi-demographic populations
Performance Metrics:	Number of community partners, community events increased by 25% over 2016 baseline by 2019
	Increased participation due to expanded outreach to 20% over 2016 baseline by 2019

	Number of senior center participants that receive education sessions about economic support programs such as SNAP, Energy Assistance and other community resources that can assist with maintenance of community residence increased by 20% over 2016 baseline by 2019
	75% of senior centers will achieve their wellness goals by 2019
Objective 4.4: Implement a person-centered approach to dining options	
Strategies:	Evaluate the extent of choice of dining options
	Conduct training with all AAAs about menu options, vouchers, etc.
	Expand the role of site councils to improve dining choices
	Work with center management/wellness coordinators/RDs to work on a biannual plate-waste study
	Develop and implement outreach and culturally appropriate meal options for underserved populations
Performance Metrics:	100% of menus will provide meal options by 2019
	Increase number of community partners by 20% over 2016 baseline by 2019 (for centers using vouchers)
	Increase number of dining options (culturally competent meals, vegan and vegetarian options, etc.) by 25% over 2016 baseline by 2019
	Increase number of underserved individuals who have received outreach and or economic support education through the senior centers by 10% over 2016 baseline by 2019

Goal 5: Increase veteran enrollment and successful completion of SCSEP program (leading to unsubsidized employment)

Objective 5: Develop collaborative relationship with public and private agencies serving veterans' employment needs	
Strategies:	Engage veteran centers and develop collaborative relationships for SCSEP service
	Develop relationship with GA Department of Labor, office of veterans employment
Performance Metrics:	SFY 16 – Conduct training for all sub-grantees to raise awareness about veterans' employment barriers
	SFY 17 – SFY 18 - Ensure that no less than 20% of statewide SCSEP enrollees are veterans
	SFY 18 – SFY 19 – Maintain at least 85% of veterans enrolled in SCSEP training

Goal 6: Increase enrollment of older adults with minimum English language proficiency (i.e., refugees, recent immigrants, etc.)

Objective 6: Intentionally focus on minorities by establishing collaborative relationships with agencies serving minority communities in Georgia	
Strategies:	Reprint SCSEP information literature in multiple languages
	Employ local media to reach to hard-to-reach communities
	Establish relationships with civic organizations serving minorities statewide
	Develop training curriculum for SCSEP Coordinators about recruiting host agencies and potential employers that support this population

Performance Metrics:	SFY '16 - Ensure that no less than 2% of statewide SCSEP enrollees are from hard-to-reach communities
	SFY 17 – 18 – Ensure that no less than 4% of statewide SCSEP enrollees are from hard-to-reach communities
	SFY 18 – 19 – Ensure that no less than 6% of statewide SCSEP enrollees are from hard-to-reach communities

Goal 7: Increase participants' placement in entrepreneurial ventures in order to enhance participants' opportunities for entrepreneurship

Objectives 7: Enhance participants' knowledge of opportunities for self-employment and foster opportunities for participants to engage in startup businesses	
Strategies:	Target and recruit more host agencies that offer entrepreneurial opportunities to participants
	Engage state agencies that promote entrepreneurship in Georgia
	Solicit startup funding for participants
Performance Metrics:	SFY 16 - Conduct at least one workshop for all enrollees in each sub-grantee program
	SFY 17 – SFY 18 – Develop 3 new partnerships with potential funders for startup opportunities by 2019
	SFY 18 – SFY 19 – Provide opportunities for at least 5 participants to launch a business

Goal 8: Expand efforts to support individuals to remain in their desired residence as long as possible

Objectives 8: Expand and increase statewide access to home modification/home repair services	
Strategies:	Develop co-op with local organizations (Boy Scouts; home improvement stores; high schools; tech programs; and faith-based communities)
	Increase home modification/home repair services access statewide
Performance Metrics:	Home modification/home repair services are available in all 12 AAAs by 2019
	Increase number of consumers receiving home modification/home repair services by 40% by 2019 (Note: for SFY 2014, 2 AAAs provided this service to 143 people; this would take it to 200 statewide)
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 2: "In general, do you like where you are living right now?"

Goal 9: Advocate for person-centered long-term care facility resident access to less restrictive housing options

Objectives 9: Provide advocacy for residents of long-term care facilities, particularly nursing home residents, to access less restrictive housing options	
Strategies:	MDS-Q information received monthly from Options Counselors will be distributed to local representatives of the SLTCO to follow up and assist nursing home residents who have expressed interest in learning more about less restrictive housing options

	When representatives of the SLTCO make presentations to resident councils at nursing homes, assisted living communities and personal care homes, the representative will include information about how to access less restrictive housing options through referral to facility Social Worker, or referral directly to Aging and Disability Resource Connection
	Representatives of the SLTCO will include information about how to access less restrictive housing options when providing consultations to facility staff, community education outreach activities and at other trainings
Performance Metrics:	SFY 16: Determine a baseline of information and assistance to residents and families, facility consultations, community education outreach events and training events for representatives of SLTCO related to how to access information about less restrictive housing options
	SFY 17 - 19: The Office of the SLTCO will increase by 5% per year the number of activities including information and assistance, consultations, community education outreach and training for representatives of the SLTCO, related to how to access less restrictive housing options

Goal 10: Increase the numbers of individuals served by GeorgiaCares from "targeted populations"

Objectives 10: Increase the number of client contacts	
Strategies:	Market the DAS toll-free number to increase calls routed to the local GeorgiaCares programs. Provide various methods of contact; one-on-one, mail, telephone, email, GeorgiaCares website (www.mygeorgiacares.org) for clients seeking Medicare assistance
	Expand reach to limited English proficient populations by recruiting bilingual volunteers and use the Language Line services to assist clients
	Maintain off-site counseling stations in every county to provide services locally to clients
Performance Metrics:	Increase the number of client contacts by 3% each year
	Maintain 2-day standard of promptness for returning client calls (GeorgiaCares Standards and Guidelines)

Goal 11: Increase the number of consumers reached that could benefit from assistance offered through the Medicare Improvements for Patients and Providers Act (MIPPA)

Objective 11: Extend outreach and assistance efforts for Medicare beneficiaries, including disease prevention and wellness promotion	
Strategies:	Develop collaboration between GeorgiaCares, ADRC and Health and Wellness staff to conduct outreach and educate Medicare beneficiaries
	Establish and foster community partnerships with organizations and agencies serving Medicare beneficiaries

	Increase marketing efforts for the GeorgiaCares program to improve brand awareness
	Continue partnership with Fort Valley State University mobile information technology center to reach individuals in rural counties
Performance Metrics:	Increase the number and percent increase of enrollments for MSP and LIS applications each year by 3% within the state during SFY 16-20
	Establish 1 offsite counseling station in each county within the state during SFY 16-20
	Establish one new partnership in each county within the state during SFY 16-20

Goal 12: Improve quality of services performed by CCSP providers

Objective 12: Increase the professional capacity of CCSP Providers and Care Coordination agencies	
Strategies:	Partner with AAAs and professional membership organizations to provide annual continuing education programs by service type for current providers
	Partner with DCH to ensure providers' compliance with the Centers for Medicare and Medicaid Services (CMS) Final Rule on Home and Community-Based Services (HCBS)
	Develop and implement a Mentoring Pilot Project for new providers
	Develop a Tool Kit of Best Practices and Resources to assist the AAA with quarterly network meetings. Provide training to Care Coordination agencies and CCSP Providers on best practices regarding adult learning, facilitation skills, etc. to enhance their training of direct service workers
Performance Metrics:	SFY 16: Launch 1 CCSP training for providers by service type (to be conducted on an annual basis)
	SFY 17: Launch the Mentoring Pilot Project to match 2 current providers with 2 new providers by service types
	SFY 17: Provide 2 additional trainings for providers by service type
	SFY 18: Provide 1 additional training for providers by service type
	SFY 18: Recruit and add 2 current and 2 new providers into the Mentoring Program
	SFY 19: Provide 1 additional training for providers by service type

Goal 13: Ensure consumers receive services in their own homes and communities

Objective 13: Increase greater access to 1915 (c) Medicaid waiver and non-Medicaid services across the state	
Strategies:	Expand service types and options to be available to consumers (i.e. assistive technology, home modifications, kinship care/paid family caregivers, consumer-directed option, fee-for-service care coordination)
	Incorporate person-centered planning and consumer choice into the delivery services

Performance Metrics:	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 10: "How did you first find out about the services available to you?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 12: "Do you have a case manager or care coordinator– someone whose job it is to help set up and coordinate services with you?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 16: "Can you choose or change what kind of services you get and determine how often and when you get them?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 17: "Can you choose or change who provides your services if you want to?"
	SFY 16-19: Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results question 21: "Do you always get enough assistance for self-care when you need it?"

Goal 14: Strengthen the Elderly Legal Assistance Program (ELAP)

Objective 14: Target the substantive core legal priority areas that Older Georgians will have access to, for an adequate supply of quality publicly funded legal services to address their eligibility for and receipt of benefits, housing, health insurance, health care, advance planning and protection from consumer fraud and abuse	
Strategies:	Develop a plan for outreach to potential clients
	Develop an educational/publicity plan or protocol to disseminate to targeted groups
	Host public forums or education sessions to provide group info
	Designate point person to receive calls or act as issue specialist
	Conduct targeted satisfaction survey on this issue to determine the impact on the lives of the clients served to determine if the performance measure set was achieved
Performance Metric:	The number of cases successfully handled as listed in the objective will increase by 3% over the 2015 baseline during the next fiscal year

Goal 15: Exceed the expectations of our clients

Objective 15: Strengthen continuous quality improvement system across programs and services	
Strategies:	Develop a dashboard system of transparent progress disclosure
	Develop online training modules for programs and processes
	Develop CQI training materials for community partners
	Enhance division process evaluation and improvement
	Evaluate and update quality measures (MAPS, Contract Management, Process Management, ODIS Updates, etc.)

Performance Metrics:	Implementation of dashboard system
	Number of online trainings developed and implemented
	Number of trainings viewed electronically

Goal 16: Improve the capacity of Georgia's aging and behavioral health networks to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness, and referrals

Objective 16.1: Increase demonstrated knowledge of aging and behavioral health issues to address the needs of older adults with behavioral health conditions by increasing knowledge, awareness and referrals.	
Strategies:	Develop annual assessment tool in collaboration with Coalition partners
	Develop training module/materials for appropriate staff (revise each year to align with identified issues)
	Administer required training with pre/post assessment to statewide audience annually via WebEx (live & recorded)
	Training will include data collection related to behavioral health calls and information provided.
	Analyze data in quarterly ADRC reports adjusting training/guidance as needed
	Utilize ADRC behavioral health assessment test-annual
Performance Metric:	Percent change in pre/post-assessment results
Objective 16.2: Increase referrals from ADRC to behavioral health providers by 5% per year, establishing baseline in year 1.	
Strategies:	Coalition will review ADRC database for behavioral resources resources annually for additions/deletions
	ADRC Resource Specialists will receive training on behavioral health resources, identification/vetting of local resources
	All ADRC staff will receive annual training on behavioral health needs/resources
	ADRC marketing materials will include provision of behavioral health information/resources
	ADRC outreach by local programs will include behavioral health information
Performance Metric:	Increase in numbers of behavioral health referrals with additional training provided as needed

Goals and Objectives (ACL Discretionary Grants)

Goal 1: Support older adults and people with disabilities to transition from an institutional setting to a setting of their choosing using a person centered approach through the Money Follows the Person grant and other means

Objective 1: Maintain Nursing Home Transitions over the Plan duration	
Strategies:	Enhance partnerships with Centers for Independent Living for cross support in transition activities
	Identify additional community resources (outside of MFP Grant & Medicaid waivers) to support transition activities
	Increase non-MDSQ referrals through integration of DAS programs & other referral sources

	Find programmatic efficiencies within DAS/AAA frameworks to reduce administrative cost per transition
	Increase the use of transition services
	Increase public awareness of nursing home transitions Ensure quality of data collection and entry
Performance Metrics:	Number of Transitions
	Number of MFP Completions

Goal 2: Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse

Objective 2: Increase the number of volunteers, beneficiaries educated, and media events statewide.	
Strategies:	Develop partnerships at the AAA level to advertise volunteer opportunities, host offsite counseling stations, and provide educational presentations.
	Provide SMP Foundations, Group Education, and Counselor training for volunteers at each AAA. The role of the volunteer will determine the type of training.
	Utilize various media outlets to expand the mission of the Senior Medicare Patrol statewide. Media outlets include billboards, newspapers, TV and radio PSAs, and social media.
	Provide targeted training and education to isolated and hard-to-reach populations.
	Partner with Forensic Science Investigative Unit for dissemination of SMP materials to Adult Crime Tactics Training participants as well as email subscribers and other conferences, trainings, etc.
	Partner with LTCO to train volunteers about Medicare fraud, waste, and abuse.
Performance Metrics:	Number of volunteers per AAA
	Number of group education events conducted each year
	Number of internal DAS partners
	Number of community partners

Goals and Objectives (Participant – Directed/Person Centered Planning)

Goal 1: Utilize a person-centered approach to service delivery designed to support older adults and individuals with disabilities living in the community

Objective 1: Develop and implement consumer driven mechanisms of support to support community based long term living	
Strategies:	Implement the community living program in all 12 AAAs
	Continue development of and technical support for Village Models
	Develop and implement Senior Center without Walls models in 4 AAAs
Performance Metrics:	Enroll 240 clients in CLP by 2019.

	Establish 5 villages that are capable of being self-sustaining by 2019.
	Establish 4 centers without walls by 2019
	Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 16: "Can you choose or change what kind of services you get and determine how often and when you get them?"
	Collect three years of baseline data for use in targeting improvement related to NCI –AD consumer survey results for question 17: "Can you choose or change who provides your services if you want to?"

Goal 2: Develop and Implement a person-centered approach to service mix

Objective 2: Develop and implement a new non-programmatic regional wait list for HCBS services based	
Strategies:	Analyze and assess current wait lists and how they are used
	Develop new method to merge specific service wait lists into one centralized needs-based wait list
	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for a CLP or support options model to meet the individual's needs
	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individuals greatest need
Performance Metrics:	SFY 16: Conduct analysis of all AAA wait lists
	SFY 17: Develop method to merge wait list
	SFY18-19: Merge and maintain wait lists

Goal 3: Maximize the variety of approaches to support consumer control and choice

Objective 3: Develop and implement the purchase and use of assistive technology as an option in place of service.	
Strategies:	Develop a tool to match individuals to assistive technology
	Implement an assistive technology program
	Establish a baseline of number of HCBS consumers referred for AT
	Establish a baseline of number of HCBS consumers currently using AT
Performance Metrics:	SFY 16: Develop assistive technology matching tool using assessments currently used (DON-R)
	All AAAs have AT program implemented and functioning by 2019
	Increase number of consumers referred for AT by 25% by 2019
	Increase number of consumers using AT by 25% by 2019

Goal 4: Increase professional capacity of Georgia's aging network to better meet the needs of family caregivers and at-risk adults

Objectives 4: Form collaborative teams and partnerships, conduct workshops, and utilize technology to increase professional capacity	
Strategies:	Establish a Work Team composed of DAS, Alzheimer's Association, and Georgia Alzheimer's and Related Dementias Advisory Council (GARD) Service Delivery members to develop a protocol for referral to a physician for probable dementia
	Conduct annual workshops to share best practices for recruiting, certifying, and retaining Powerful Tools for Caregivers class leaders and Master Trainers
	Facilitate conference calls and webinars between Health and Wellness coordinators and caregiver specialists to increase cross referrals between programs.
	Co-sponsor an annual financial exploitation summit with other organizations
	Participate in DAS-sponsored Financial Exploitation Work Team
	Incorporate Alzheimer's Association dementia capable training across the network
	Develop process for conducting ongoing cost-benefit analyses of caregiver services offered (cost-per-service vs. number of caregivers served vs. outcomes)
Performance Metrics:	**Protocol for Probable Dementia** SFY 16: Convene Work Team. Determine parameters of the protocol, including but not limited to self-referrals, confidentiality. Make recommendations to DAS
	SFY 17: DAS finalizes protocol, and modifies appropriate policies and standards; disseminates information to ADRC and case management staff
	Powerful Tools for Caregivers SFY 16: Identify baseline of class leaders and Master Trainers for each AAA
	SFY 17: Conduct workshops on best practices to AAA network
	SFY 18: Provide site visits and mentors to AAAs identified as needing technical assistance
	SFY 19: Compare baseline data to current numbers of class leaders and Master Trainers for each AAA to ensure goal of 20% more class leaders, and 24 more Master Trainers, is met
	Caregiver Programs Establish a baseline of caregiver intention to place during 2016. During FY17,18 and 19 decrease intention to place by 10%
	Statewide Referral Website SFY 16: Identify which AAAs are using the livewellagewell.info website. Contact those AAAs not using the website to provide technical assistance
	SFY 17: Monitor website quarterly to ensure that 100% of AAAs are adding classes for family caregivers and class leader trainings

Goal 5: Support Grandparents and other Relative Caregivers to maximize family independence

Objectives 5: I Increase access to and use of formal resources and prevention of disruption of family care systems	
Strategies:	Meet at least twice per year with state's Kinship Care Coordinators
	Meet at least twice per year with Grandparents Raising Grand Children Work Team
	Pursue designation of September as "Kinship Care Month" in Georgia
	Develop mechanism to document families providing kinship care vs. foster care system
Performance Metrics:	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019
	Increase number of caregivers and children served by Kinship Care services by 10% by 2019
	Increase number of referrals on behalf of kinship families by 10% by 2019

Goal 6: Ensure maximum access and efficient delivery of Home and Community Based Services to older adults, persons with disabilities, and caregivers

Objectives 6: Provide the right service(s) to the right person at the right time for the right duration	
Strategies:	Develop and approve Risk Assessment Tool
	Develop operational definitions for OAA target criteria
	Train all network staff involved in access to services on Risk Assessment Tool and operational definitions for OAA target criteria
	Enhance conflict-free assessment and utilization review process
	Determine baseline average per capita cost for HCBS services compared to monthly cost of nursing home
	Determine baseline of persons who have decline in Level of Risk or number of Risk domains based on Utilization Review
	Identify baseline % of current consumers receiving OAA services that meet target criteria
Performance Metrics:	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019
	Number of persons served who have decline in Level of Risk or Number of Risk domains based on UR will increase by 25% by 2019
	100% of persons referred for HCBS from wait list will meet target criteria by 2019
	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year
	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.

Goal 7: Increase participation in and the sustainability of evidence-based health and wellness programs offered across the state

Objectives 7: Increase participation in and the sustainability of evidence-based health and wellness programs offered across the state	
Strategies:	Communicate available evidence-based programs to ADRC staff on a regular basis
	Continue to maintain a statewide referral website to list all available evidence-based services (workshops, trainings, etc.)
	Present available evidence-based programs to health care professionals via association meetings, conference calls, conferences, etc.
	Incorporate evidence-based health and wellness programs in annual Healthy Communities Summit pre-intensive sessions
	Provide continuous technical assistance to AAAs engaged in evidence-based program implementation
	Develop and implement DAS-wide falls prevention protocols (assessments, referrals, etc.)
	Provide guidance for establishing fee-for-service mechanisms for organizations offering evidence-based programs
	Convene workgroup to develop/select appropriate falls assessment and develop statewide protocol for falls discovery, documentation and referral
	Partner with local, state and national organizations to increase referrals and promote continuous quality improvement for evidence-based programs in Georgia
	Maintain established health care professional partnerships and expand on them regionally; provide regular communication opportunities (teleconference and face-to-face – group and one-on-one) to provide assistance to AAAs
Performance Metrics:	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019
	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019
	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs
	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019
	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019
	Increase statewide marketing of evidence-based health and wellness programs

Goal8: Empower residents of facilities to fully participate in directing their care

Objectives 8.1: Develop and implement a plan to increase resident and family self-advocacy	
Strategies:	Determine what resources for self-advocacy are currently available
	Determine any gaps
	Develop resources to fill the gaps
	Analyze resident councils and family councils in each LTCO region
	Increase the number of resident councils and family councils
	Increase local LTCO representative participation in resident and family councils
Performance Metrics:	SFY 16:Convene workgroup to determine resources and gaps
	SFY 17:Create materials to be distributed and a plan for deployment
	SFY 18: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy
	SFY 19: Evaluate success of plan
Objectives 8.2: Increase awareness of community options including MFP	
Strategies:	Provide local LTCO representatives with materials to distribute to residents and families, including brochures and other materials about the ADRC, MFP and HCBS
	Provide regular outreach to nursing home staff about community options and MFP
	Include in local LTCO representatives' training conferences information about how to use the materials to provide information to residents about other options
Performance Metrics:	SFY 16,17, 18 and 19: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information

Goal 9: Goal: Empower older people and people with disabilities, along with their support systems to make informed decisions about community vs. institutional living based on their preferences, values, and strengths

Objectives 9.1: Expand awareness of and access to the ADRC - the No Wrong Door, Single Entry Point for all long-term supports and services	
Strategies:	Establish marketing strategies to serve individuals who pay privately
	Provide collaboration events for community partners (hospitals, home-health agencies, faith-based communities and institutions, and medical offices) to reach individuals who may be at medical or financial risk for institutional placement
	Market the ADRC toll-free number in Spanish
	Promote utilization of COMPASS system by ADRC staff to initiate Medicaid applications when necessary
	Expand strategies to build collaboration with aging and disability partners, including the Centers for Independent Living
Performance Metrics:	Number of incoming ADRC contacts, including increasing number of incoming ADRC contact for caregiver and kinship care

	Increase types of referral sources
	Number of individuals diverted from institutional placement
	Number of Medicaid applications generated by ADRC staff
	Number of private-pay individuals served
	Number of aging and disability cross-referrals
	Number of individuals with disabilities served
Objectives 9.2: Increase community options counseling to individuals who are most at risk for institutional placement	
Strategies:	Promote and provide options counseling certification to all AAAs for ADRC staff
	Expand Access Point staff that are certified in options counseling
	Provide training and quality assurance on correct documentation and data entry for options counseling. Train hospital and nursing home discharge planners on accessing community services
	Ensure that all ADRC staff are trained in using Risk Assessment to identify targeted group
Performance Metrics:	Number of individuals who receive community options counseling increases by 25% from 2016 baseline
	Each of the 12 AAAs have identified and have expanded Access Point staff and at least one is certified in Community Options Counseling
	Each of the 12 AAAs have at least three Community Options Counselors

Goals and Objectives (Elder Justice)

Goal 1: Empower persons under guardianship of the department through greater autonomy, independence, and self-determination

Objective 1.1: Promote increased autonomy and independence for persons under guardianship of the department	
Strategy:	Provide at least one training per year to Public Guardianship Office (PGO) staff on how to help a person under guardianship plan for termination of the guardianship and how to refer a case for restoration of rights or modification
Performance Metric:	Increased number of persons under guardianship to whom assistance with petitioning for restoration of rights or modification for a more limited guardianship is offered
Objective 1.2.: Boost self-determination in decisions made on behalf of persons under guardianship	
Strategy:	Enhance PGO staff's practice of determining the preference or wishes of a person under guardianship and incorporating that input into surrogate decision-making by providing PGO staff at least one training annually on surrogate decision-making, including the substituted judgment model, and strategies on seeking input from the person under guardianship

Performance Metrics:	An increase of at least 50% of staff trained in seeking, documenting, and using the input of the person under guardianship in surrogate decision-making
	More references in case management notes to the person under guardianship's preferences and wishes

Goal 2: Decrease unnecessary removal of rights

Objective 2: Promote the use of lesser restrictive alternatives to guardianship of the department	
Strategy:	Increase awareness in stakeholder community on alternatives to guardianship by partnering with allies in the court system, the medical community, and the mental health provider community to train stakeholders in each of the three larger communities about the use of less restrictive alternatives to guardianship
	Increase the number of multi-disciplinary/multi-agency groups in which PGO staff participates, to coach and advocate for avoiding guardianship through less restrictive alternatives
	Refer cases that are more appropriate for less restrictive alternatives back to court
Performance Metrics:	Established partnerships with ally-stakeholders
	Decreased number of appointments for persons under guardianship for whom no alternatives have been attempted
	Increased number of persons under guardianship whose cases are referred back to the court for restoration of rights or modification for a more limited guardianship

Goal 3: Provide persons under guardianship with strong guardian-advocates

Objective 3.1: Implement a program that develops the professional competencies of PGO staff	
Strategies:	Develop a monthly in-service training taught by professionals of disciplines relevant to guardianship case management so that PGO staff is educated in substantive issues
	Since staff are spread throughout the state, develop a virtual space for PGO staff to staff cases, discuss resources, and vet ideas or strategies
Performance Metrics:	Increased number of benefit appeals
	Increased attendance of and participation in care plan meetings
	Sharing of successful strategies in the staff's virtual meeting space
	Consistent participation in monthly in-service trainings

Goal 4: Protect residents of long-term care facilities from abuse, neglect and exploitation

Objectives 4: Local LTCO representatives will be active partners with Georgia Bureau of Investigation, Healthcare Facility Regulation (HFR), APS and other agencies in developing and implementing activities to address A/N/E for residents of facilities	
Strategies:	Develop materials for local LTCO representatives to share with resident and family councils and staff in-service specifically related to A/N/E
	Develop materials to use for community educations related to A/N/E
Performance Metrics:	SFY 16: Increase by 10% the participation of local LTCO representatives in relocations activated by HFR

	SFY 17: Increase by 10% the number of resident council and staff in-service presentations related to prevention and intervention in A/N/E
	SFY 18: Increase by 25% the number of local LTCO representatives who have completed ACT training
	SFY 19: Increase by 10% the number of local LTCO representative A/N/E presentations to the community

Goal 5: Increase professional capacity to address abuse, neglect and exploitation of older adults and adults with disabilities

Objective 5.1: Increase the number of At-Risk Adult Crime Tactics (ACT) Certified Specialists by 20% by 2019	
Strategies:	Conduct at least 10 ACT classes per year
	Develop a pilot train-the-trainer model to increase the number of ACT trainers without decreasing quality
	Pursue partnerships to market ACT training and provide larger training venues
	Train all APS staff within 1 year of their employment
Performance Metrics:	SFY 16: Identify partners to improve marketing of ACT and increase additional outreach opportunities. Develop train-the-trainer pilot
	SFY 17: Implement and evaluate the train-the-trainer ACT pilot. Develop and maintain partnerships
	SFY 18-19: Depending on pilot results, develop plan to roll out statewide train-the-trainer program. Continue activities from SFY 16. Develop and maintain partnerships
	SFY 16-19: Maintain at least a 90% positive response rate to 6-month survey of ACT specialists measuring application of knowledge. Maintain at least a 20% increase in knowledge of ACT Specialists through pre-test and post-test questions
Objective 5.2:Certify at least 1 law enforcement officer in every county in Georgia by 2019	
Strategies:	Conduct at least 10 ACT classes per year
	Develop a pilot train-the-trainer model to increase the number of ACT trainers without decreasing quality
	Schedule ACT classes in areas with a higher need for training
	Develop and deploy targeted training for prosecutors
Performance Metrics:	SFY 16: Determine the number of counties with no law enforcement officers trained. Develop outreach plan to schedule future ACT classes. Develop train-the-trainer pilot
	SFY 17: Implement and evaluate the train-the-trainer ACT pilot
	SFY 18-19: Depending on pilot results, develop plan to roll out statewide train-the-trainer program. Continue activities from SFY 16. Develop and maintain partnerships
	SFY 16-19: Maintain at least a 90% positive response rate to 6-month survey of ACT specialists measuring application of knowledge. Maintain at least a 20% increase in knowledge of ACT Specialists through pre-test and post-test questions

Objective 5.3: Increase the number of professionals trained through outreach events other than ACT by 20% by 2019	
Strategies:	Partner with all programs within DAS to provide training to program staff on recognizing and reporting abuse
	Provide technical assistance and templates for the AAA to provide training at the local level
	Provide a quarterly webinar on recognizing and reporting abuse available to all professionals
	Actively pursue training opportunities through statewide conferences reaching professionals
	Pursue partnerships with professional organizations to market and provide training opportunities for their members
Performance Metrics:	SFY 16: Develop schedule of webinar training and resources for AAAs. Develop outreach plan for training all program staff
	SFY 17: Deploy outreach plan developed on SFY 17. Develop partnerships with professional organizations
	SFY 18: Provide training resulting from SFY 17 partnership development
	SFY 19: Continue activities from SFY 16-18
	SFY 16-19: Actively pursue training opportunities through statewide conferences

Goal 6: Increase collaboration among stakeholders to address abuse of older adults and adults with disabilities

Objective 6.1: Participate in multi-disciplinary teams addressing abuse of older adults and adults with disabilities	
Strategies:	Continue involvement in the Georgia Bureau of Investigation's At-Risk Adult Working Group (local, state and federal partners) identifying gaps in response to at-risk adult abuse and developing strategies to fill gaps
	Continue involvement in the U.S. Attorney's Office Skilled Nursing Facility Task Force to develop strategies to address abuse in facilities
	Facilitate a Financial Exploitation Working Group to identify barriers to addressing financial exploitation and developing strategies to overcome barriers
	Provide technical assistance to other states through the National Adult Protective Services Association on partnership development
	Provide technical assistance to the Elder Rights Teams provided through the AAA to ensure coordinated efforts between local and state initiatives
	Provide technical assistance to local criminal justice agencies in developing local task forces
Performance Metric:	SFY 16-19: Continue involvement in multi-disciplinary groups and document activities and process changes
Objective 6.2: Develop a process for collecting data on law enforcement cases of abuse against older adults and adults with disabilities	
Strategies:	Engage law enforcement partners to determine most effective way of tracking data
	If a mandating is an option, identify steps needed to make change

	If a mandated option is not available, work with state law enforcement to develop a voluntary option
	Work with law enforcement partners to educate local law enforcement on using the option identified
Performance Metrics:	SFY 16: Meet with law enforcement partners to determine most effective way of tracking data. Provide recommendations for implementation
	SFY 17: Based on findings from SFY 16, implement recommendations
	SFY 18-19: Work with law enforcement partners to educate local law enforcement on the option provided

Goal 7: Ensure the protection and rights of older and disabled individuals who are victims of abuse, neglect and exploitation

Objective 7.1: Determine effectiveness of Georgia Abuse, Neglect and Exploitation (GANE) app in identifying at risk individuals and use of protective interventions	
Strategies:	Collect and analyze data on usage of Temporary Emergency Respite Funds (TERF); law enforcement interactions with APS Central Intake back door and referrals to Alzheimer's via GANE
	Identify and implement strategies to improve the effectiveness and efficiency of the app
	Make enhancements to the app and/or processes connecting users to the protective interventions
	Survey individuals to determine effectiveness of process to access TERF through app
	SFY 16: Analyze referral data resulting from access through GANE to the Alzheimer's Association
Performance Metrics:	Increase TERF interactions by 5% by 2019
	Increase ANE reporting by law enforcement by 5% by 2019
	Increase referrals to Alzheimer's Association by 5%
Objective 7.2: Increase number of APS clients moved to community based services by 5% by 2019	
Strategies:	Establish baseline number of APS clients who moved into HCBS, CCSP, Service Options Using Resources in a Community Environment (SOURCE), Independent Care Waiver Program (ICWP), and non-Medicaid services SFY13-15
	Identify services needed by APS clients (investigation/ongoing)
	Coordinate with ADRC to screen and identify options for APS clients in the aging network
	Track number of clients admitted to service and on the waitlist
	Monitor clients' status to determine if services are provided
	Report total clients referred by APS to HCBS and received services
	Continue process and evaluate at end of SFY19 to determine number increase (from baseline)
	Analyze and evaluate data to determine possible root causes for

	APS clients not moving to HCBS and convene workgroup to develop strategies to improve access to HCBS/CCSP for APS clients
	Deploy improvement strategies and monitor APS client statuses
	Review the performance of the provider awarded the contract for TERF on an annual basis
Performance Metrics:	Establish baseline number of APS clients who moved into HCBS or CCSP SFY13-15
	Determine % increase (from baseline) APS clients receiving and/or on waitlist for HCBS/CCSP services
Objective: 7.3 Reduce the incidence of elder abuse, neglect and exploitation across HCBS Programs	
Strategies:	Continue to educate providers about elder abuse, neglect and exploitation
	Develop a system to ensure adequate monitoring of all service types
	Provide information to all HCBS consumers on how to self-report ANE
	Utilize data obtained from critical incident reports and the complaint log to develop training to address these findings
	Continue to build partnerships within the Department of Community Health and other State agencies in order to increase provider compliance with policy and improve training
Performance Metrics:	SFY 16: Conduct on-site provider monitoring of Personal Support Services providers by visiting every 5th PSS service provider
	SFY 16: Partner with Forensic Unit to provide 2 trainings on abuse, neglect and exploitation
	SFY 17: Increase the % of on-site provider monitoring by 25% over SFY 15 % of on-site provider monitoring conducted in SFY 15
	SFY 17-19: Increase the % of Personal Support Services (PSS) providers who receive on-site monitoring by 25% over SFY 15 % of on-site provider monitoring conducted in SFY 15

Goal 8: Increase understanding of "suspicious deaths" in older adults amongst medical examiners, coroners, medicolegal death investigators, and criminal justice professionals

Objective 8: Develop a process for identifying "suspicious" deaths in adults 65 and older	
Strategies:	Facilitate a half-day summit with medical examiners and coroners to identify how they view deaths of adults 65 and older
	Develop checklist for death investigators to use on-scene
	Develop a basic ANE training course for Medical Examiners/Coroners/Medicolegal Death Investigators
	Develop checklist for death investigators to use on-scene

Performance Metrics:	SYF 16: Meet with MEs/Coroners/Medicolegal Death Investigators to identify how they view deaths of adults 65 and older and provide recommendations
	SYF 17: Based on findings from SY16, implement recommendations of meetings and provide initial results of FCMEO research project
	SYF 18-19: Work with forensic specialist and death investigator on Elder Death Investigation Text

Quality Management

DAS uses the Baldrige Criteria for Performance Excellence to systematically improve quality throughout the organization. An annual self-assessment and quarterly reviews of performance metrics allow DAS to ensure that key outcomes for both customers and the Aging Network are achieved and sustained. The Baldrige Criteria encompassan overview of the organization's leadership, strategy, customers, measurement analysis and knowledge management, workforce, operations, and results. In 2009 DAS was the recipient of the Georgia Oglethorpe Progress Award, which promotes improvement and performance optimization. The Georgia Oglethorpe Award is the state version of the Malcolm Baldrige Award for Performance Excellence.

The Division uses comparative data to examine organizational performance and improvement opportunities. DAS' quality assurance activities include quarterly review of performance measures of operational and service effectiveness and efficiency, quarterly and annual compliance reviews of contractors, annual customer, and workforce satisfaction surveys. DAS conducts quarterly customer satisfaction surveys. The Regional Coordinators at DAS complete these surveys to help to ensure the information in the surveys are appropriately separated from the agency providing the services. Each local program manager uses the survey results to improve customer service.

DAS has procured Harmony for Aging, the most widely used solution in the United States for home and community-based Medicaid Waiver management and federal NAPIS and National Ombudsman Reporting System compliance. Today more than 35 state-level agencies utilize Harmony. Harmony for Aging will help DAS automate processes so that it can provide the best service for consumers.

Attachments

Attachment A – State Plan Assurances and Required Activities

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES
Sec. 305(a) - (c),
ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.
States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall 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 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 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 who are victims of 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.

(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 subclause (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

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas 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 (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall 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--
(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; and

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

(9) Each area agency on aging shall provide assurances that 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 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall 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.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will 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.

(13)(C) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will 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 non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, 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) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out 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; and
(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.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the

entity best able to provide the particular services;

(11)(C) the State agency will provide for the coordination of the furnishing of legal services to older individuals within the State, and provide advice and technical assistance in the provision of legal services to older individuals within the State and support the furnishing of training and technical assistance for legal services for older individuals;

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of Low-Income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) 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 older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this

title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in childcare, youth daycare, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if

appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

REQUIRED ACTIVITIES
Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency-
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services

5/12/15
Date

Attachment B – Information Requirements

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Response: DAS utilizes its Intrastate Funding Formula (IFF) to ensure preference in providing services to older individuals with greatest economic need and older individuals with greatest social need. In the IFF, emphasis is placed on low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. See DAS' IFF in Attachment 'D.'

Section 306(a)(17)

Describe the mechanism for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Response: Within the Area Plan standard assurances, each AAA must state how it will coordinate its emergency preparedness activities. All AAAs have an individual assigned with primary responsibility for emergency management planning and require that person to develop a long-range emergency preparedness plan. They are also typically required to work with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery. See DAS' Emergency Planning and Management policy in Attachment "G."

Section 307(a)(2)

(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category or service.*

Response: Title III B includes Maintenance of Effort and/or Minimum Percentages for LTCO, Legal, In-Home and Access. DAS has allocated $6,412,852.00 in SFY 2016 (June 30, 2015 through July 1, 2016) to carry out Title III B. Eighty-five percent of which are federal funds, five percent are state funds and the remaining fifteen percent come through a minimum required match. The minimum proportion of the funds received by each area agency on aging carry out part B is 5%. There is no minimum percentage mandate to area agencies for individual services within Title III B.

Section (307(a)(3)

The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

Response: For each fiscal year of this State Plan, DAS will not expend less than the amount expended for services for older individuals residing in rural areas than expended in fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

Response: During the beginning of each state fiscal year, DAS issues a budget allocation. At this time, DAS does not project allocations. However, with each allocation, older individuals residing in rural parts of each service area receive funding. A key attribute of DAS' IFF is the allocation of funds for individuals 60 and older residing in rural areas. There is fifteen percent weighted variable for individuals who are 60 and older residing in rural areas.

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Response: DAS utilizes several tools to help determine the location of the older individuals residing in rural areas in Georgia. Some include mapping, census data and analysis through DAS' data management system. AAAs then target these individuals and utilize a person centered approach to service delivery designed to support older adults and individuals with disabilities to live longer, safely and well.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Response: DAS' IFF provides a greater weighted variable (15%) for individuals who are age 60 and older and reside in rural areas, in addition to a lesser 10% weighted variable for individuals who are 60 and older. Sixty and older rural for the previous fiscal year numbered 457,199, while population ages 60 and older (non-rural) was 1,528,041. Georgians ages 60 and older both in rural and non-rural areas are having their needs met by providing them access to community resources and/or assisting them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

Section 307(a)(14)
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency*; and
(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

Response: DAS' IFF breaks this into two separate variables, with differing weights. Total statewide 65+ low income minority population considered for the preceding fiscal year was 50,148, and the variable has the assigned weight of 10%. Older individuals with limited English proficiency numbered 34,079, and the variable has a weight of 4%. In an effort to meet the needs of low-income minority older individuals, and individuals with limited English proficiency, DAS and the Area Agencies shall provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

Section 307(a)(21)
The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Response: Two-tenths of one percent of Georgian's aging population are reported as American Indian or Alaska Native, numbering an estimated 2,093 individuals. DAS will purse numerous activities to assure older Georgians who are American Indian or Alaska Native will have access to Title III funded services. DAS will provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible. Additionally, they will also have the opportunity to review the DAS State Plan and other documents made available for public comment.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Response: See DAS' Emergency Planning and Management in Attachment "G."

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Response: DAS' Division Director is responsible for reviewing and approving all Emergency Preparedness policy and procedures. He or his designee are also responsible for implementing said policies and procedures.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note:*

Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

Response: DAS, in carrying out any chapter of this subtitle ((Section 705(a)(7)) for which it receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

Response: DAS will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle ((Section 705(a)(7));

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

Response: DAS, in consultation with AAA, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

Response: DAS will not supplant, any funds that are expended under any Federal or State law

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

Response: DAS will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

Response: With respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3, DAS will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

- public education to identify and prevent elder abuse;
- receipt of reports of elder abuse;
- active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
- referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

Response: DAS will not permit involuntary or coerced participation in adult protective services activities by alleged victims, abusers, or their households.

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

Response: All information gathered in the course of receiving reports of abuse, neglect and exploitation, and making referrals shall remain confidential except:

- if all parties to such complaint consent in writing to the release of such information;
- if the release of such information is to a law enforcement agency, public protective;
- service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
- upon court order.

Attachment C – Public Hearing Data

Public hearing participants identified services most needed to maximize consumers' independence. The top three services, ranked in order of importance statewide, are: (1) transportation, (2) health care, and (3) housing.

Services Most Needed By Consumers to Maximize Their Independence

537 Survey Respondents Maximize Independence	Respondents	% of responses	% of all respondents
Transportation	369	18.2%	68.7%
Health Care	314	15.5%	58.4%
Housing	270	13.3%	50.2%
Financial Assistance	222	11%	41.3%
Exercise/Nutrition	221	11%	41.1%
Support for Caregivers	202	9.9%	37.6%
Prescription Assistance	165	8.2%	30.7%
Legal	104	5.15%	19.4%
Abuse Prevention	66	3.2%	12.7%
Employment	55	2.7%	10.2%
Volunteer Opportunities	33	1.6%	6.1%
	2021		

Public hearing participants identified services most needed to stay healthy or improve their health. The top three services, ranked in order of importance statewide, are: (1) health care, (2) exercise nutrition, and (3) transportation.

Services Most Needed by Consumers to Stay Healthy or Improve Health

537 Survey Respondents			
Stay Healthy	**Respondents**	**% of Responses**	**% of all respondents**
Health Care	354	18.6%	66%
Exercise/Nutrition	319	16.7%	59.4%
Transportation	295	15.5%	54.9%
Prescription Assistance	219	11.5%	41%
Housing	181	9.5%	33.7%
Financial Assistance	160	8.4%	30%
Support for Caregivers	156	8.2%	29%
Abuse Prevention	75	3.9%	14%
Legal	62	3.3%	11.5%
Employment	42	2.2%	7.8%
Volunteer Opportunities	41	2.2%	7.6%
Total Respondents	1904		

Services Most Needed By Consumers to Maximize Their Independence by Age Group

Age Group (Years)	**Primary Need Identified**	**Percent by Age Group**	**Secondary Need Identified**	**Percent by Age Group**
18-59	Transportation	19.46%	Health Care	16.08%
60-64	Transportation	19.17%	Housing	15.81%
65-84	Transportation	17.76%	Health Care and Exercise/Nutrition	14.41%
85 and over	Transportation	17.04%	Health Care	14.28%
No Response	Support for Caregiver	15.31%	Exercise/Nutrition	13.48%

Services Most Needed by Consumers to Stay Healthy or Improve Health by Age Group

Age Group (Years)	Primary Need Identified	Percent by Age Group	Secondary Need Identified	Percent by Age Group
18-59	Health Care	21.98%	Exercise/Nutrition	19.87%
60-64	Health Care	20.49%	Exercise/Nutrition and Transportation	16.80%
65-84	Health Care	18.26%	Transportation	15.65%
85 and over	Exercise/Nutrition	20.05%	Health Care	18.91%
No Response	Exercise/Nutrition and Transportation	19.44	Health Care	17.59%

The survey question **What must we Start, Stop or Change** was presented as an open-ended query, where 333 respondents replied. Broadly categorized, the results are as follows:

Broad Category Response	Number of Responses	Representative Statement
Funding	61	To maximize independence, Ga needs to provide more funding for adult daycare and daycare for Alzheimer's and dementia
Maintain or Increase Services	60	Improving all services will help individuals remain independent. Stop screening by income alone. We all enjoy good programs and entertainment.
Transportation	50	We need to have a better transportation schedule for people going to the center and the doctor.
Affordable Health Care and Medicaid/Medicare needs	25	Older adults need more affordable health care, help with more prescriptions, and more affordable and dependable transportation for appointments. Persons with disabilities need affordable housing.
Caregiver Supports	9	Georgia must start offering more supportive services that help keep seniors at home.
Home and vehicle modifications	6	Georgia needs to help fix problems with seniors'

		homes, such as home repair and roofing. Seniors cannot physically repair their homes, let alone the financial aspect of it all. Provide more accessible vehicles for seniors.
Improve DFCS Systems	12	Georgia needs to improve its DFCS system so that elders can easily apply for and continue the public benefits to which they are entitled. Elders often need legal assistance to access their benefits.

Attachment D – Intrastate Funding Formula

The Older Americans Act requires the SUA, in consultation with AAA, to develop a formula for allocation of funds within the State that takes into account the geographic distribution of older individuals within the State and the distribution among PSAs of low-income minority older individuals with the greatest economic and social need.

The Intrastate Funding Formula (IFF) is used by State Units on Aging to distribute funds to AAA for Titles III and VII of the Older Americans Act. The Older Americans Act, as amended, requires in Title III Section 305(a)(2)(C), 42 U.S.C. that the SUA:

> "States shall,
> (C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account--
> (i) the geographical distribution of older individuals in the State; and
> (ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

DAS revises the Intrastate Funding Formula decennially (every ten years) based upon demographics and population changes from the most current Census data. The last revision to the DAS IFF was on 2014. Yearly, estimates released by the Census Bureau for factors in the DAS formula are applied to subsequent allocations to account for any funding impact to AAAs related to population changes.

DAS utilizes the following factors to distribute OAA funds by Planning and Service Area (PSA). The current formula provides a specific weight for each of the following populations: persons age 60 years of age and older, persons age 75 years of age or older, low-income minority population age 65 and older, low-income 65 and older population, estimated rural population 60 years of age and older, limited English speaking population 65 years of age and older, disabled adults 65 years of age and older, and living alone 65 years of age and older.

Definitions for each population are indicated below:

60+ population
The number of persons in the age group 60 and above.

75+ population
Number of persons in the age group 75 and above.

Low-income minority 65+ population
The numbers of persons in the age group 65 and above who are minorities (non-white) and are below the poverty level, as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents "special attention to low income minority older individuals" as required by the OAA.

Low-income 65+ population
Numbers of persons in the age group 65 and above who are at or below the poverty level as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents economic need as defined by the OAA.

Estimated rural 60+ population
An estimate of the numbers of persons in the age group 60 and above who reside in a rural area as defined by the Census Bureau. This factor represents the social need factor of "geographic isolation" as defined by the OAA.

Limited English speaking 65+ population
Numbers of persons in the age group 65 and above who speak a language other than English and speak English "not well" or "not at all." This factor represents the social-need factor of language barriers as defined by the OAA.

Disabled 65+ population
Numbers of persons in the age group 65 and above who have a "mobility or self-care limitation" as defined by the Census Bureau. This factor represents the social need-factor of "physical and mental disability" as defined by the OAA.

Living Alone 65+
Number of persons in the age group 65 and above who live alone

Factors and Weights:

Population 60+	**10%**
Population 75+	**30%**
Low Income Minority 65+	**10%**
Low Income 65+	**13%**
Rural 60+	**15%**
Disabled 65+	**10%**
Limited English Speaking 65+	**4%**
Living Alone 65+	**8%**

The above factors have been incorporated into a mathematical formula for administration as reflected below. In addition to these factors and weights, the Division of Aging Services incorporates a 6 percent funding base for parts B, C1, C2, and E of Title III of the OAA, not to exceed $200,000 annually.

Intrastate Funding Formula

Y=((.10(X)(%60))+((.30(X)(%75))+((.10(X)(%LIM))+((.13(X)(%LI))+
((.15(X)(%RUR))+((.10(X)(%DIS))+((.04(X)(%LES))+((.08(X)(%LA))

Factors:

Y	The service allocation for a Planning and Service Area (PSA)
(X)	The total services allocation amount for the state.
%60	The PSA percentage of the State total population ages 60 and above.

%75	The PSA percentage of the State total population ages 75 and above
%LIM	The PSA percentage of the State total population ages 65 and above who are low income and are minorities
% LI	The PSA percentage of the State total population age 65 and above who are low income
% RUR	The PSA percentage of the State total population age 60 and above who live in rural areas
%DIS	The PSA percentage of the State total population who are age 65 and above and are disabled
%LES	The PSA percentage of the State total population age 65 and above and have limited English speaking ability
%LA	The PSA percentage of the State total population who are 65 and above and living alone

Attachment E – Demographic Data

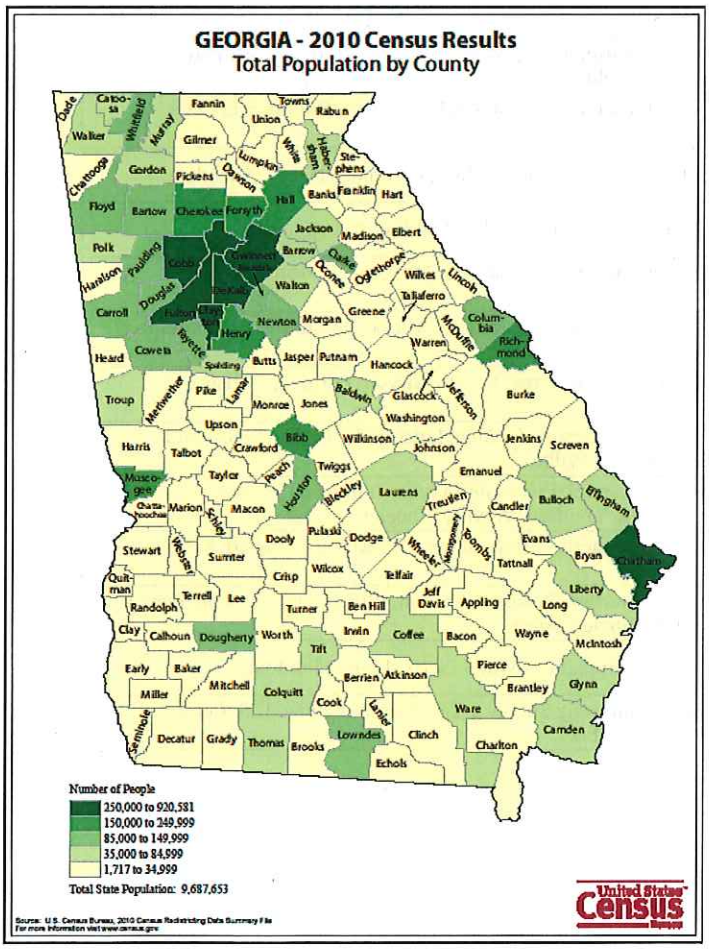
Aging Trends in Georgia

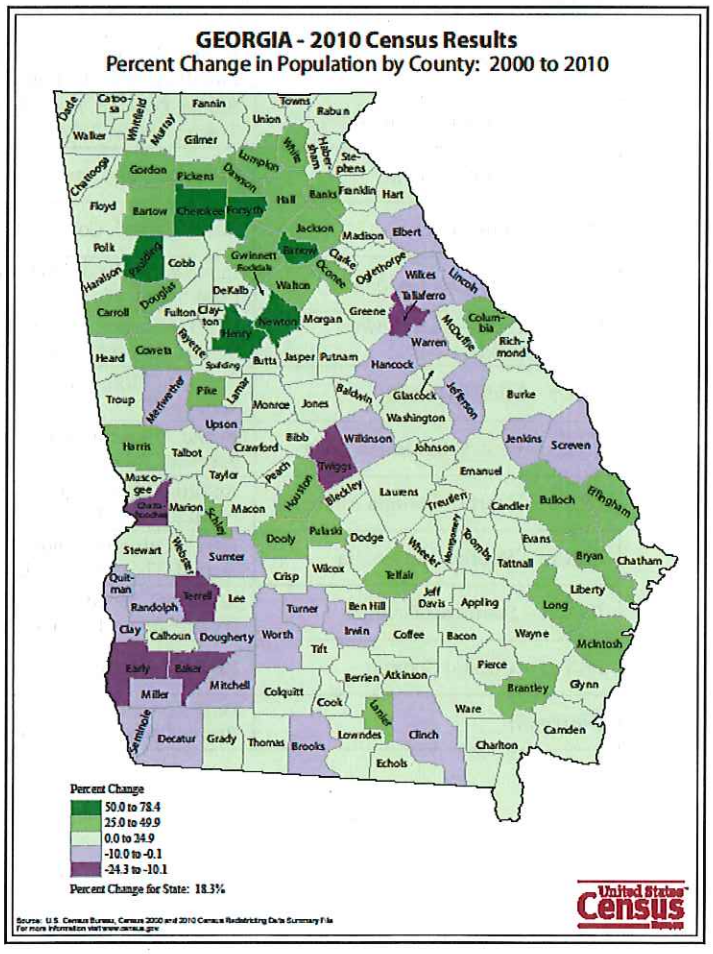
- Georgia's population ages 60 and above increased from a reported 1,071,080 in the 2000 Census to an estimated 1,599,098 per the 2009-2013 American Community Survey, a 49.3 percent increase.

- Georgia's population, ages 65 and above, is expected to increase 142.95% and 65.5% as a percent of the total population, between 2000 and 2030.

- During the 20th century, the number of Georgians age 60 and above increased ten-fold, compared to a four-fold growth in the population overall.

- Georgia continues to be a young state compared to the nation. Although the median age continues to rise, was lower than all but five states in 2010. This is due to several factors. Georgia has a higher minority population than the national average. These groups have higher birth rates and lower median age than the non-Hispanic white population. In addition, Georgia's high level of migration from other states is concentrated in younger population age cohorts. This is demonstrated by the fact that Georgia has a higher percentage of its population in the 25 to 44 age group than the national average (32.4 percent versus 30.2 percent). Only two states, Alaska and Colorado, have a higher percentage of their population in this group.





Georgia Population Data Summary
2009 - 2013 Estimates

PSA	60+ Population	60+ as % of Total Population	65+ Living Alone	65+ Living Alone as % of 65+ Population	65+ In Poverty	65+ In Poverty as % of 65+ Population	65+ Limited English	65+ Lim Eng as % of 65+ Population
1-Northwest Georgia	158,883	20%	27,284	25%	12,173	11%	1,176	1.1%
2-Georgia Mountains	123,045	25%	19,439	22%	7,889	9%	2,670	3.1%
3-Atlanta Region	578,171	15%	94,555	25%	36,123	10%	25,305	6.7%
4-Three Rivers	88,945	19%	15,537	25%	6,116	10%	640	1.0%
5-Northeast Georgia	97,441	20%	15,772	23%	6,547	10%	1,337	2.0%
6-River Valley/Lower Chattahoochee	67,365	21%	15,049	32%	6,424	14%	826	1.7%
7-Middle Georgia	89,926	21%	15,587	25%	7,073	11%	724	1.2%
8-Central Savannah	86,010	22%	16,194	27%	7,375	12%	1,300	2.2%
9-Heart of GA Altamaha	60,311	20%	12.858	30%	6,765	16%	326	0.8%
10-Southwest Georgia	69,303	21%	13,006	27%	7,016	14%	439	0.9%
11-Southern Georgia	74,099	19%	14,460	28%	7,395	14%	488	0.9%
12-Coastal Georgia	108,937	16%	20,272	27%	7,553	10%	1,406	1.9%
State of Georgia Totals	1,602,434	20%	280,013	26%	118,449	11%	36,637	3.4%

PSA 1 – Northwest Georgia	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
PSA 2 – Georgia Mountains	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
PSA 3 – Atlanta Region	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
PSA 4 – Three Rivers	Butts, Carroll, Coweta, Heart, Lamar, Meriwether, Pike, Spalding, Troup, Upson
PSA 5 – Northeast Georgia	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
PSA 6 – River Valley/Lower Chattahoochee	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
PSA 7 – Middle Georgia	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
PSA 8 – Central Savannah River	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
PSA 9 – Heart of Georgia Altamaha	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
PSA 10 – Southwest Georgia	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
PSA 11 – Southeast Georgia	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
PSA 12 – Coastal Georgia	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Sources:	Data from 2009 - 2013 American Community Survey 5-Year Summary File, U.S. Census Bureau, American Community Survey Office

Georgia Population Data Summary Continued
2009 - 2013 Estimates

PSA	75+ Population	75+ as % of Total Population	65+ Disabled	65+ Disabled as % of 65+ Population	65+ Minority In Poverty	65+ Minority In Poverty as % of 65+ Population	60+ Rural	60+ Rural as % of 65+ Population
1-Northwest Georgia	44,933	5.8%	45,558	41%	1,295	1.2%	74,935	47%
2-Georgia Mountains	34,524	7.1%	31,123	36%	792	0.9%	61,909	50%
3-Atlanta Region	147,913	3.6%	127,149	34%	20,495	5.5%	21,219	4%
4-Three Rivers	24,594	5.4%	24,547	40%	2,578	4.2%	43,415	49%
5-Northeast Georgia	26,568	5.3%	25,230	37%	2,163	3.2%	46,040	47%
6-River Valley/Lower Chattahoochee	20,471	5.8%	20,396	43%	3,824	8.1%	25,634	38%
7-Middle Georgia	26,009	5.5%	23,763	38%	4,118	6.6%	32,629	36%
8-Central Savannah	24,680	6.8%	24,266	41%	4,360	7.3%	30,164	35%
9-Heart of GA Altamaha	17,976	5.9%	17,914	42%	2,523	5.9%	38,773	64%
10-Southwest Georgia	20,913	6.3%	20,109	41%	4,144	8.5%	32,973	48%
11-Southern Georgia	21,136	5.5%	23,255	45%	2,863	5.5%	38,807	52%
12-Coastal Georgia	30,200	4.1%	27,143	36%	3,678	4.9%	26,219	24%
State of Georgia Totals	439,918	5.6%	410,453	38%	52,833	4.8%	472,718	30%

PSA 1 – Northwest Georgia	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
PSA 2 – Georgia Mountains	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
PSA 3 – Atlanta Region	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
PSA 4 – Three Rivers	Butts, Carroll, Coweta, Heart, Lamar, Meriwether, Pike, Spalding, Troup, Upson
PSA 5 – Northeast Georgia	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
PSA 6 – River Valley/Lower Chattahoochee	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
PSA 7 – Middle Georgia	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
PSA 8 – Central Savannah River	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
PSA 9 – Heart of Georgia Altamaha	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
PSA 10 – Southwest Georgia	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
PSA 11 – Southeast Georgia	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
PSA 12 – Coastal Georgia	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh

Sources:	60+ Rural based upon 2010 Census, Summary File 1, U.S. Census Bureau All remaining data from 2009 - 2013 American Community Survey 5-Year Summary File, U.S. Census Bureau, American Community Survey Office

Population by Age Group: February 2013, Population Estimates

Geography	All Ages	50+	55+	60+	65+	70+	75+	80+	85+
United States	100.0%	33.7%	26.6%	19.9%	14.1%	9.5%	6.2%	3.7%	1.9%
Georgia	100.0%	30.5%	23.6%	17.2%	11.9%	7.7%	4.6%	2.6%	1.2%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0101: Age and Sex; 2013 American Community Survey 1-Year Estimates

Population by Age Group: February 2013, Population Estimates

Geography	Total Population	60 to 64 years	65 to 74 years	75 to 84 years	85 years and over	60 years and over	65 years and over	Percent 60+	Percent 65+
United States	316,128,839	18,335,473	25,290,307	13,277,411	6,006,448	62,909,639	44,574,166	19.9%	14.1%
Georgia	9,992,167	529,585	729,428	349,726	119,906	1,718,653	1,189,068	17.2%	11.9%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0101: Age and Sex; 2013 American Community Survey 1-Year Estimates

Percent of Persons 60+ By Race and Hispanic Origin – 2013 Estimates

Geography	Total 60+	Persons Not Hispanic or Latino						Hispanic/Latino (may be of any race)
		Black/African American	American Indian/Alaskan Native (Alone)	Native Hawaiian/Pacific Islander (Alone)	Asian (Alone)	Two or more Races	White (Alone – Non-Hispanic)	
United States	100.0%	12.6%	0.8%	0.2%	5.1%	3.0%	62.4%	17.1%
Georgia	100.0%	31.0%	0.2%	0.0%	3.6%	2.1%	54.6%	9.1%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0102: Population 60 Years and Over in the Unites States; 2013 American Community Survey 1-Year Estimates

Types of Disability for the Population 65 Years and Over with Disabilities – 2013 Estimates

Note: A person may have more than one disability

Geography	Population 65 years and over	Persons with any difficulty	Persons with Hearing difficulty	Persons with Vision difficulty	Persons with Cognitive difficulty	Persons with Ambulatory difficulty	Persons with Self-Care difficulty	Persons with Independent Living difficulty
		Number	Number	Number	Number	Number	Number	Number
United States	43,353,631	15,775,788	6,572,050	2,966,615	3,993,337	10,090,255	3,688,100	6,692,064

Georgia	1,161,918	441,225	171,891	91,887	121,099	294,390	106,881	190,157

Source: U.S. Census Bureau, 2013 American Community Survey
Table S1810: Disability Characteristics; 2013 American Community Survey 1-Year Estimates

Types of Disability for the Population 65 Years and Over with Disabilities – 2013 Estimates

Note: A person may have more than one disability

Geography	Population 65 years and over	Persons with any difficulty	Persons with Hearing difficulty	Persons with Vision difficulty	Persons with Cognitive difficulty	Persons with Ambulatory difficulty	Persons with Self-Care difficulty	Persons with Independent Living difficulty
		Percent	Percent	Percent	Percent	Percent	Percent	Percent
United States	100.0%	36.4%	15.2%	6.8%	9.2%	23.3%	8.5%	15.4%
Georgia	100.0%	38.0%	14.8%	7.9%	10.4%	25.3%	9.2%	16.4%

Source: U.S. Census Bureau, 2013 American Community Survey
Table S0102: Population 60 Years and Over in the Unites States; 2013 American Community Survey 1-Year Estimates

Projections of the Population by Age 1990 to 2030

Ages 65 and Up	1990	2000	2010	2020	2030
Georgia	654,270	785,275	980,824	1,409,923	1,907,837
Increase by each 10 year period		131,005	195,549	429,099	463,506
Percent increase by each 10 year period		20.02%	24.90%	43.75%	32.09%
Increase with 2000 as base			195,549	624,648	1,122,562
Percent increase 2000 to 2030					142.95%

Source: U.S. Census Bureau, 2005 Interim State Population Projections
Table 5: Population under 18 and ages 65 and older, 2000, 2010 and 2030; and Table B1: Summary Tables of Projections - The total population by selected age groups.
https://www.census.gov/population/projections/data/state/projectionsagesex.html

Projections of the Population, by Age, 1990 to 2030 (in thousands)

Georgia	1990	2000	2010	2020	2030
ages 0 – 4		595,150	730,521	816,822	922,860
ages 5 – 17		1,574,084	1,771,865	2,020,441	2,223,764
ages 18 – 24		837,732	975,875	1,050,505	1,171,301
ages 25 – 64		4,394,212	5,129,995	5,546,062	5,792,076
ages 65 and up		785,275	980,824	1,409,923	1,907,837
Total population		8,186,453	9,589,080	10,843,753	12,017,838
65+ as a percent of total		9.59%	10.23%	13.00%	15.88%
Percent increase of %65+ 2000 to 2030					65.50%

Source: U.S. Census Bureau, 2005 Interim State Population Projections
Table B1: Summary Tables of Projections – The total population by selected age groups.
https://www.census.gov/population/projections/data/state/projectionsagesex.htmltes

Attachment F – Special Initiatives

Georgia Alzheimer's Disease and Related Dementias State Plan

Almost 30 years ago, at the request of the then-Atlanta Chapter of the of Alzheimer's Disease and Related Disorders Association, the Governor's Office and the Department of Human Resources delegated responsibility to the Office of Aging to conduct an Alzheimer's Disease Study Committee. Little was known about Alzheimer's at this time and much of the effort was devoted to understanding the nature of Alzheimer's. Early strides were made in identifying funding for respite services and expanding the Community Care Services Program, and the Office on Aging was directed to take an active role in educating the public.

In many ways, the initial study document was ahead of its time, and many of the recommendations floundered due to a lack of data (and the ability to collect and analyze data). Additionally, the public lacked a clear understanding of the extent to which Alzheimer's disease and related dementias would impact the state and nation.

The Alzheimer's Disease and Related Dementias State Plan builds upon previous work done by DAS in developing dementia-capable systems, coupled with knowledge gleaned through the Georgia Chapter of the Alzheimer's Association, the National Alzheimer's Plan and The Healthy Brain Initiative as well as professional expertise, personal experience, and public input from across the state.
This plan provides:

1. Numerous recommendations to State Agencies, Offices and Departments as a starting point for transitioning Georgia into becoming a dementia-capable state. Some recommendations will be acted upon immediately and others will take time, legislation or commitments from State leadership to ensure resources are available. These should be revisited regularly to ensure that we are meeting expected outcomes.

2. A guide for Public Health to begin to develop capacity to address Alzheimer's disease and related dementias as a public health crisis. It also provides recommendations for engaging public and private sector stakeholders to improve the State's response to community needs associated with Alzheimer's disease and related dementias.

This plan was developed to ensure that people with dementia, their families, and caregivers have ready access to reliable information, support and services and that they are delivered as effectively and efficiently as possible. Dementia is a devastating disease that causes changes in one's memory, behavior, and ability to think clearly. Statistically, dementia will eventually impact every region, every county and family in the state of Georgia. Alzheimer's is the sixth-leading cause of death in America. In Georgia in 1985, there were an estimated 40,000 people living with dementia. In the past six years alone, the number of Georgians reporting symptoms of dementia increased by 22 percent to 130,000 – this is a 427% increase from the 1985 estimates. The Georgia Alzheimer's and Related Dementias State Plan, signed by Governor Deal in 2014, puts forth a series of recommendations, which, if implemented, moves Georgia toward becoming a much more dementia-capable state.

The full document is posted at this link: **http://aging.dhs.georgia.gov/dementia-resources**.

Attachment G – Emergency Planning and Management Policy

CHAPTER 3000 AAA ADMINISTRATION

SECTION 3017 – Emergency Planning and Management

POLICY STATEMENT:

Area Agencies on Aging (AAA) are responsible for identifying themselves to and consulting with local (county and regional) emergency management agencies; public utilities; law enforcement authorities; other community service providers; state, county and municipal governments; and any other entities or organizations which have an interest or role in meeting the needs of the elderly in planning for, during and after natural, civil defense or other man-made disasters.

REQUIREMENTS:

AAAs are expected to:

- Designate a staff person to have primary responsibility for emergency management planning and coordination;
- Participate in state, regional, county and/or municipal planning activities with other human service agencies and entities and organizations charged with the responsibility of meeting the needs of disaster victims;
- Assist in identifying "at risk" elderly in the planning and service area, including but not limited to current consumers of contracted services;
- Require by contract provision that service providers develop plans for emergency management that fit the scope of their individual operations;
- Assure by annual review that service providers' policies, procedures and capabilities are adequate to meet the needs of the elderly in their areas prior to, during and after emergencies;
- Provide periodic training to providers regarding emergency management resources and activities;
- Upon request, provide information to the Division of Aging Services (DAS) regarding the impact of emergencies on the elderly population in the planning and service area;
- Provide authorized services to the elderly victims of disasters;
- Collect data necessary to submit reimbursement requests for services provided during the emergencies, which may be covered by other sources of funding available outside the aging program contract for disaster assistance;
- Participate in initial meetings of FEMA and GEMA on-site teams to assist in establishing recovery operations when appropriate.

SCOPE OF EMERGENCY PLANS and ACTIVITIES:

AAA plans will address four categories of activity: preparation, immediate response and stabilization, recovery and evaluation.

Preparation:

AAA emergency plans will address at a minimum:

- the types of natural disasters prevalent in the planning and service area (those that reasonably can be anticipated);
- the AAA's capabilities and limitations in addressing such incidents;
- ongoing maintenance and updating of resource databases;
- AAA emergency policies and procedures, including:
    - staff duties and responsibilities, including specific chain of command and alternates, if agency leadership is unavailable;
    - alert procedures for working and non-working hours;
    - procedures for providing for alternate communications channels and equipment;
    - locations of operations centers and alternates when primary offices are affected;
    - assuring availability of office supplies for alternate locations, staff identification badges, and the like.
    - roles of various relief organizations operating in and primarily responsible for relief authority in the area;
    - strategies for maintaining contact with staff, local organizations, and the Division if essential public services, such as communications and transportation, are limited or unavailable;
    - current disaster response systems and the Area Agency's linkages to, for example, county law enforcement and public safety agencies, emergency management agencies;
    - community education to alert first responders/other entities to special needs of the elderly and the Area Agency resources;
    - identification and mapping, if feasible, of heavy concentrations of elderly, including those residing in institutions, and households in which seniors reside alone, including apartments, and mobile homes;
    - demographic profiles of elderly in the area for targeting of specialized recovery assistance.

Response:

The initial reaction to ensure safety, hygiene/sanitation, and security, either in advance of an impending emergency or immediately following, will include:

- initiation of planned communications strategies and determination of impact of disaster on staff;
- assignment of duties;
- contact with key providers;
- initiation of disaster-specific record-keeping, including but not limited to records of :
    - staff time, including overtime;
    - supplies used;
    - documentation of contacts with seniors;
    - type and amount of services provided;

- personal expenses;
- specific telephone logs.

- preliminary assessment of scope of impact, including, but not limited to:
  - geographic scope and numbers of affected elderly/other target populations and their short and long term needs;
  - kinds of services needed, including impact on transportation resources;
  - identification of service gaps
  - provision of information to DAS.

- employment, training and deployment of field and outreach workers.

- follow-up contacts with all seniors/others initially assisted to determine additional needs which have developed, appropriateness of additional available resources, and need to advocate for additional resources.

Recovery:

Recovery involves sustained care over a longer period of time, for the purpose of assisting people in re-establishing as normal a life as possible. Recovery includes:

- shifting from emergency response to providing answers to more complex, long-range and long term problems, including arranging for psychological/mental health services for disaster victims;
- providing access to increased resources that have become available;
- participation in long range planning and coordination with other agencies;
- maintaining contact and providing services, including meeting non-immediate needs identified during the response phase.

Evaluation:

Evaluation involves analysis of the effectiveness of an emergency plan once deployed and provision of input and feedback to staff, volunteers and other community organization, following response and recovery phases. Evaluation results will drive improvements in emergency planning.

EMERGENCY MANAGEMENT SERVICES:

AAAs and their subcontract service providers are authorized to provide the following services to manage the emergency needs of the elderly:

- expansion of information and assistance services on a 24-hour basis, including escort assistance;
- special outreach activities to encourage elderly disaster victims to apply for benefits at federal emergency disaster assistance centers (DACs) as soon as they are established;
- special transportation for elderly disaster victims to DACs, doctors, clinics, shopping and such essential travel in the event that vehicles are not readily available. Since FEMA funds may be available to fund this service, the Area Agency will consult with the on-site federal coordinating officer prior to expending Older Americans Act or state funds on this service;

- assistance by case managers acting as disaster assistance advocates to older persons in the DACs in the benefits application process, including follow up to assure older victims receive approved grants and services and are protected from unscrupulous contractors for housing and other repairs;
- handyman and chore services, including clean-up, in the event that FEMA cannot provide these services in sufficient volume through volunteer efforts;
- licensed appraiser services to assist elderly disaster victims in arriving at realistic estimates of losses incurred;
- legal services, only when scope of the primary elderly legal assistance program must be expanded to address insurance and disaster grant assistance settlements;
- assistance to move elderly disaster victims from temporary housing back to their own places of residence;
- other Older Americans Act services, including meals, when assessments indicate that disaster related needs are unresolved by federal, state, or voluntary disaster assistance programs.

REIMBURSEMENT PROCEDURES FOR EMERGENCY SERVICES:

Reimbursement for the services specified above are authorized by the Older Americans Act, §310, as amended. AAAs shall forward requests for reimbursement to DAS within 30 business days of the date that disaster recovery operations are completed.

AAAs will prepare the reimbursement requests as follows:

- Sort the expenses for which reimbursement is requested into categories by service, as listed in the preceding section.
- Provide a narrative for each category, which documents the number of units provided and the number of elderly served. This will be the cover page for each set of reimbursement documentation materials.
- Enclose the billing documentation, such as paid bills and invoices, with the narrative for each category of service provided.
- Attach a description of the cause and scope of the disaster.
- Attach the certificate of non-duplication of services provided by the FEMA office, if it is available.

DAS will review all reimbursement requests, seek any additional information or clarification needed, and forward to the Administration on Community Living for payment.

Attachment H – Acronyms/Abbreviations

AAA	Area Agencies on Aging
ACL	Administration for Community Living
ACT	Adult Crime Tactics
ADRC	Aging and Disability Resource Connection
AIMS	Aging Information Management System
ANE	Abuse/Neglect/Exploitation
APS	Adult Protective Services
CCSP	Community Care Services Program
CILS	Centers for Independent Living
CLP	Community Living Program
CMS	Centers for Medicare and Medicaid Services
CO-AGE	Coalition of Advocates for Georgia's Elderly
CQI	Continuous Quality Improvement
DAS	Georgia Division of Aging Services
DCH	Department of Community Health
DD	Developmental Disabilities
DFCS/DFACS	Georgia Department of Family and Children Services
DHS	Department of Human Services
DON-R	Determination of Need - Revised
DPH	Georgia Department of Public Health
ELAP	Elderly Legal Assistance Program
FSIU	Forensic Special Investigations Unit
G4A	Georgia Association of Area Agencies on Aging
GCOA	Georgia Council on Aging
HCBS	Home and Community Based Services
HDM	Home Delivered Meals
HFR	Georgia Healthcare Facility Regulation
IFF	Intra-State Funding Formula
LIS	Low-Income Subsidy
LTCO	Long Term Care Ombudsman
LTCOP	Long Term Care Ombudsman Program
MAPs	Measurement and Analysis Plan (performance indicators)
MDS	Minimum Data Set
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MSP	Medicare Savings Program
NAPIS	National Aging Program Information System
NCI –AD	National Core Indicators – Aging and Disabilities
NH	Nursing Home
NHT	Nursing Home Transitions
OAA	Older Americans Act

PGO	Public Guardianship Office
PSA	Planning and Service Area; Personal Support Aide
QOL	Quality of Life
RC	Regional Commission
RD	Regional Director
PSS	Personal Support Services
SCSEP	Senior Community Service Employment Program
SMP	Senior Medicare Patrol (See SHIP)
SNAP	Supplemental Nutrition Assistance Program
SFY	State Fiscal Year (July 1 through June 30)
SLTCO	State Long Term Care Ombudsman
SUA	State Unit on Aging