AREA PLAN ON AGING

EASTERN CONNECTICUT

AREA AGENCY ON AGING, INC

dba

SENIOR RESOURCES – AGENCY ON AGING

October 1, 2025 – September 30, 2028

Submitted July 1, 2025

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Verification of Intent

The proposed Area Plan is hereby submitted for the Eastern Connecticut Area Agency on Aging d/b/a Senior Resources Agency on Aging Planning and Service Area for the period of October 1, 2025, through September 30, 2028.

The Area Plan includes all assurances to be followed by the Eastern Connecticut Area Agency on Aging d/b/a Senior Resources Agency on Aging under the provision of Title III of the Older Americans Act of 1965, as amended. The Area Agency, as identified above, will assume full authority to develop and administer the Area Plan in accordance with the requirements of the Act and related Federal and State regulation and policies In accepting this authority, the Area Agency assumes responsibility to develop and administer the Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older adults in the planning and service area.

The proposed Area Plan has been developed in accordance with all rules and regulations specified under the Older Americans Act and is hereby submitted to the Bureau of Aging for approval.

6/30/2025 _____

Date Signature, Executive Director of Area Agency on Aging

The governing body of the Area Agency has reviewed and approved the proposed Area Plan.

6.5.25 _____

Date Chairperson, Board of Directors

6-4-2025 _____

Date Chairperson, Advisory Council

Acronyms

AAA – Area Agency on Aging

ACL – Administration for Community Living

ADL's – Activities of Daily Living

ADS – Aging and Disability Services

AIRS – Alliance of Information and Referral Systems

BOA – Bureau of Aging (formerly SUA – State Unit on Aging)

CDSMP – Chronic Disease Self-Management Program

CPSMP – Chronic Pain Self-Management Program

CEJC – Coalition for Elder Justice in Connecticut

CERT – Community Emergency Response Team

CHOICES – Connecticut Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening

CHSP – Congregate Housing Services Program

CSRCP – Connecticut Statewide Respite Care Program

DSMP – Diabetes Self-Management Program

ESF – Emergency Support Functions

FTE – Full-Time Equivalent

HUD – Housing and Urban Development

I & A – Information and Assistance

IADL's – Instrumental Activities of Daily Living

LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer

LTSS – Long-Term Supports and Services

MIPPA – Medicare Improvement for Patients and Providers Act

MIS – Management Information System

NFCSP – National Family Caregiver Support Program

NCOA – National Council on Aging

OAA – Older American Act

OEMS – Office of Emergency Management Services

QPR – Question, Persuade and Refer

RSC – Resident Services Coordinator

SHIP – State Health Insurance Assistance Program

SIRS – SMP (Senior Medicare Patrol) Information and Reporting System

SMP – Senior Medicare Patrol

Narrative

Executive Summary

Senior Resources, Eastern Connecticut's Area Agency on Aging, is pleased to share our latest Area Plan on Aging. This plan is developed in accordance with the requirements of the Older Americans Act and in concert with the State of Connecticut Bureau of Aging State Plan. While not inclusive of all the ways in which we work to provide our Aging Answers format of assistance to clients with a myriad of questions and concerns, our intention is to address the important concerns related to aging and older adults in our communities and to prepare for the future of aging in our area through both current and long-term supports, particularly as they relate to the Older American Act programs. The comprehensive and collaborative aging network has been a cornerstone of Area Agency on Aging work for over 50 years, including community-based providers, professionals and an array of agencies at the local, state and federal levels.

Older adults are not different from citizens of any other age in that they want to have choice and control over the decisions which impact their lives. To this, we work directly and extensively with older adults and their families regarding ways to maximize their independence, empower decision-making and foster quality and quantity of life. Through our programs, we seek to provide a range of long-term care services and supports and we advocate for and find solutions to gaps in services.

This Area plan encompasses many lessons learned through the Pandemic with incorporation of technology, prioritization of services, efficiency of funding and communication of individual preferences. The key areas of focus being Long Term Supports and Services, Healthy Aging and Elder Rights. These areas are an important concern to Connecticut residents' ability to live with dignity in the community setting of their choice or desire. Our work focuses on supporting individuals and caregivers with sustainable and adequate resources, thinking creatively to provide the most care with limited resources and to plan for future needs. We are excited to offer a wider array of outreach education in a variety of formats with the hope that we will no longer be a "best kept secret that shouldn't be a secret". We encourage clients to share their stories with

us and the greater community so that we continue to expand and enhance our connections throughout our towns, cities and collaborative networks.

Context

The Eastern Connecticut Area Agency on Aging was incorporated in 1976 to administer the Older Americans Act of 1965 and now operates with the business name Senior Resources. Senior Resources is a private non-profit organization with an Advisory Council and Board of Directors that bridges management of Federal, State and other funds with direct services and aging network collaborations in our communities. The Eastern region consists of 56 towns and 2 Tribal nations spanning 4 counties and bordering 2 states and the shoreline. Senior Resources works in close connection with the other 4 Area Agencies on Aging as AgingCT. Together, we strengthen our voice for legislative advocacy, thought leadership and professional enhancement of our network. Senior Resources participates in programs and services beyond the Older Americans Act including Veterans Directed Care with The Veterans Administration, Money Follow the Person with Department of Social Services, Benefits Enrollment Center with National Coalition on Aging, Senior Farmer Market Nutrition Program with Department of Agriculture and volunteer led fundraising activities. For the purposes of this report, we will focus on the Older Americans Act and other activities done in conjunction with the Department of Aging and Disability Services, Bureau of Aging.

Mission Statement: To provide access to information and services to empower adults to live with dignity.

Our Mission relates to the Area Plan goals in that we respect the individuality of each person to provide meaningful tools which support increased knowledge, awareness and informed decision making to promote living a full life of health and happiness.

Core Values

Senior Resources espouses person-centered support and services for all individuals. To accomplish this goal, we maintain five core values:
Listen to the needs of each individual as expressed by them,
Empower individuals to make informed choices,

Assist with access to affordable benefits and services,
Respect all individuals within the reach of the agency, and
Nurture to provide care, grow support, develop ideas, and succeed.
These core values are integral to each interaction with clients seeking assistance or information as well as all our aging network collaborations. A strong collaboration throughout our communities allows for more consistent, effective and efficient reach to many people both as individuals and as helpers.

Accomplishments and Challenges

While the accomplishments are expressed in greater detail in Attachment E, some areas of particular interest include:

Goal: Empower older individuals to reside in the community setting of their choice.

Through the addition of Service Navigation and a more cohesive Aging Answers concept which focuses on person centered planning, individuals are more engaged in the process of determining their community setting of choice and more aware of the ways to access supportive options to keep them there. We have worked to provide seamless referral and assistance to internal and external programs and assistance with applications to facilitate an efficient and effective process of connecting individuals to the “next step” or a broader array of supports that will help them.

Goal: Provide older adults with prevention and wellness opportunities.

Through our continued provision of high-quality professional involvement of a Registered Dietitian, expansion of this role to include Spanish and English languages and significant work to increase the participation in evidence based or other wellness programs, we have engaged a larger number of people in prevention and wellness opportunities throughout our region. We encourage prevention and wellness opportunities throughout the aging network and participate in collaborative networks throughout our region.

Goal: Protect elder rights and well-being and prevent elder abuse, fraud, neglect and exploitation.

Through expansion of the Senior Medicare Patrol program to further engage community members and Medicare beneficiaries in the prevention, identification and reporting of scams or abuse, further outreach to the community with and through our aging network connections and enhanced educational opportunities shared with the public, we continuously work to protect elder rights and seek ongoing needs as well as gaps in services through monthly focused discussion at Multi-disciplinary (M-Teams). We advocate for issues which impact older adults such as Medicaid asset limits and participate in many collaborative efforts to reduce the risk of abuse, fraud, neglect or exploitation at the local, state, regional and federal level.

Since October 1, 2021, we have faced challenges, opportunities and success to broaden, strengthen and deepen our work to support older adults and caregivers with an efficient, effective and professional aging network. This has included changes in leadership at the executive and financial levels due to retirement. We have achieved growth of the AgingCT network as a convener of thought leadership with annual AgingCT Summits and other Statewide educational offerings. AgingCT has impacted state legislation to successfully advocate for the funding of Service Navigators and expanded Nutrition funding as well as increased awareness about Medicaid asset limits, housing concerns and much more. Senior Resources has expanded our methods to reach people through social and traditional media methods including video, television and written formats. We encouraged creative ways to connect with the community through Farmer's Markets, YouTube, Webinars, Conference Call Office hours, Hybrid meetings, Grocery delivery, outdoor "tent" events, cooking programs, partner networks, professional affiliations, municipal connections, first responders and more. Senior Resources has had the opportunity to manage a region of Senior Nutrition Programming directly which has resulted in tremendous positive connectivity in the region with participants, caregivers, professionals, businesses and legislators.

Senior Resources has a strong, committed and talented staff that can find creative solutions, using technical and other efficiencies, when possible, to find a way to make a "win" for our clients and meeting or exceeding our contractual obligations.

As the largest Area Agency on Aging covering 56 towns, with many of them having limited resources available, a continuing challenge is to ensure that we are connected to all these areas. Through ongoing education and outreach, we have strengthened the connections with our aging network with in-person and hybrid meetings, client home visits, assisted meal delivery routes, chambers of commerce participation, health collaborative involvement, councils of government attendance, personal site visits and much more. We are increasing connections through our News You Can Use newsletters, Facebook postings and followers, Instagram, LinkedIn, You Tube and Constant Contact methods of sharing and learning information throughout our region. The News You Can Use newsletter allows network partners to share their information and events through our listserve connections.

Funding for needed services is frequently a challenge. Due to ARPA funding, we were able to conduct a special project related to transportation. Transportation, particularly in the Northeast region, has been a challenging conundrum as long as anyone can remember since there is little to no infrastructure, a long way to travel, and little to no funding to get there. Utilizing the ARPA funding, we sought to make an impact that had never been a previous option, funding vehicles that could be used for more door-to-door transportation, and programs which will support this in the future. We also are using the funding to support people maintaining their own transportation methods and innovative ways to connect to available resources through partner organizations.

Senior Resources has always been a welcome support in our communities. We have grown and continue to expand our role as a convener, educator and advocate for older adults and caregivers while we maintain a balance of our roles as direct providers, care managers, planners, networkers and thought leaders.

Needs and Targets

Senior Resources focuses on needs in an ongoing way through continuous review of types of service requests in all our areas, legislative listening sessions, goal development, multi-disciplinary team involvement, work team groups, and direct care roles with our program recipients including in-home visits throughout our region.

According to the United States Census Bureau, Eastern Connecticut is in significant need related to age and financial security. The Southeast Region data shows 20.2% of the population that is aged 65 or older, exceeding the Connecticut state average of 16.4%, and 12.4% live below the poverty line (compared to **10.3% statewide), with a median household income of $84,185, below the state's $91,665. The Northeast Region is also 20.2% of the population age 65 or older with 7.6% of people living below the poverty line. (data for the Middlesex County region is difficult to extrapolate from this source)

Adults aged 60 and older want to stay in their home and community. What they need is early intervention with unbiased accurate information, financial security and support, and/or increased knowledge of the support available in their community. This includes the Long-Term Supports and Services, Healthy Aging and Elder Rights goals outlined in this plan as all these support people to self-direct and achieve connection to the person-centered solutions necessary for their success. The ability to reach people where they are and in ways that they will comprehend is an ongoing need. The ability to fund services such as nutrition, transportation, benefits screening, application assistance, caregiver support, housing modification, wellness education, technology, heating assistance, Medicare & Medicaid counseling, etc. are all critical needs which cannot be answered in silos or only through online access points. Older adults need a personal connection to supportive services and the ability to trust the source of information or access to the (often) multiple services they need. Eastern Connecticut is more challenged than the rest of Connecticut in Greatest Social Needs with 37% of our population over the age of 60 residing in rural locations. Those living in rural communities may have trouble readily accessing services due to transportation, direct care workforce, distance to services, and higher costs of services due to geographic isolation.

According to the Healthy Aging Data Reports, many chronic conditions remain with the highest incidence category (over 32%) in Eastern Connecticut for Diabetes, Stroke, Chronic Obstructive Pulmonary Disease, Hypertension, Heart Attack, Ischemic heart disease, Congestive heart failure, Arthritis, Hip Fracture, Colon Cancer, Lung Cancer and all with significant clustering of multiple 4+ conditions. Older adults are becoming

more likely to seek information from a variety of sources; however, this increases the risk of falling victim to biased or invalid information. Our need to get in front of this risk to make a positive connection to good trustworthy information is more crucial than ever.

Providers for various services vary greatly throughout our region due to extreme variability in population size and services available. The Northeast region is the most difficult area to find providers with a small hospital system, low income and generally rural geography; however, there are hopeful improvements with Transportation initiatives supported by Senior Resources, health focused professional organizations that are growing, and expanding roles of a YMCA, Mental Health services and Community Health Centers in the region. The Southeast region typically has a wider range of service providers but the challenges they face (along with all regions) include staffing positions available and keeping up with the costs of employing personnel safely (background checks, insurance, liability, etc.). The Windham region has similar provider issues to the Northeast but has recently expanded access to many beneficial services through the Windham Senior Center, collocated with the Community center and health center. The Midstate Region providers for Nutrition have historically been a challenge but, due to a series of other events, have improved significantly with a local food provider for congregate meals that has increased participation and satisfaction tremendously. The ability to maintain flexibility in finding providers that can best meet the needs of a region has been shown as a crucial way to positively impact service and improve participant health in this region. The Estuary region has a mix of affluence and poverty, clustered access to services and remote locations. All these regions within our region require a variety of providers to best meet the needs of older adults and caregivers.

Senior Resources covers a large geographic area which encompasses fifty-six towns within Middlesex County, New London County, Windham County, and a small portion of Tolland County. The area also includes two Tribal Nations: the Mashantucket Pequot Tribal Nation and the Mohegan Tribal Nation. While Connecticut covers 5,543 square miles, Eastern Connecticut’s service area covers 1,778 square miles or one third of the

state's land mass. Target setting is somewhat based on experience of how many people we currently reach with programs and an ongoing strategy to reach new people, especially those in the greatest social need or greatest economic need categories. Data from the ACS 2014-2018 study indicates that eight towns within the Eastern region include the highest percentage (17-52%) of adults age 65+ with less than High School Education and an additional 8 towns with the next highest level (11-17%). Many areas overlap with the higher rates of income below the poverty level, especially with 10 towns indicating higher than the state average of individuals 65+ with an annual income less than $20,000. Additional information from CMS 2016-2017 indicates that of our 56 towns, 34 towns have Medicare beneficiaries that are clinically diagnosed with Obesity higher and significantly higher than the state average of 22.5% (17 towns at 26.5 to 31.7%).

The Area Agency on Aging releases a Request for Proposal out to community providers. These providers are knowledgeable of their community members and needs. They target the populations they think will be willing to come in for services. Of course, there are some population groups that do not ask for help, and it may be difficult to have them accept assistance. We encourage an open policy in that everyone that is eligible for the service, such as Older Americans Act guidelines, is welcome and can be assisted by these services. We offer many tenants of outreach and public education about programs and services available to reach the broadest array of people throughout our region. If there are not enough funds, prioritization is given to those in the greatest social or economic need.

Our ongoing work and outreach lead us to new connections at many different points in the area plan process. We recently hired a bilingual Spanish employee which has fostered deeper connection to some minority groups and those with limited English proficiency. We expand connections in collaborative work groups such as hospital community outreach and homelessness organizations. We utilize personal and professional connections to the community through civic and organizational connections such as Veterans, Emergency Medical Services, Commissions on Aging, Municipal government and more. All while continuing to serve and maintain connection with

existing clients and colleagues and the “word of mouth” that comes through expanding our network and providing excellent service and resources.

All prospective community grantee applicants have a census available to them to determine the number of people in each target group and then predict how many of those may be interested in the service they will be providing. Agencies that apply for Title III funds to support the people in their area do so with the knowledge of the need for services that will keep them at home and in their community for as long as possible. These applications are reviewed for accuracy upon receipt and then reviewed by the Allocations Committee and ultimately their recommendation is submitted to the Senior Resources Board of Directors.

Targets are a forecast of participation in programs but are inherently difficult to predict. Current target data is being closely scrutinized during the community grantee application process to be closer to observed actual data.

For example, here is the current target report for FFY 2025.

Target Category	Title III-B	6 Mo stats	Title III-C1	6 Mo stats	Title III-C2	6 Mo stats	Title III-D	6 Mo stats
Total Unduplicated Participants	4,941	1,626	2,411	2,337	2,009	1,236	150	34
Low Income Participants At or below 100% FPL	767	290	1,023	315	670	228	8	0
Minority Participants	334	146	388	251	238	106	4	1
Low-Income Minority Participants	211	72	229	112	164	50	3	0

Participants at or below 150% of Poverty	803	Not in A&D	439	Not in A&D	415	Not in A&D	7	Not in A&D
Rural Participants	522	Not in A&D	497	Not in A&D	359	Not in A&D	38	Not in A&D
Participants w/ limited English Proficiency	130	Not in A&D	74	Not in A&D	83	Not in A&D	2	Not in A&D
Participants w/ Severe Disabilities	143	58	28	47	63	187	5	0
Participants At-Risk of Institutionalization	503	Not in A&D	31	Not in A&D	103	Not in A&D	4	Not in A&D
Participants w/ Alzheimer's & Related Disorders	115	87	29	76	60	198	2	0

Data is collected monthly. Waiver programs and Subgrantees submit statistical information by the 15th of each month. All information is entered into Wellsky by the end of that same month. During the data entry, only complete information is entered. If any data is not complete, it does not go into Wellsky until it is. During the upcoming Area Plan, we will be implementing a Technology Hub to better enable waiver program staff and community grantees to see their progress in funding use and access parameters of target data in real time.

Targets are monitored every six months for evaluation and possible intervention or adjustment. Reports are sent to the Bureau of Aging at the beginning of every fiscal year, the 6-month mark, and at the end of the fiscal year. The goal is to be within 20% of designated targets. Deviation from this is explained when possible.

Quality Management

Quality management, including monitoring and evaluation, of all services provided is a critical element of efficient and effective service provision and funding stewardship. Contractor Orientation is held before the contract year begins to review and instruct on the use of all reporting documents. Ongoing technical assistance is available throughout the contract year if needed. All grantees are monitored at least once per fiscal year. A series of questions are asked to ensure each grantee follows federal guidelines for Title III. Desk top monitoring is conducted throughout the year by reviewing monthly statistics that are submitted. If Grantees are under serving or over serving, there is a conversation as to the reason for this. A plan may be put into motion to provide the service appropriately. Applicable data is entered into the WellSky system. This includes community grantees, Senior Nutrition Program, The Congregate Housing Services Program and the National Family Caregiver Support Program. Information and Assistance data is collected by Senior Resources on a spreadsheet and submitted to the Bureau of Aging. CHOICES data is collected on a State Health Insurance Assistance Program (SHIP) form and reported through a national data management system. Senior Medicare Patrol (SMP) reports data in a specific national data management system. Benefits Enrollment Center data is submitted to the National Council on Aging through a designated data system. Information & Referral/Public Education data is tallied quarterly for reporting to the Bureau of Aging. Progression of use of funds to budget is reviewed monthly by Senior Resources financial staff and presented for review with the Board of Directors. Senior Resources participates in an annual independent audit process with full accountability of financial compliance.

Senior Resources reports progress on the current Area Plan to the Advisory Council on a quarterly basis for their review and discussion. Year-end reports are submitted to the Bureau of Aging for an annual review. This annual reconciliation includes a review of service utilization and consumer demographic reports to the initial target.
All community grantees are monitored for progress of utilization through monthly data collection and financial reporting. Grantees are also monitored through a more in-depth

review of the physical requirements of application such as site set up, policies, procedures, and client paperwork management such as outlined for the authorized purposes and in compliance with Federal statutes, regulations, and the terms and conditions of the grant award, including: (i) evaluating each subrecipient's risk of noncompliance to ensure proper accountability and compliance with program requirements and achievement of performance goals; (ii) reviewing subrecipient policies and procedures; and (iii) ensuring that all subrecipients and subgrantees complete audits as required in 2 CFR part 200, subpart F and 45 CFR part 75, subpart F.

Area Plan Development Process

The Area Plan Development Process is ongoing in nature as we are constantly monitoring the achievement of goals, measurement of outcomes and barriers to success. This continuous cycle allows us to make modifications along the way which will help to more accurately achieve the goal. Sometimes, new goals are added. Surveys are conducted related to each program and reviewed as received as well as in summary. The needs of the region are gathered on an ongoing basis through monthly review and discussion of Gaps in Services at M-team meetings and through collaborative partnerships with regionally focused teams. Focused team meetings are held monthly to share back information and insight gained by staff members in their roles as direct service provider, case managers, program coordinators, public education providers and community outreach participants. This brings relevant and timely consideration of both short-term and long-term needs in the community and how our process can shift or work to meet those needs when possible.

During October, November and December 2024, the Executive Director made personal on-site visits to most of the Senior Centers in our region to discuss the thoughts and concerns of the aging network leaders in each of those areas and how the Agency on Aging can support them in meeting these needs and/or finding other solutions. Some discussion points included the ability to have enough technology at locations to support “satellite” education so that a greater variety of specialized professional speakers can reach all areas, enhancing mutual support of all activities in the aging network arena

through social media or other virtual content from reliable and unbiased sources, and continuing to improve the image of aging in our communities as a vital and active endeavor.

During the monthly M Team meetings September 2024 through May 2025, aging network professionals discussed gaps in services and other concerns or needs which included:

- Support for Veterans include comprehensive assessment, education and consultation; education and information about available resources; and expansion of ways for Veterans to manage their own care.
- Support for Seniors experiencing hoarding or other mental health issues such as intervention for clean-up, ongoing case management support and education for the public on recognition, early intervention or prevention of the issue.
- Address housing issues for Seniors such as assessment of needs and challenges, resource allocation to help seniors find appropriate options, collaboration with housing authorities to provide support which maintain people in their housing, and advocacy for policies which support senior housing.

On January 6. 2025, Senior Resources hosted a Legislative listening session with satellite in-person host sites around the region all on one zoom. This allowed for small in-person interactions with local invited legislators, Senior Resources representatives and aging network providers as well as shared ability to discuss larger perspectives. The needs of our region were discussed and reviewed for an hour-long program with opportunity for questions or further discussion. The ability to maintain funding for Service Navigation assistance was a significant point with supporting discussion as well as the ongoing concerns of the ability to fund long-term supportive services in our communities.

Our staff participated in a Success, Weakness, Opportunities, Threats analysis during a staff meeting on January 16, 2025. Some noted successes were the ability to find creative solutions, incorporate technical efficiencies, meet or exceed targets and make sure that clients are satisfied. Some weaknesses were time management, and the amount of time spent on data entry or “billing”, keeping volunteers engaged, and getting

accurate information from clients upon intake. Opportunities included ways to expand our use of grant-funded activities and to further our reach for community grantees in new or different ways. Threats include the uncertainty of funding sources in a changing political governance. All this together brings further clarity of the need for efficient and effective provision of services in everything that we do.

Our Area Plan development team discussed this and other information on February 13, 2025, and during weekly meetings through the end of April 2025. We attempted to focus on our role in supporting the overarching goals of Long Term Supports and Services, Healthy Aging and Elder Rights. For Long Term Supports and Services, our work includes person centered evaluation, service navigation, bridging clients from one introductory program to other longer term supports, application assistance, in-home care education and supports, legislative advocacy and caregiver support. For Healthy Aging, The Senior Nutrition Program success with highly nutritious and delicious meals along with professional education and counseling with Registered Dietitians can make significant improvements to participant health, mentally and physically. Educating Medicare beneficiaries on their access to preventive, therapeutic and long-term care with the ability to afford appropriate medications and supports as well as benefits screening and overall improvement to financial health through knowledge and planning has a tremendous impact on health as evidenced by impact survey reports of our clients in many programs. The stories of Caregivers and other aging network partners that are so appreciative of the assistance to connect to supports which make them stronger in their roles and less stressed in continuing their crucial support. For Elder Rights, the team discussed our valuable role in education, outreach and prevention of abuse, fraud, neglect or exploitation with involvement in larger committed organizations as well as our “boots on the ground” presentations on scams, advanced care directives, EMS or other first responder training, legal services referrals, work with Municipal Agents and Senior Centers as well as continued person centered listening in each of our encounters.

We have drawn from innumerable access points of information and discussions throughout the region from all our team members, network partners, consumers, caregivers, and data to develop this area plan with very important work to do in our region and state.

Goals, Objectives, Strategies and Measures

Goal 1: Long Term Services and Supports
Empower older adults to reside in the community setting of their choice

Objective 1	**Strengthen the aging network by promoting a person-centered approach with comprehensive referral and assistance.**
Strategy 1.1	Plan and monitor staff involvement in continuing education opportunities with information shared back to others that did not attend event.
Outcome	Increased knowledge, improved skills and completion of required webinars, trainings, and certifications to ensure knowledge is current and aligned with policy and regulatory requirement changes.
Measure	Documentation of training consistent with contract.
Strategy 1.2	Continue person-centered care training for required staff.
Outcome	More utilization of the person-centered care approach throughout diverse programs.
Measure	Expanding use of person-centered principles in multiple program formats.
Strategy 1.3	Increase awareness of services and support through targeted communication campaigns and outreach opportunities that address the diversity of needs among aging population groups with greatest social and economic need.
Outcome	More older adults with the greatest social and economic need are aware of supportive services via targeted outreach communication campaigns and have access to culturally appropriate communication resources.
Measure	Outreach offerings monitored throughout the region, offered in more than one language and with various focal topics to garner interest. The number of participants, location, topic and any barriers can be noted. Monitor how outreach offerings are coordinated such as through created online request jotform available through our website.

Strategy 1.4	Promote access points for information and referral to older adults and their caregivers.
Outcome	Increased capacity among older adults and caregivers to identify referral points in the community and unbiased access to other forms of media or information that broaden equitable access to resources and supportive services.
Measure	Promote focal point and other agencies throughout the region. Cross promotes educational and other outreach events through social media, websites and other media. Connect with at least 5 locations that have not recently hosted events with a goal to ensure expanded reach throughout our 5 regions both in person, virtually or digitally.
Strategy 1.5	Promote access to Aging and Disability Resources such as the NWD system.
Outcome	Support BOA with implementation of NWD system. Enhance and expand existing and new professional collaborations.
Measure	Continue collaboration with AgingCT and AgingAnswers programs including connections with BOA contracted programs.
Strategy 1.6	Partner with 211, myplacect.org and other publicly accessible entities to increase visibility of long-term supports and services.
Outcome	Continued collaboration for training and resource-sharing, ensuring the most up-to-date information is available to aging network partners and consumers.
Measure	Monitor number of professional collaboration partnerships and educational opportunities offered.
Objective 2	**Empower and assist older adults and their caregivers.**
Strategy 2.1	Utilize standardized guidelines, best practices, and parameters of excellence for work with older adults and caregivers.
Outcome	Family caregivers receive adequate, accurate and informative resources in a manner that they comprehend.
Measure	Continue to provide professional and comprehensive support of caregivers through education programs consistent with contracts.

Strategy 2.2	Support public service campaigns and caregiver roadmaps to inform and assist caregivers who may not know what resources are available to them.
Outcome	More caregivers throughout the state of Connecticut have access to appropriate solutions in navigating support and services for older adults living with Alzheimer's Disease and Related Dementias (ADRD), and their families and care partners at the community level.
Measure	Maintain and expand informational videos or other materials through our existing channels such as YouTube, Television, social media, Website and newsletters.
Strategy 2.3	Continuing to support partner engagement opportunities for cross-collaboration and coordination of educational information related to caregiving.
Outcome	Ongoing collaboration and cross-coordination to ensure access to better quality of educational information about supportive services, and resources for family caregivers and older adults throughout the aging network in Connecticut.
Measure	Maintain and enhance connections with educational institutions, professional organizations, first responders and tribal nations.
Objective 3	**Identify and assess gaps and seek potential solutions in support and services for older adults living with Alzheimer's Disease and Related Dementias (ADRD), and their families and caregivers at the community level.**
Strategy 3.1	Enhance training and service coordination for individuals living with ADRD to promote appropriate and equitable supportive services.
Outcome	More families and caregivers experience improved service coordination from innovative training and best practices used by ADRD community-based organizations to promote appropriate supportive services.
Measure	Maintain and/or expand opportunities for support groups and other community connections including in person and/or hybrid options with adult day programs, long term care facilities, senior centers, community

	centers and other areas. Advocate for adequate funding of supportive services.
Strategy 3.2	Facilitate and/or participate in community partnerships related to individuals living with ADRD and their caregivers.
Outcome	Increased engagement with local communities to deepen collaboration among all partners who produce the best practice guidelines and undertake appropriate actions to be adopted and implemented.
Measure	Continue community network collaboration through existing relationships, support groups, support groups of other organizations, chambers of commerce, councils of government and other connections.
Strategy 3.3	Coordinate with community providers to promote inclusive and dementia-friendly communities.
Outcome	More community providers learn about the parameters of and the opportunities of the inclusive and dementia friendly communities.
Measure	Provide educational outreach opportunities including Dementia topics to all aging and community network partners, businesses and other organizations.
Objective 4	**Support a comprehensive and inclusive network of Senior Centers and Municipal Agents to share information and program resources.**
Strategy 4.1	Participate in an advisory working group to help inform the BOA about Senior Center related issues to prioritize services and support in the senior center network.
Outcome	Increased inclusive collaboration and coordination between senior centers and municipal.
Measure	Continuing and expanding connective work with Senior Centers, Commissions on Aging, and all community organizations to gather information on needs and collaborate to provide solutions responsive to these needs. Continue to expand our Advisory Council membership and roles within communities.

Strategy 4.2	Support a system to streamline communication and increase networking between the BOA, AAAs, senior center professionals, municipal agents and other entities supportive of community aging in place.
Outcome	Increased and consistent communication is observed.
Measure	Continue email distribution communication as well as other social media or other methods in consistent cadence of monthly and/or quarterly.
Strategy 4.3	Support distribution of public-facing materials to define and promote the support and services available through senior centers and the aging network to increase access and raise understanding of the services available in the community.
Outcome	Increase knowledge among existing and new consumers about the services available in each community. More community members use senior centers and/or related services because they are aware of available opportunities.
Measure	Maintain the Senior Center Directory and continue collaborative activities throughout our 56-town region. Highlight and share connections, best practices and/or great ideas from regional partners.
Objective 5	**Promote inclusiveness through outreach to population groups with the greatest social and economic need.**
Strategy 5.1	Continue to reach out and coordinate Title III programs with tribal groups receiving Title VI funds through engagement with tribal authorities.
Outcome	Increased communication to identify key strategies and best practices between tribal authorities, BOA, and Senior Resources for efficient coordination of Title III and VI programs to reach older adults with the greatest social and economic needs.
Measure	Support existing Board leadership connection with tribal nation. Continue efforts to collaborate with Tribal organizations to offer programs and services in concert with their existing opportunities.

Strategy 5.2	Promote partnerships between ADS, DPH, AAAs and community organizations to conduct outreach to individuals and their caregivers to ensure increased access to appropriate resources and supportive services.
Outcome	Increased knowledge shared between state and local agencies gained from outreach to individuals and their caregivers to better understand the gaps in access to supportive services.
Measure	Maintain and/or expand community connections to reach individuals and their caregivers.

Goal 2: Healthy Aging

Provide older adults with prevention and wellness opportunities

Objective 1	**Strengthen opportunities for equitable access to evidence-informed nutrition and wellness programs in the aging and public health networks.**
Strategy 1.1	Utilize Registered Dietitians in Nutrition Education and Counseling throughout the region related to the Senior Nutrition Program including participants and other eligible people, offered in English and Spanish.
Outcome	Older adults in underserved groups experience healthier attitudes and make informed choices resulting from improved delivery of nutrition education and counseling**.**
Measure	Achieve deliverables of related waivers. Special Waiver for Midstate Senior Nutrition Program with in-depth monitoring of program success parameters, satisfaction scores, etc. Utilize a bilingual and bicultural Registered Dietitian on staff
Strategy 1.2	Expand outreach and identify new partners for delivery of prevention and wellness workshops through the aging network to increase participation in underserved groups.
Outcome	More older adults from underserved communities are reached and attend the program workshops.
Measure	Monitor the number of speaker requests for wellness topics using the form on our website and through outreach team monitoring. Expand IIIB Waiver for Public Education so that assorted programs, including wellness topics, can be offered throughout the region. Expand CHSP waiver for C1 Nutrition Education and Counseling Expand the variety of IIID programs
Strategy 1.3	Support partnerships with the Department of Public Health (DPH) and others to build fall prevention programing.
Outcome	Participate in Fall Prevention Coalition with state agencies, Area Agencies and Aging and community partners to create a fall prevention framework throughout the state. Participate in Department of Public Health coordinated wellness app lifestyle coaching.
Measure	Continue participation in Falls Prevention Coalition Activity Cross promotes and support Fall Prevention programs and community grantees in the aging network Continue collaborative work with Public Health partners in evidence based and evidence informed programs. Monitor cohorts of participants in Lifestyle Wellness programs.
Objective 2	**Strengthen nutrition services to address malnutrition.**
Strategy 2.1	Offer nutrition education and counseling with access to a Registered Dietitian throughout the region.

Outcome	All Senior Nutrition Program home delivered meal participants are provided access to a bilingual English/Spanish Registered Dietitian for individualized person-centered care to address malnutrition risk.
Measure	Registered Dietitians participate in creation of a prioritization tool. No waiting list in our regions currently. Expand assessment and treatment of malnutrition as part of the community/institutional cycle. Promote Senior Nutrition Program Benefits Access as tactics for prevention of Malnutrition. Enhance Caregiver and other provider education of nutrition supports to decrease risk of and/or to promote treatment of Malnutrition. Benefits Enrollment Program services to increase access to programs which promote food access and security. Coordinate Senior Farmer Market Program participation to increase understanding, access and redemption of funded programs and encourage expanded consumption of a variety of local produce.
Strategy 2.2	Continue or expand community partnerships and explore a referral system to reduce food insecurity among underserved older adults and to increase access to nutritious foods.
Outcome	Increase awareness of programs and services and how to access them in any community specific ways. Offer presentation to community or legislative groups for increased focus on older adults and caregivers.
Measure	Participation in Food Policy Workgroup and other state or federally coordinated programs related to Malnutrition risk reduction. Coordinate partnerships for expanded food security of older adults Advocate for SNAP, SNFMP and other funding to support the aging population. Provide access to benefit assistance.
Objective 3	**Increase awareness of health equity among partners in the aging network to remove barriers to health program participation.**
Strategy 3.1	Support awareness of mental and behavioral health needs among older adults, utilizing trauma-informed resources for community partners, and increase referrals to supportive services.
Outcome	AAA and aging network staff receive training to more effectively assess suicide or mental health risk and refer to appropriate resources.
Measure	Continue participation in multiple regional health networks. Discuss gaps in services and cross-promote opportunities among aging network partners. Provide coordinated training throughout aging network partners.
Strategy	Support or expand opportunities for social connection through

3.2	increased participation in the Senior Nutrition congregate meal program, and Health Promotion programs.
Outcome	Older adults experience the benefits of nutrition and health programs and continue to seek on-going opportunities for social connection.
Measure	Provide more and more diverse Nutrition Education and Health program opportunities to the eligible population of OAA programs.
Strategy 3.3	Strengthen relationship with DPH around emergency preparedness, infectious disease prevention, and immunization utilization.
Outcome	State and regional agencies are prepared for large-scale emergency or pandemic information campaigns.
Measure	Participate in OEMS Region 4 and ESF Committees for Eastern Region Emergency Preparedness team planning and engagement. Promote staff involvement in local preparedness activities.
Objective 4	**Increase public knowledge and awareness of brain health and Alzheimer's Disease and Related Dementias (ADRD).**
Strategy 4.1	Work with groups and other organizations to foster, build or increase participation in programs to expand awareness of Alzheimer's Disease and Related Dementias.
Outcome	Participate in collaborative groups, support groups which support public awareness. Increase publicly accessible information and training related to dementia resources.
Measure	Work with additional aging network partners. Allocate funding to community dementia supportive programs
Strategy 4.2	Provide education and resources about brain health, including diseases, risks, and protective factors.
Outcome	Provide presentation and training as well as support that includes links to reliable websites, printed materials, social media postings and other methods. More residents across the state are knowledgeable and take effective measures to maintain brain health, reduce risk, and enhance protective factors.
Measure	Provide up to date and accessible information through our Website, social media and Print formats.
Objective 5:	**Promote access to information and services for older adults and their family caregivers.**
Strategy 5.1	Support concepts related to increased awareness about ageism and to shift attitudes about aging.
Outcome	More individuals are knowledgeable about the concepts of ageism and aging, participate in educational workshops, and healthy aging programs at community partner sites.
Measure	Promote positive and supportive concept of aging in all areas including Website, social media and Print formats.

Strategy 5.2	Support the development of a Multisector Plan for Aging and Disability to transform policy, infrastructure, and service coordination across agencies. Continuing a diverse and multi-faceted network of working relationships with state agencies, private businesses, non-profit organizations and others that work to support service coordination.
Outcome	Clients and caregivers can access needed services with decreased frustration or confusion.
Measure	Support our connection with multi-sectors of aging through existing and enhancing relationships.
Strategy 5.3	Support the focus on fostering livable communities.
Outcome	Municipalities have access to technical assistance, resources and best practices around fostering livable communities.
Measure	AgingCT participates as a Board Member of the CT Age Well Collaborative. Continuing communication and collaboration with municipalities, commissions on aging, senior centers, municipal agents for the elderly, chambers of commerce, councils of government and other focused organizations working toward livable communities throughout our region.
Strategy 5.4	Increase access to technology to reduce social isolation and increase connectedness.
Outcome	More older adults throughout the state access technology and feel less isolated because of increased connectedness.
Measure	Support and assist access to technology resources and provide ongoing access to materials in various and/or hybrid formats. Provide additional training (i.e. Session 0) for programs which benefit from technological access.

Goal 3: Elder Rights

Protect elder rights and well-being, and prevent elder abuse, fraud, neglect, and exploitation

Objective 1	**Identify new members and increase sustainable stakeholder participation throughout the aging network consistent with the Coalition for Elder Justice in Connecticut and other organizations.**
Strategy 1.1	Build a person-centered capacity with a focus on Elder Rights through education, information, and awareness campaigns targeting emergency and first responders.
Outcome	Increased education, information and awareness campaigns targeted to emergency and first responders to reinforce knowledge and awareness of the need to adopt a person-centered attitude and skills among service providers.
Measure	One presentation per year to first responders and provision of carry cards with our information to first responders in every town and state police that cover our region. Strive to offer education as free continuing education units whenever possible. Staff members that are first responders provide insight and feedback. Encourage first responders to attend M-teams or other related training.
Strategy 1.2	Identify opportunities to increase coordination of initiatives identified among aging network (including CEJC members) on issues of prevention of fraud, abuse, and exploitation to prioritize Elder Rights awareness.
Outcome	Increase knowledge and awareness of issues affecting older adults from varied agencies and community partners which creates collaborative opportunities to prioritize Elder Rights across the aging network.
Measure	Provide educational outreach events consistent with program contracts for CHOICES, SMP, MIPPA and Title IIIB Public Education, with emphasis on topics which relate to Elder Right issues. Promote community education events for Title IIIB community funding for Legal Services and the Consumer Law Project. Continue M-Teams meetings to coordinate aging network providers to discuss confidential case issues and gaps in services related to Elder Rights. Encourage Education/presentations by different programs at each AAA and region. Support financial management training for older adults and caregivers or promote assistance when needed.
Strategy 1.3	Continue leadership roles in the CEJC and Area Agencies on Aging to develop, share, and disseminate information and resources about

	prevention of elder abuse throughout the aging network.
Outcome	AAA representative participates in CEJC Steering Committee and all other activities. Share information through Aging Networks including Senior Centers, Municipal Agents for the Elderly, M Teams, Banks. Share or create information to share through various platforms including YouTube, social media, etc.
Measure	Attendance at CEJC meetings, Number of Elder Justice related topics conveyed through AAA Newsletters, social media or other communication methods
Strategy 1.4	Strengthen partnership with CEJC stakeholders including Protective Services for the Elderly (PSE) to educate the public about abuse, neglect, and exploitation, and the mechanisms for reporting concerns, and continue to refer individuals as appropriate.
Measure	Aging network and community members are educated on abuse, neglect, and exploitation of older adults, and are aware of how to report concerns.
Outcome	Provide educational outreach, including appropriate referrals to PSE or other Aging Network resources, through public access television, public presentations, websites, etc. Encourage partnership or panel presentation with Protective Services for the Elderly and other CEJC focused programs. Promote awareness of Aging Answers programs at AAAs and examples of complex Service navigation scenarios that were prevented, resolved or improved.
Objective 2	**Empower marginalized or disempowered groups, including those in long term care facilities, to increase participant knowledge of resident rights, as well as the role and duties of the Long Term Care Ombudsman Program (LTCOP).**
Strategy 2.1	Assist to disseminate information about LTCOP and promote awareness to enhance the quality of life and care for Connecticut's citizens receiving various long-term supports and services and their caregivers.
Outcome	More older adults, caregivers and community members are aware of the LTCOP supports and services. Increased number of residents understand how the role of the LTCOP and rally support from LTCOP to enhance their quality of life and care as needed.
Measure	Share content through AAA networks and resources. Have LTCOP do a presentation at Senior Resources for staff and the public that would be available virtually and recorded to provide information about the new support and services they offer. Support and assist to coordinate as needed LTCOP presentations at a Senior Centers (held in each of our counties in our service area) with a panel of speakers on relevant topics to the audience. Foster and maintain relationships. Coordinate promotion within

	Money Follows the Person staff and programs.
Strategy 2.2	Analyze data to understand the concerns of marginalized groups and tailor the program's educational communication strategies to increase individual knowledge base.
Outcome	Increased data providing more knowledge about the concerns of underserved groups.
Measure	Implement BetterAge software with sublicensees at Senior Centers to gather data on participant concerns and needs. M Team discussion of gaps in services as well as ongoing discussion related to Area Planning. Consider gathering data on the needs of interpreting DSS, SSA and other government program literature. Underserved populations to consider include those released from incarceration, Solo Agers, and those living in remote locations. Consider forming support groups for families of residents in SNFs or collaborate with local groups to provide them. Available as professional speakers for public outreach and education to all areas, including long-term care facilities.
Strategy 2.3	Use individual stakeholders and subject matter expert voices within outreach strategies.
Outcome	More older adults and caregivers take action to reach out for support more often when in need. Underserved groups and marginalized residents are educated about their rights and engage in planning for and addressing barriers to better quality of life as recipients of long-term supportive services and care.
Measure	Offer Public Education events to long term care facilities like those topics provided in the community, senior centers, etc. and including hybrid access events and training, particularly for staff and caregivers.
Objective 3	**Support the State's initiative to offload excess nursing home beds by approximately 2,500 and rebalancing of the long-term care continuum, while protecting resident rights.**
Strategy 3.1	Maximize use of and advocate for adequate community based long term services and support to avoid need of nursing home placement, including appropriate housing options in all communities that are undergoing rightsizing projects.
Outcome	More residents in communities undergoing rightsizing projects understand impending lifestyle changes and accept informational engagements about alternative communities offering long term support and services.
Measure	Avoidance of nursing home placement through programmatic goals of home and community based long term supports and services.

	Collaborative support of homelessness diversion supports. Information, referral and assessment as well as Service Navigation roles in person centered planning. Referral to Money Follows the Person as appropriate. Utilization of Congregate Housing Support Programs where available.
Strategy 3.2	Monitor and support State Ombudsman participation in the Medicaid Long-Term Services and Supports Rebalancing Initiatives Steering Committee to advocate for long term care recipients. Offer involvement to Steering Committee for community Medicaid long term supported clients as well.
Outcome	Engage long term Medicaid services participants to identify relevant strategies and action plans to uphold Elder Rights.
Measure	Continue supportive partnerships with aging network organizations and state agencies.
Objective 4	**Increase equity for Connecticut residents, including those in nursing homes, residential care homes, and assisted living communities, by expanding their access to Home and Community-Based Services (HCBS) and ensuring their voices are heard by public officials.**
Strategy 4.1	Advocate for Home and Community Based Services and Long Term Supports to create safe, person-centered plans of care at various levels of need in the community.
Outcome	More citizens from underserved groups, including those in residential care communities, participate in assessments to identify barriers to eligibility of supportive services.
Measure	Offering informational presentations in various living environments, including Residential Care Homes, assisted living and independent housing in our region. Help individuals in these communities to access Connecticut Home Care Program for Elders (CHCPE). Share information about AAA advocacy activities and focus topics. Provide educational opportunities to discuss ways to be involved. Encourage participants to share the story of how programs and services impact their lives in the community.

Required Attachments

Attachment A: Area Plan Assurances –

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

Sec. 306. AREA PLANS

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

Each such plan shall—

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

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

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

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

(C) legal assistance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) older individuals residing in rural areas;

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

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

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

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

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

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

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

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with

disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

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

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

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

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

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

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

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

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

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

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected

officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) provide assurance that -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

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

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

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

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

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

(A) health and human services;
(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(M) any other service as determined by such agency.

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

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

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

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

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

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

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

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

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

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

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

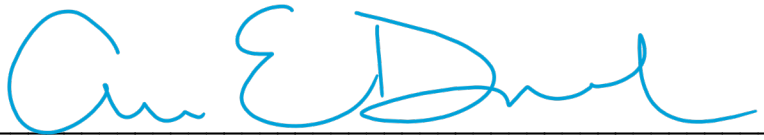
(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

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

(1) contracts with health care payers;

(2) consumer private pay programs; or

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



7/1/2025

Executive Director, Area Agency on Aging Date

Attachment B: Emergency Preparedness Plan

The Planning and Service Area of Eastern Connecticut encompasses 56 individual towns and cities. Each municipality has its own emergency preparedness plan. It is not within the scope of available resources; either human or financially, to play a significant role in any municipal or regional emergency preparedness activities. The agency will respond to emergency warnings, bulletins and other notification devices to stay abreast of potential threats. The Director of Contracts is the Disaster Communications Officer.

Communication Plan

Pertinent information will be disseminated to providers of aging services as well as our existing client base. All appropriate efforts will be made to receive and send information to increase awareness of emergency situations. Methods may include, but are not limited to, email, fax, telephone tree and cell phone communication.

In the event of an emergency, Senior Resources contacts the Elderly Nutrition Providers (ENPs) to verify that emergency meals are in place for all home-delivered meal participants. If the emergency is weather related, ENPs are required to make plans for early delivery and/or weekend coverage. ENPs are advised that shelf-stable meals are the first preference but if not available easily prepared meals must be delivered. If the emergency is unexpected and preparations cannot be made prior to the event, as soon as is safely possible, Senior Resources will contact the ENPs to determine status of the delivery of home delivered meals and plans to restart service if it has been interrupted.

The Area Agency on Aging is not an emergency services agency. The after-hours, weekends and alternative solutions for regular communication systems will be directed to the 911 system.

The Disaster Communications Officer will report all pertinent information to the appropriate contact at the Bureau of Aging as necessary.

Public Information Plan

The development of emergency planning, which is sensitive to the needs of the aging community, is required for the health and safety of all people in our service area. Senior

Resources has determined its role in emergency preparedness as an educator or resource for referrals. In this role, Senior Resources will use emails, the website, Facebook, and telephone communications to advise individuals of appropriate planning actions which should be undertaken to be as prepared as possible in the event of an emergency. Our updated Website will include pertinent emergency information for seniors and their families, including suggestions on preparing an emergency plan and kit. The Website will link to other sources and emergency contact information for each town and will be continually updated.

Outreach and Assistance

An instructional emergency preparedness handout was prepared which will be distributed to clients in our Senior Community Cafes, Home Delivered Meal Program, Respite Programs, Congregate Housing Services Program, and Money Follows the Person Program.

Funded community-based service providers are asked to develop their own emergency preparedness plan based on their resources and municipal commitments. These plans are provided with their Title III applications and are monitored for compliance during the regularly scheduled annual monitoring visit. Direct services Providers are responsible for outreach and assistance to clients before, during and after an emergency.

Emergency Operations Procedure

Evacuation: The physical location of Senior Resources will be evacuated as appropriate following the chain of command delineated in the organization chart. Staff members are responsible for shepherding any volunteers and clients out of the building (example: a staff person meeting with an older adult for health insurance counseling has the responsibility of escorting the client out of the building). The highest-ranking staff member on the scene has the responsibility to announce and oversee the evacuation, including a final inspection of the office prior to exit. Immediately upon exit, staff and clients are to convene in the parking lot at a distance deemed safe based upon the nature of the emergency (for example, in the case of an uncontrolled fire, staff and visitors will comply with the direction of the first responders). Reentry to the building will be allowed after properly authorized personnel have declared the building safe for entry.

Senior Resources has fire extinguishers, smoke alarms, and emergency exits on-site at the physical plant.

Records: The agency installed electronic back-up measures for the retrieval of computerized documentation. All staff members are instructed and trained in the agency's confidentiality requirements for safe record-keeping.

Public Health Emergency: In the event of a public health threat, all staff members and volunteers will comply with any direction provided by the Centers for Disease Control, World Health Organization, Department of Public Health, Governor's Office, Bureau of Aging or other duly recognized personnel. Should a staff member be stricken with an illness which may constitute a public health risk, the staff member is expected to report such an illness to the appropriate health care provider and comply with recommended protocols.

Inclement weather: The agency established an inclement weather policy wherein the Executive Director or designee will close the office as needed to ensure the safety of staff and clients. All Staff members are contacted by the Executive Director or designee via text messages, phone calls or a message on the office answering machine. If Staff cannot be reached via text message or phone calls, a public announcement will be made via WTNH-TV school and business closings division.

All AAA Title III funded nutrition programs are required to provide shelf stable meals prior to the onset of cold weather months and at other times during the year as needs demand. All nutrition and supportive services providers are required to notify AAA immediately if any interruption in scheduled services occurs, during or after the emergency. This includes updating AAA about any changes in service status and actions being taken to address the interruption of services post event. AAA staff will ascertain whether adequate care is in place and will contact consumers receiving support or care coordination services from AAA who are identified as high risk and lacking other personal and/or community support.

The M-Teams have adopted and publicized an inclement weather policy following the public-school notification system. The in-person meeting is canceled if the area public school(s) at the host site are closed or delayed (this system has been in place since 2001); however, the meeting can still be held in a virtual forum if desired.

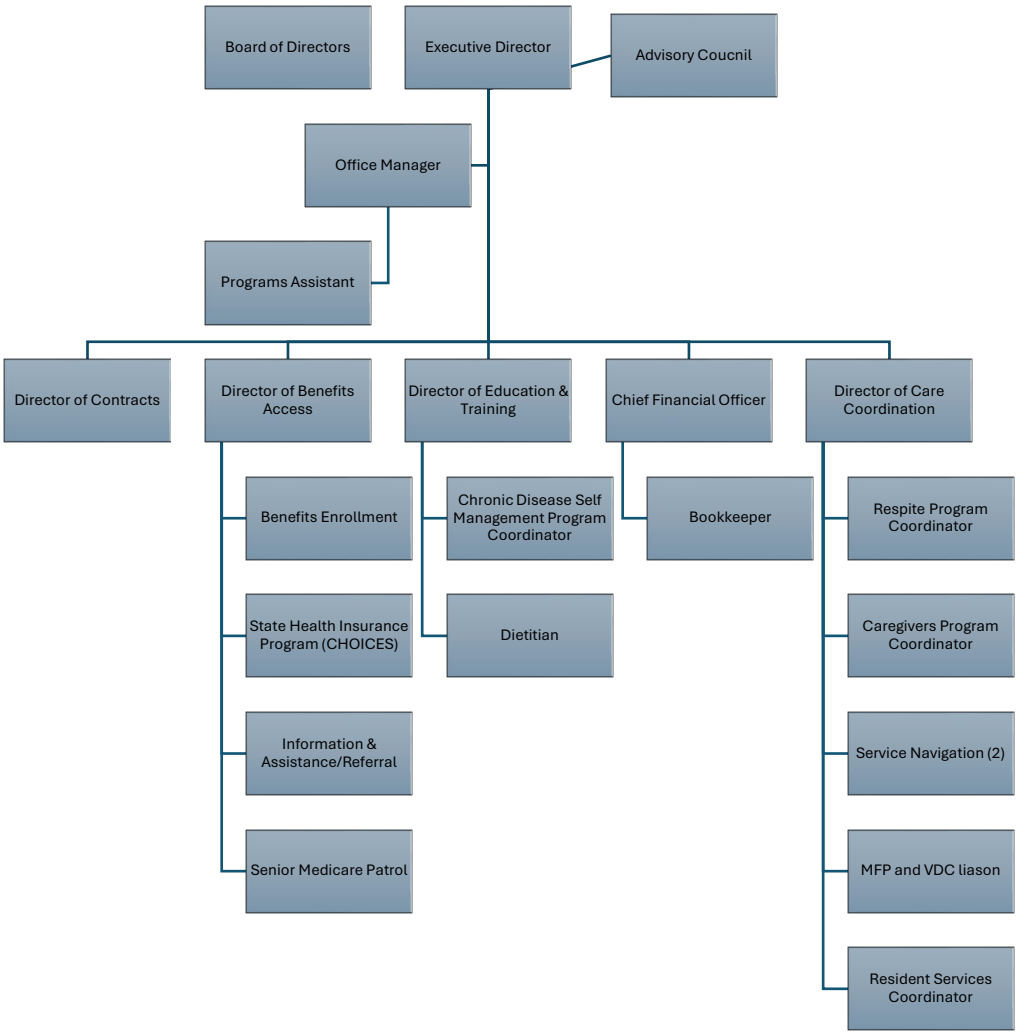
To the best of our ability, we reach out to our clientele before the weather event, based on information received from the latest forecast.

Situation Reporting

The Executive Director of Senior Resources Agency on Aging has a Disaster Recovery Plan in place to protect employees, safeguard vital records and resources at the agency's physical location. If because of an emergency event there is a reportable injury or damage, the Executive Director will contact the President of the Board, the Director of the Bureau of Aging and any appropriate insurance providers.
The Disaster Communications Officer will contact the Bureau of Aging Program Manager or Nutrition Consultant with a status update on meals delivery and other services as the details become available.

Attachment C: Organizational Structure

Note that this organizational structure is geared to programmatic offerings, not staff positions. Aging Answers encourages a more well-rounded team approach and responsiveness to person-centered provision of care. We are also directly managing the Midstate Nutrition Program through a special waiver.



Attachment D: Focal Points

Focal Points are community locations which function as a point of entry for accessing aging and disability services. Although there are hundreds of sites and organizations which provide this function, the following locations participated in the application and review process in January – February 2025 and are exemplary providers in their region including access to services such as meals and nutrition; health, fitness and wellness; transportation; public benefits counseling; employment assistance; volunteer and civic engagement; social and recreational activities; and education and arts, while also meeting all applicable health, safety and accessibility standards.

Site Name	Address	Location	Contact Person	Designation Date
Estuary Council of Seniors	220 Main Street	Old Saybrook, CT 06475	Heather Milardo Development@yourestuary.org 860-388-1611	02/26/2025
Portland Waverly Senior Center	7 Waverly Avenue	Portland, CT 06480	Sarah Elliott-Caratasios Selliott@portlandct.org 860-342-6760	02/26/2025
Quinebaug Valley Senior Citizens Center	69 South Main Streeet	Brooklyn, CT 06239	Sophie Charron Director@qvscc.org 860-774-1243	02/26/2025
New London Senior Center	10 Brainard Street	New London, CT 06320	Marina Vracevic Mvracevic@newlondonct.gov 860-437-6339	02/26/2025
Sprague Senior Center	1 Main Street, PO Box 677	Baltic, CT 06330	James Smith Seniorcenter@ctsprague.org 860-822-3000	02/26/2025
Thrive 55+ Active Living Center	102 Newtown Road	Groton, CT 06340	Mary Jo Riley Mriley@grton-ct.gov 860-441-6636	02/26/2025
Rose City Senior Center	8 Mahan Drive	Norwich, CT 06360	Michael Wolak Mwolak@cityofnorwich.org 860-889-5960	02/26/2025
Colchester Senior Center	15 Louis Lane	Colchester, CT 06415	Patty Watts Pwatts@colchesterct.gov 860-537-3911	02/26/2025

East Lyme Senior Center	37 Society Road	Niantic, CT 06357	Kristen Caramanica Kcaramanica@eltownhall.com 860-739-5859	02/26/2025
Montville Senior Center	12 Maple Avenue	Uncasville, CT 06382	Kathleen Doherty-Peck Kpeck@montivlle-ct.org 860-848-0422	02/26/2025
Ashford Senior Center	25 Tremko Lane	Ashford, CT06278	Monica Gallegos Seniorcenter@ashfordtownhall.org 860-478-5122	02/26/2025
Lebanon Senior Center	22 Imogene Lane	Lebanon, CT 06249	Darcy Battye Dbarrye@lebanonct.gov 860-642-2042	02/26/2025
Windham Senior Center	1 Jillson Square	Willimantic, CT 06226	Angela Fournier Afournier@windhamct.gov 860-450-2100	02/26/2025

Attachment E: Accomplishments

The five Agencies on Aging long standing collaboration became more formalized with the creation of Aging CT and establishing Aging Answers to improve access to long term supports and services for seniors and their families in CT. The Aging CT website, launched in 2023, facilitates statewide access to Aging and Disability answers. Area Agency on Aging staff meet regularly with other AAA staff and Bureau of Aging program staff to ensure uniform training, assessment tools and procedures across the state. Inform USA and Person-Centered Planning and CHOICES certifications to help ensure a standardized knowledge base.

An Annual statewide Aging CT Summit, additional statewide educational events, and the Aging CT Newsletter have provided education and training to AAA and BoA staff as well as other aging and disability professionals and facilitated professional networking to improve consumer/caregiver experience.

Senior Resources has enhanced outreach and education efforts, with a focus on economically disadvantaged and minority communities. These efforts include:

- *Meet Me at the Market* – Benefits Enrollment and Nutrition staff attend local farmers markets to promote Farmers Market Vouchers and to encourage consumers to access available benefits.
- *CHOICES outreach* – in person and virtual presentations to make sure Medicare beneficiaries can make informed decisions about their insurance.
- *Healthy Living Expos* – Regional gatherings of service providers in one location so that consumers can easily obtain a variety of resources. This is also a good networking opportunity for professionals.
- *News You Can Use* – Monthly e-newsletter that serves as a clearinghouse of timely information about events, services and resources throughout the region.
- *Talk Back with Sheila Horvitz* – Broadcasted on local Cable TV, Facebook and YouTube – Staff members are interviewed on a local cable show hosted by one of our Advisory Council members to get information about our programs out to the public.

- *Community Volunteerism and Involvement* – Several staff members participated in the 2024 annual Walk to End Alzheimer's in the Eastern region, United Way Community Day Projects, Chamber of Commerce Leadership projects, and other events. Staff are encouraged to participate in the Commission on Aging or other similar committees in their town.
- *CDSMP* – Our Chronic Disease Self-Management Programs help involve volunteers in our Agency's work as well as providing valuable support to individuals struggling to manage medical conditions.
- *Health collaboratives* – Senior Resources is a member of the Eastern CT Health Collaborative, the Northeast HealthQuest group, the Nonprofit Alliance for Eastern Connecticut, the Social Services Committee of Southeastern Connecticut Council of Governments, the Health and Wellness Committees of Chambers of Commerce and other health related initiatives and participates with other regional stake holders in data gathering and strategic planning to make sure the needs of our vulnerable populations are being met.
- *Multidisciplinary Team meetings* – Senior Resources hosts monthly meetings of professionals throughout our region for information sharing, problem solving and education as well as valuable networking.
- *Emergency Response Teams* – Several of our staff volunteer as First Responders and have been instrumental in developing carry cards for emergency response teams to leave at a call so that families have information about Senior Resources after the emergency has passed.
- *Dementia Friends and Powerful Tools for Caregivers* – These evidence-based programs provide valuable support to communities seeking education about dementia and to caregivers looking for support in their roles.
- *Volunteers*-– CHOICES, SMP and CDSMP have all successfully recruited volunteers to expand our educational and outreach capacities to inform people about elder abuse, fraud, neglect and exploitation, Medicare and Medicaid and Live Well programs.
- *PSE referral portal* – Senior Resources staff worked closely with the Department of Social Services to create, troubleshoot and pilot the Protective

Services online reporting portal, and now have mandated reporting accounts to facilitate and track referrals.

Within the agency, we strive to provide a seamless experience to the people who reach out for support through the implementation of Aging Answers. This approach has many aspects. Internally, various departments including Service Navigation, I&A/R, CHOICES, BEC, SMP, CSRCP, NFCSP and administration now track client contacts through Adage, a Care Management software platform. Mutual access to information allows collaboration among staff members working with the same consumers to access different supports and services so they have access to an expert in each area without having to re-tell their story.

In addition, we collaborate with other service providers so that consumers can move easily through the service system. We work closely with waiver program Access Agencies to dovetail Bureau of Aging funded programs (NFCSP, RCP, CHSP) with Medicaid funded programs to help provide a seamless transition, and to provide support to families and individuals during the sometimes-challenging LTSS application process.

We are co-located with the Disabilities Network of Eastern CT so can easily consult on challenging consumer situations, share resources, and schedule one stop appointments so people don't have to come to the office more than once.

We have a Spanish/English Bilingual staff person who can provide knowledgeable and compassionate translation assistance for callers who are hesitant to confide in people outside of a trusted agency.

The implementation of Service Navigation has helped hundreds of individuals and families access in depth support during this past Area plan year, allowing Senior Resources to expand our availability and assistance to the people living in our 56-town region.

Attachment F: Accounting Systems Certification

Independent Auditors' Report

To the Board of Directors of Eastern Connecticut Area Agency on Aging, Inc.
d/b/a Senior Resources

Report of the Audit of the Financial Statements Opinion

We have audited the accompanying financial statements of Eastern Connecticut Area Agency on Aging, Inc. d/b/a Senior Resources (the Agency), which comprise the statements of financial position as of September 30, 2024 and 2023, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Agency as of September 30, 2024 and 2023, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Agency and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Agency's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Agency's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Agency's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 27, 2025, on our consideration of the Agency's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Agency's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Agency's internal control over financial reporting and compliance.

Fiondella, Milone & LaSaracina LLP

Glastonbury, CT
February 27, 2025

Attachment G: Request for Waiver from Procurement

Senior Resources submits Request for Waivers in order to provide services directly to program participants in our region when this is the most efficient and effective way to meet the needs of our entire region.

Title IIIB: We request for up to 25% of the available funds in order to provide Information, Assessment and Referral and Public Education with 1.7 FTE staffing to cover our entire 56 town region.

Title IIIC2: We request for up to 10% of the previous year's available regular funds in this area to provide Nutrition Education, Assessment and Counseling to Home Delivered Meal participants and those that are eligible for this program. We employ 0.75 FTE bilingual Registered Dietitian to provide this service in a high quality, well rounded and consistent manner throughout the region.

Title IIID: Senior Resources seeks 90% or more of the available funds to provide a variety of evidence-based programs throughout the region over the course of the area plan. This will include the Live Well Chronic Disease Self-Management, Diabetes Self-Management and Pain Self-Management through the end of our license to do so in July of 2026 and Mind Over Matter programs for incontinence issues through a recently purchased 3-year license. We are applying to provide Cooking Matters programs to make up the balance of programming needs during the Area Plan timeframe and will also consider Bingocize as a pre-approved and highly regarded option and/or renewal of the LiveWell license. The funding in this area would result in a maximum of 0.5 full time equivalent to staff time.

Title IIIE: National Family Caregiver programs will continue to be managed entirely through Senior Resources with a Case manager, Support Group Leader and administrative support to a total of 1.6 full time equivalents.

Support of the Congregate Housing Services Program with Title IIIB and IIIC1 funds. Title IIIB is used as matching funds for the HUD program to support CHSP. Title IIIC1 is used as a source of funds for the Congregate Meals, similar but separate from the Senior Nutrition Program RFP process of providing meals in the region. An addition to this request includes Nutrition Education, Assessment and/or Counseling available to residents of CHSP locations utilizing Senior Resources Registered Dietitian.

Attachment H: Cost Sharing Provisions

Senior Resources will not be revising or expanding any Title III funded cost sharing policies for the FFY 2026-FFY 2028 Area Plan period.

References:

Dugan, E., Silverstein, N.M., Lee, C.M., Porell F., (2021). ***Connecticut Healthy Aging Data Report*****. www.healthyagingdatareports.org**

2023 Profile of Older Americans**. U.S. Administration for Community Living, May 2024.**