DARS | Virginia Department for Aging and Rehabilitative Services

DIVISION FOR AGING SERVICES

The Area Plan for Aging Services

Fiscal Years 2024-2027

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PSA #: 15

Counties:

Charles City
Chesterfield
Hanover
Henrico
Goochland
New Kent
Powhatan

Cities:

Richmond

Third Year of the Area Plan:

October 1, 2025 through September 30, 2026

Virginia Department for Aging and Rehabilitative Services

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Area Plan

PURPOSE

This Area Plan for Aging Services (Area Plan) outlines the scope of aging related services provided by the Area Agency on Aging (AAA) with funding from the Virginia Department for Aging and Rehabilitative Services (DARS). The Area Plan is based on a comprehensive assessment of the demographic characteristics and needs of the older population in the AAA's planning and service area (PSA). AAAs are required to submit their Area Plans to DARS for review and approval.

The Area Plan serves as a roadmap for the AAA's management, administration, service system development, service delivery, and advocacy efforts during the planning period. It aligns services with the principles of the Older Americans Act (OAA), including:

- Promoting and sustaining the independence and dignity of older individuals, particularly those capable of self-care, through home-based services and community support.
- Removing individual and social barriers to economic and personal independence for older individuals.
- Supporting a continuum of care, including long-term care, family support, and community-based services that help older adults live in their homes and communities.
- Ensuring older individuals have the freedom to manage their own lives, can actively participate in planning the services provided for their benefit, and are protected against abuse, neglect, and exploitation.

In developing the Area Plan, the AAA identifies the unique needs of the older population in their community, evaluates the effectiveness of existing services, and sets priorities for current and future service delivery. The Area Plan outlines a broad range of services, such as nutrition programs, transportation, caregiver support, health promotion, and other supportive services. It also demonstrates how the AAA will coordinate services, maximize resources, and ensure accessibility and service availability for all older adults in the PSA.

The Area Plan is a public document, available for review by community members, stakeholders, and other interested parties. This open access promotes transparency by allowing the public to provide feedback and participate in decision-making regarding resource allocation and the prioritization of OAA services.

In Virginia, the Area Plan updated at least every four years to reflect changing community needs, service delivery methods, and funding priorities.

PART 1: BACKGROUND OF THE AREA AGENCY ON AGING

An **Area Agency on Aging (AAA)** is a local organization created pursuant to the Older Americans Act (OAA), which is designated within the Virginia Administrative Code and in contract with the Virginia Department for Aging and Rehabilitative Services (DARS) to develop and administer the Area Plan, as approved, for a comprehensive and coordinated system of services for older persons. Each AAA serves a specific geographic area, known as the planning and service area (PSA). An AAA's PSA is typically a city, county or a group of cities and/or counties. The AAA is tasked with ensuring that the needs of older individuals in that PSA are met through a range of services and programs.

The OAA intends that the AAA be the lead on all aging issues on behalf of all older individuals and family caregivers in the PSA. The AAA performs a broad range of functions, under the leadership and direction of DARS, aimed at developing or enhancing comprehensive, coordinated community-based systems that serve the PSA. Key AAA functions include:

1. **Advocacy**
2. **Planning**
3. **Coordination**
4. **Interagency Collaboration**
5. **Information Sharing**
6. **Monitoring**
7. **Evaluation**

Overall, AAAs serve as the central hub for aging services within their PSAs, ensuring that older adults have access to the resources they need to live independently and with dignity. Their activities are guided by the principles and requirements set forth in the OAA which emphasize the importance of local coordination, responsiveness to community needs, and service integration.

The **The Capital Area Agency on Aging DBA The Span Center** is a

(Complete legal name of the agency)

☐ local government

☒ private nonprofit organization incorporated under the laws of Virginia

☐ joint exercise of powers organized pursuant to §15.2-1300 et seq. of the Code of Virginia

☐ multipurpose agency

MISSION STATEMENT

Empowering Older Adults, Persons with Disabilities, and Caregivers to live with dignity and choice.

GOVERNANCE

While not included in the Area Plan, Area Agencies on Aging (AAAs) shall make the following documents available to the public upon request:

1. **Governing Board Composition and Bylaws**
2. **Advisory Council Composition and Bylaws**
3. **Governing Board and Advisory Council Meetings, including Public Access**

PUBLIC PARTICIPATION

State the process the agency used to receive public comment and review of the Area Plan and its amendments. Also describe how the AAA Advisory Council was consulted. **Include the date of the public participation period and how the public input influenced the Area Plan process:**

Community Input Is Vital. Our FY2026 Area Plan process included:
1. Pre-Plan Period: We conducted listening sessions in each PSA15 locality from April 2025 through May 2025. We also held 8 public listening sessions and then hosted targeted sessions within residential communities, councils on aging, local senior groups like Goochland Silver Warriors, recreation centers, etc. We received feedback from program participants, Friendship Cafe participants, including the Korean Senior Center, Foster Grandparents and volunteers. We conducted an online survey shared via social media, through agency emails, and shared with our No Wrong Door Advisory Council. This year we hosted our 1st Legislative Breakfast, where 21 local, state and federal leaders or their designated staff members joined together to discuss what they are hearing from their constituents. All valuable insights into the creation of the FY2026 Area Plan.
2. Planning Process: Listening session feedback was shared with the leadership team in reviewing and planning for service delivery of OAA programs moving forward. Some changes were made based on discussions and the current federal fiscal environment. The draft area plan has been completed.
3. Public Comment Session and Public Hearing - June 20 to July 18, 2025. Hearing July 8, 2025. The Advisory Council will meet on June 23, 2025 to review plans and make additional recommendations. For public: We will post the area plan on our website. We will advertise through social media, partners and NWD advisory council through Constant Contact.

SUMMARY SOURCE OF FUNDS

Each Area Agency on Aging (AAA) must prepare and develop an Area Plan for approval by the Virginia Department for Aging and Rehabilitative Services (DARS). Each plan must provide information and assurances that the AAA will, on the request of the State and for the purposes of monitoring compliance with this Act, (including conducting an audit), disclose all sources and expenditures of funds such AAA receives or expends to provide services to older individuals.

Disclose all funding amounts and sources below:

Estimated Funds for Fiscal Year 2026	
Source	**Amount**
Department for Aging and Rehabilitative Services	
Older Americans Act (include Nutrition Services Incentive Program or NSIP)	$4,959,208.00
State General Funds	$1,819,684.00
Virginia Insurance Counseling and Assistance Program (VICAP); including State Health Insurance Assistance Program (SHIP) and Medicare Improvements for Patients and Providers (MIPPA)	$215,505.00
Respite Care Initiative	$50,000.00
Dominion Energy Senior Cool Care	$7,500.00
U.S. Dept. Of Agriculture – Senior Farmers Market Nutrition Program (USDA-SFMNP)	$2,100.00
Supplemental Nutrition Assistance Program (SNAP) Outreach	$34,455.00
Senior Community Service Employment Program (SCSEP)	$409,393.00
Other State Government Sources	
Dept. of Rail and Public Transportation (DRPT)	$424,505.00
Dept. of Medical Assistance Services (DMAS)	$19,362.00
Dept. of Social Services (VDSS)	
Dept. of Behavioral Health and Developmental Services (DBHDS)	$250,000.00
Virginia Housing (formerly Virginia Housing Development Authority)	
Dept. of Education (VDOE)	
Other Federal Government Sources	
AmeriCorps	$281,176.00
U.S. Centers for Medicare and Medicaid Services (CMS)	
Veterans Administration	

Local Government Sources	
Charles City (Rural County)	$8,000.00
Richmond City	$40,000.00
Henrico	$56,000.00
Chesterfield	$10,000.00
Goochland	$10,000.00
Hanover	$10,000.00
New Kent	$5,000.00
Powhatan	$10,000.00
Private Sources	
Orell Trust	$100,000.00
Richmond Memorial Health Foundation	$100,000.00
Herndon Foundation	$15,000.00
Altria Foundation	$25,000.00
Genworth Foundation	$30,000.00
Jenkins Foundation	$30,000.00
The Community Foundation	$25,000.00
United Way	$19,200.00
Sheltering Arms	$30,000.00
Other Sources	
Contributions/In-Kind	$55,000.00
Charges/Fees	$7,000.00
Investment Earnings	$22,000.00
Other Income	
Carry Over From FY2025	$300,000.00
Virginia Commonwealth University	$110,000.00
Bay Aging - VAAA Cares	$114,000.00
Fundraising	$100,000.00
Bon Secours	$50,000.00
Total Projected Revenues	$9,754,088.00

PART 2: OBJECTIVES AND STRATEGIES

IDENTIFICATION OF POPULATIONS OF GREATEST NEED

Area Agencies on Aging (AAAs) must identify populations within their service areas who are at Greatest Economic Need (GEN) and Greatest Social Need (GSN) which should inform the Area Plan to improve service delivery, outreach and resource allocation.

Older Populations with Greatest Need	# of Older Individuals	Data Source(s)
Greatest Economic Need (GEN)		
At or below federal poverty	19,735	Weldon Cooper
Poverty as further defined by the state	8,840	DARS - Minority and Poverty Combined
Greatest Social Need (GSN)		
Physical and mental disabilities	67,400	Weldon Cooper
Language barriers	5,021	Weldon Cooper
Cultural, social, or geographical isolation, including due to:		
Racial and ethnic status	78,704	Black, Asian, Hispanic and Multiple, Weldon Cr
Native American identity	2,235	Weldon Cooper
Religious affiliation	156,701	Estimated based off Pew Research Center
Sexual orientation	9,857	MAP, Movement Advancement Progress est. 3.9
Gender identity or sex characteristics	1,379	(14% of Sexual Orientation MAP)
HIV status	595	Virginia HIV Surveillance Annual Report (VDH)
Chronic conditions	67,400	Weldon Cooper
Housing instability	56,164	United Way Alice (est ALICE threshold)
Food insecurity	25,022	Feeding American (9.9% Food Insecure in VA)
Lack of access to reliable and clean water supply	7,000	USA Facts (.29%)
Lack of transportation	14,406	CDC Data Brief Estimate/Trans Disadvantaged
Utility assistance needs	8,000	Estimate from low income/poverty
Interpersonal safety concerns	27,800	VDSS Estimates of Abuse
Rural location	1,772	Census
Any other status that threatens the capacity of the individual to live independently	65,320	Living Alone - Weldon Cooper

In reviewing the data above, provide a general description of the demographic characteristics of the planning and service area (PSA), with specific emphasis on populations of GEN and GSN. Note any data limitations.

PSA15: Importance of Demographics

With over 252,000 older adults aged 60+, PSA 15's older adult population is larger than any other locality in the Commonwealth. We also have the 2nd highest population of individuals living in poverty and a large group of minorities living in poverty. We have a diverse planning area. Our localities are rural, urban, and suburban. Within each locality there are inequities depending on the zip code where someone was born/raised. We continue to see an increase in the older adult population through 2030. In our area, older adults face housing instability at a greater rate than any time in history as people aged 55 and up account for 44% of the homeless population in the Greater Richmond Region. Rates of financial hardship differ by race/ethnicity in Virginia due to persistent systemic racism, discrimination, and geographic barriers that limit families' accesses to resources and opportunities for financial stability. Combined with chronic conditions, geographic isolation, ethnicity - almost half our population could be seen as those in greatest economic or social need. We feel confident in writing this even though there are limitations to data, given many older adults are not surveyed on certain topics and historically are underrepresented in the Census. Also, while not a large population, our area also serves a historically marginalized group, the Chickahominy Tribe - both in community and on tribal lands. From our own community listening sessions and tracking calls - there is a growing concern among older adults that they will not have the financial resources to age well. Over 50% of tracked Information and Assistance calls in FY2024 were requests for information on financial assistance and housing. Now is a critical time for our organization to utilize resources smartly to have the greatest impact on those in greatest economic and social need.

This FY2025 our focus will be on:

- individuals at greatest economic need, assessing using a combination of income at, below or just above poverty level, including impact of expenses.
- individuals at greatest social and economic need due to geographical isolation
- individuals in greatest social and economic need due to racial or ethnic identity, Native American identity, and LGBTQ+ identity.
- This focus includes the intersectionality of all the above.

UNMET NEEDS ASSESSMENT AND EVALUATION

The Area Agency on Aging (AAA) is required to submit objective, and where possible, statistically valid data on the unmet needs for supportive services, nutrition services, disease prevention and health promotion, family caregiver support, and multipurpose senior centers. The evaluations for each AAA must consider all services in these categories regardless of the source of funding for the services and provide evaluative conclusions based on the data. Unmet needs information can be collected from PeerPlace and any other information for unmet needs that can be identified.

Identify the source(s) of information or data on unmet needs and provide an overview of the information and data, including how that unmet needs information and data have informed the development of the Area Plan.

Area Planning Process - Unmet Needs:
1. Demographic Analysis: We took a deep dive into the demographics of our region as outlined above to help us understand our population's needs. 2. Partnerships, The Advisory Council and Advocacy: We have also developed deep partnerships with other community-based organizations, local governments and advocacy groups to understand the growing needs in PSA15. The Span Center is a part of the Richmond Region Non-Profit Collaborative: Partnering for Older Adult Advocacy and Shared Learning. Its mission is to promote positive aging in the Richmond region through networking, shared learning, collective advocacy, and a commitment to racial equity. Our advisory council shares information on the communities they represent. Our Long-Range Planning and Public Policy Committee proposes future goals and directions to guide service delivery and financial sustainability. 3 Data Analysis of Unmet Needs via Information and Referral Program: We track calls in Peer Place, CRIA Communication and Unmet Needs in CRIA2 Encounters and analyze the data. 4. Community Listening Sessions: We host robust listening sessions in each locality as part of our area planning process. These sessions help us learn from those in need of gaps and barriers in service. This year we held a leadership breakfast, gathering all the local, state and federal governmental leaders to share what they are hearing from their constituents.
How Data Informed the Area Plan: We view service delivery through the lens of lenses of need, racial, ethnic and health equity as well as a person-centered, trauma-informed perspective. 1. Given the unmet need around financial insecurity as well housing instability, we are expanding Emergency Services to have more flexibility in meeting needs. 2. Our new Elder Justice initiative focuses on housing and hosted in partnership with the Virginia Center on Aging and VCU Gerontology, CARITAS, DARS and No Wrong Door Virginia, Homeward and the Greater Richmond Continuum of Care. 3.Social isolation and loneliness are combated through our robust Friendship Cafe Program and TeleBridges. 4. We requested increased funding for our DRPT funded Ride Connection Program. 4. We have expanded our wellness programming and in-home support program - adding more home care providers to ensure we meet the growing need. We have continued to expand our care coordination team to provide options counseling for the growing number of individuals who have complex problems.

SERVING LOW-INCOME MINORITY OBJECTIVES

With respect to the previous federal fiscal year, provide the following information:

Number of low-income minority individuals in the service area: 8840

Describe the methods and objectives used to address their service needs.

We work to ensure that older adults who are low income and part of a minority group are a priority, focusing on three pillars: Outreach, Key OAA Programs Analysis, and Partnerships 1. Outreach efforts are targeted to ensure those in need know how we can support those in greatest need. The city of Richmond and the county of Henrico are two localities with a high number of low-income minority individuals. Our outreach reports show those localities with the highest number of outreach events at local community centers and places of faith. 2. Key OAA programs like nutrition, in-home care and care coordination have goals for the number of low-income minorities served. The goals, service units, and budgets are reviewed quarterly. If there are new concerns, outreach plans are adjusted. 3. To strengthen partnership with local organizations and localities In FY2025, we created a Community Liaison role to partner with the local Office of Aging and Disability Resources, Community Services Board, VDH, and DSS to ensure those in need know about The Span Center.

Provide information on the extent to which the Area Agency on Aging met its objectives in the previous federal fiscal year to provide services to low-income minority individuals.

Demographic: Snapshot of Low-Income Minority.
In FY2024: over 60% of all clients identified with a minority group. 23% of all clients identified as living in poverty. For clients identified as living in poverty, a total of 804 unique individuals - 788 were low income and minority. Ensuring Good Data Collection: The key to ensuring our objectives were met is quality data. Our biggest challenge is capturing poverty level status as many individuals choose not to disclose as income verification is not a requirement of the OAA. To compensate, in FY2025, we created a data quality assurance team to address missing demographics, especially poverty and race status in Peer Place reporting. While for FY2024 - 24% of our unique people served were low-income minorities, we had a high missing data rate for poverty status. In FY2025, we are on track to have a lower missing data point due to new data goals requirements.

ALIGNMENT WITH STATE PLAN GOALS

The State Plan for Aging Services (State Plan) establishes five goals for aging services in Virginia. Area Plans must be informed by the State Plan and align with the goals established:

☒ Unless otherwise stated, the Area Agency on Aging (AAA) confirms that the objectives of this Area Plan align with those in the State Plan.

☐ The AAA is creating separate goals and objectives that align with the State Plan and are outlined below:

Not applicable.

HOW OBJECTIVES AND STRATEGIES INFORM THE AREA PLAN

Briefly describe how the unmet needs assessments, identification of populations of Greatest Economic Need (GEN) and Greatest Social Need (GSN), the State Plan for Aging Services, public participation in the development of this Area Plan, and Area Agency on Aging (AAA) Advisory Council input have informed this Area Plan.

Our Pre-Plan Work and Public Participation Informs the Area Plan:
The leadership team, advisory council, key internal partners in the development of The Area Plan, along with program staff - who are experts in their programs, were all involved in the Area Plan Process. The teams spent time reviewing and discussing the following information to inform service delivery. For example, if a program service delivery needs updating, if a Direct Waiver is needed, or if a program no longer fits the needs of PSA15.
Key Components:
1. FY2026 Amended 4 Year Area Plan Brief: information from listening sessions, community partner input, public comment period, advisory council members, public hearing and board
2. A review of the budget with analysis of unit/unit cost and persons served by program
3. A review of locality snapshots
4. A review of the State Plan for Aging Services

Please note: We will host a public comment period from June 20, 2025 to July 18, 2025 and public hearing on July 8, 2025. Comments to be incorporated post public comment period.

FUNDING WITHIN THE PLANNING AND SERVICE AREA

For Area Agencies on Aging (AAA) that serve more than one locality (i.e. city or county) in Virginia:

Describe plans for how funding will be distributed within the planning and service area (PSA) in order to address populations of Great Economic Need (GEN) and Greatest Social Need (GSN).

Ensuring Equitable Access and Distribution of Funding:

Our leadership team, including the CEO and CFO, work to ensure funding is distributed within PSA15 to ensure equitable access to all programs through various mechanisms:

1. Our VP of Brand and Communication analyzes outreach efforts based on population to ensure we target and reach those individuals in GEN and GSN. Our outreach team uses an outreach matrix to ensure we reach all localities.

2. All OAA programs are offered in all localities.

3. We create quarterly "snapshot of service" by locality. This snapshot highlights by each locality the number of people served, and units recorded. The leadership team analyzes these snapshots for gaps in services, and if identified, are addressed through community collaboration and outreach. Snapshots are also shared with each locality - key partners, governmental organizations and locality leadership.

4. Leadership team review AMR at budget meeting to ensure we are on track and monthly, budget and AMR data are reviewed at management budget meeting. All managers are encouraged to manage data to understand gaps in services.

5. In FY2025, our executive leadership team created a community liaison role that allows every locality to have a direct contact person with The Span Center. The community liaison works with the locality - government, office on aging, department of social services and the community services board to strengthen connections between The Span Center and residents within each locality.

SERVICE COORDINATION

The Older Americans Act details information that the Area Agency on Aging (AAA) must provide related to carrying out certain requirements within the Act. This section asks for information based on specific assurances contained within the Act that must be addressed by the AAA in its Area Plan.

Describe how the AAA coordinates with mental health service organizations and agencies to increase public awareness of mental health disorders and remove barriers to diagnosis and treatment for older adults.

Supporting Older Adults with Mental Health Needs: 1. The Span Center works through outreach and information and referral to connect individuals with mental health support in their area. 2. Leadership is involved in the local Department of Health and community service boards to ensure older adult voices are heard in planning processes for Community Health Improvement Plans and access to services. 3. All staff have been trained in Mental Health First Aid. 4. Earlier this year, a meeting was held with Amy Erb (Senior Director for Region 4 Programs) and Ivy Sager (Director of the Hanover Community Services Board) to discuss a potential collaboration, though little follow-up has been needed since. Virginia's Community Services Boards (CSBs) are organized by region, with region 4 comprising seven CSBs, including RBHA, Chesterfield, Hanover, Henrico, Crossroads, D19, and Goochland-Powhatan. Region 4 is currently exploring the development of a proposal—encouraged by DBHDS—to fund a geriatric and dementia specialist. The intent is to reduce the number of older adults placed in state psychiatric facilities by advocating for more appropriate, community-based care.
5.) Our outreach efforts will include raising awareness.

Describe how the AAA coordinates with the Virginia Assistive Technology System (VATS), the state assistive technology entity, to increase access to assistive technology options for older individuals.

Connection to Assistive Technology:
1. The Span Center coordinates with VATS as a No Wrong Door partner.
2. Our Information and Referral, Care Coordination, Caregiver Support and Care Transitions teams provide referrals as needed through the NWD technology, Peer Place, to VATS.
3. Our Wellness Coordinator uses the Fall Prevention Kit as part of the Disease Prevention and Health Promotion programming.
4. We have highlighted the Social Connection Kit at various No Wrong Door meetings and outreach events.

EMERGENCY PREPAREDNESS

Describe the Area Agency on Aging's (AAA) efforts to coordinate activities and develop long-term emergency preparedness plans with local and state emergency response agencies, relief organizations, and other institutions involved in disaster relief.

The Span Center: Prepared for Emergencies:
The Span Center works to provide community readiness education for our staff, program participants and community. Typical emergencies in our area are weather related and have advance notice. Our emergency preparedness provides: advance dissemination of accessible, available and usable emergency preparedness information, emergency preparedness kits for older adults partially supported and funded through growing partnerships with corporations; identify disaster and risk communication best practices to reach adults; work with community disaster partners, like EMS, to promote disaster information and training; have a trauma informed care approach for staff as well as ensure Mental Health First Aid for all staff. We will work to build and enhance relationships with local and state emergency response agencies, key partners, health systems as well as home and community-based organizations to assist in emergencies. Using No Wrong Door data, we can identify those most at risk during an emergency and communicate with our community disaster partners. The Span Center maintains Continuity of Operations Plans, which will be updated, to govern operations during emergency and disaster situations. The Agency will follow procedures set forth by the Commonwealth of Virginia's Department of Emergency Services (with guidance from DARS), the American Red Cross and Emergency Preparedness Guidelines established by the eight local governments in PSA15.

All plans will address the following issues:
1. Essential Functions (Building Safety and Operations and Communications)
2. Delegation of Authority by the Executive Director, Board and Staff
3. Maintenance and Safety of Vital Records and Databases
4. Personnel Coordination for Emergency Functions
5. Funding sources for Continuity (FEMA, State, Private Foundations, Local Governments, Petty Cash)
6. Facility Preparation (Evacuation, Building Safety and Emergency Equipment)

The Agency participates in designated Emergency Preparedness groups for the eight localities in Planning District 15. We are a member of the Central Virginia Emergency Management Alliance.

We are in the process of developing a long-range Emergency Preparedness Plan and Hazard Plan as well as an updated Continuity of Operations Plan by October 2025, per DARS guidelines.

SERVING OLDER NATIVE AMERICANS

For Area Agencies on Aging (AAA) that have an Older Americans Act (OAA) Title VI Grantee in the planning and service area (PSA):

Describe the coordination efforts between the AAA and the Tribal Organizations on outreach activities to inform older Native Americans about OAA services and increase service access and provision.

Connecting to Our Tribal Community:

The Span Center spent FY2024 building connections to our local tribal organization serving the Chickahominy tribe through various programs:

1. Nutrition Education/Counseling: our Registered Dietitian (RD) has provided nutrition classes on relevant topics like managing diabetes or chronic disease prevention through diet, the importance of hydration and fiber as well as how nutrition, sleep and stress management are related. Classes include fresh produce for the Elders to take home along with a cookbook with simple recipes. The RD engages in discussion among the Elders while on-site and enrolls (where possible) Elders in the Farm Market Fresh program. The RD also provides feedback and guidance to leaders to ensure that the lunches that are provided within the program are nutritious and balanced.
2. The Span Center partnered with the Chickahominy Tribe during the spring of 2025 to educate tribal members about the importance of flu and COVID-19 vaccination for people of all ages with the understanding that older adults are best protected when their communities are well vaccinated. We were proud to sponsor a food truck for the Chickahominy Indian Tribe Trial Practices for Wellness in Indian Country (TPWIC) Family Fun Fair where we also participated as a community resource provider and spoke with participants about the services we offer. We also attended May's monthly elder brown bag gathering to speak about the CDC's guidance that all adults 65+ and anyone who is immunocompromised receive a second dose of the 2024-2025 COVID-19 vaccine six months after their first.
3. The Span Center, in coordination with DARS, attended a Tribal Convening on March 26, 2025, and on June 18, 2025, and are currently working with the tribal community on policy/procedures on how we will coordinate services going forward.
4. We have a member of the Chickahominy tribe on our Advisory Council as well as members of the board also working within the tribal community.
5. Our outreach team is developing partnerships with trusted leaders and organizations within the community to co-host informational events.
6. The Span Center pursued and received $5,000 NANASP funding to support tribal nutritional programming.

SERVICES TO BE PROVIDED:

Indicate which programs the Area Agency on Aging (AAA) provides with Older Americans Act (OAA) funding by checking the corresponding boxes under Title III Funding Source or with state funding by checking the corresponding box under State General Funds (GF). The funding sources indicated on this page should align with the Area Plan Budget that is submitted to DARS. Not all sources listed on the Area Plan budget, such as fees and voluntary contributions are included on this page. Some services can only be funded with specific titles of the OAA or with State General Fund (GF); shaded sections in this table indicate a specific program cannot be funded with that specific source. Some required services have been pre-checked. Programs or services marked with OAA funding on this page must have a corresponding service page in Part 3.

Area Plan Services	Title III Funding Source					
Title III Services	B	C1	C2	D	E	State GF
Group 1: In-Home						
Adult Day Care					X	X
Checking	X					X
Chore						
Homemaker	X				X	X
Personal Care					X	X
Group 2: Access						
Care Coordination	X					X
Care Transitions	X					
Communication, Referral, Information & Assistance	X					
Options Counseling						X
Transportation	X					X
Assisted Transportation						
Group 3: Legal Assistance						
Legal Assistance	X					
Group 4: Other Services						
Assistive Technology/Durable Medical Equipment (DME)/Personal Emergency Response System (PERS)						
Consumable Supplies						
Emergency Services	X					
Title III Employment Service	X					X
Medication Management						
Money Management	X					X
Outreach/Public Information & Education (PIE)	X				X	X
Residential Repair and Renovation						
Socialization & Recreation						
Volunteer Program	X					X
Group 5: Nutrition						
Congregate Nutrition		X				X
Grab and Go Nutrition		X	X			X
Home Delivered Nutrition			X			X
Nutrition Counseling		X	X			
Nutrition Education		X	X			

Group 6: Disease Prevention/Health Promotion						
Disease Prevention/Health Promotion				X		X
Health Education Screening						
Group 7: NFCSP Additional Title III-E Services						
Individual Counseling					X	
Support Groups						
Caregiver Training					X	
Respite Voucher					X	
Institutional Respite						
Other (Respite Services)						
Financial Consultation						
Direct Payments						
Other Supplemental Services						
Title VII Services	B		Elder Abuse	Ombudsman		State GF
Group 8: Elder Abuse Prevention						
Elder Abuse Prevention	X					X
Group 9: Long-term Care Ombudsman						
Long-Term Care Ombudsman	X		X	X		X
State General Fund Services						State GF
State Funded Nutrition Services						
State Funded Home Delivered Nutrition						
Care Coordination for Elderly Virginians Program						
Service Coordination 2						
Service Coordination 1						
Senior Outreach to Services						
Person Centered Options Counseling						X
Care Transitions						

Area Plans must incorporate services which address incidents of hunger, food insecurity, and malnutrition; social isolation and physical and mental health conditions. Briefly describe which services the Area Agency on Aging (AAA) will provide that address those.

Programs that address nutrition concerns include:

1. Friendship Cafe and Home Delivered Meals Programs
2. Information and Referral connect individuals to food banks and other food resources.
3. Care Coordination provides SNAP/benefits counseling and connect individuals to other resources
4. Our Employment Services program connects people to jobs.
5. SNAP Outreach

Area Plans, to the extent feasible, must provide for the furnishing of services under the Older Americans Act (OAA) through self-direction. List the relevant services the AAA will provide through self-direction, if any. If none, indicate that.

The Span Center offers a self-directed service, Respite Voucher, for caregivers.

Complete this section for all other services that the Area Agency on Aging (AAA) provides that are not funded through the Older Americans Act (OAA) Title III. Programs and services marked on this page must have a corresponding service page completed in Part 6. If additional service pages are needed for this section, they can be found on the **VDA Providers Portal.**

Other AAA Services	Providing Service
Adult Day Center	
Certified Application Counselors	
Care Transitions	X
Community Action Agency (CAA)	
DRPT Transportation	X
Emergency Services	
Foster Grandparents	X
Home Repair/Modification	
U.S. Housing and Urban Development (HUD) Housing	
Low Income Home Energy Assistance Program (LIHEAP)	
Managed Care Services	
Medicaid Transportation	
Options Counseling	
Program for All-Inclusive Care for the Elderly (PACE)	
Virginia Public Guardianship & Conservator Program	X
Retired Senior Volunteer Program (RSVP)	
Senior Community Service Employment Program (SCSEP; OAA Title V)	X
Senior Companions	
Senior Cool Care	X
Senior Farmers' Market Nutrition Program	X
Senior Medicare Patrol	X
Supplemental Nutrition Assistance Program (SNAP) Benefit Counseling	X
Virginia Insurance Counseling and Assistance Program (VICAP)	X
Weatherization	
Community Guardian Program	X
Elder Justice Model	X

WAIVER REQUESTS

MINIMUM ADEQUATE PROPORTION WAIVER

As permitted by the Older Americans Act (OAA), the Virginia Department for Aging and Rehabilitative Services (DARS) may waive the Minimum Adequate Proportion (MAP) requirement described in 22VAC30-60-100 A through C for any category of services described in 22VAC30-60-100 if the Area Agency on Aging (AAA) demonstrates to DARS that services being provided in such category in the planning and service area (PSA) are sufficient to meet the need for such services.

Public Hearing Requirement for MAP Waiver Requests:
Before an Area Agency on Aging (AAA) requests a MAP Waiver, it must conduct a public hearing as follows:

1. The AAA must notify all interested parties about the public hearing.
2. Interested individuals must be given an opportunity to provide input at the public hearing.
3. The AAA must accept written comments from interested parties for 30 days
4. The AAA must submit a complete record of the public comments along with the MAP Waiver request to DARS.

Indicate which service category a MAP Waiver is requested:

	15% Access Services – defined by the OAA, Section 306(a)(2)(A) as care coordination, communication, referral, information and assistance (CRIA) and transportation.
X	**5% In-Home Services** – defined by the OAA, Section 102(30) as adult day care, checking, chore, homemaker, personal care and residential repair and renovation.
	1% Legal Assistance – defined by the OAA, Section 102(33) as legal advice and representation provided by an attorney including counseling or other assistance by a paralegal or law student supervised by an attorney or counseling or representation by a nonlawyer, where permitted by law.

Public Hearing Date: 07/08/2025

Provide justification that demonstrates support for this MAP Waiver request. Submit a complete record of the public comments and any supporting documentation for review:

The Span Center requests a 5% In-Home Services MAP waiver for adult day care, homemaker, checking and personal care as funding is sufficient to meet the needs of the program.

We will host a public comment period from June 20, 2025 to July 18, 2025 and public hearing on July 8, 2025. Comments to be incorporated post public comment period.

COST SHARING WAIVER

As permitted by Section 315(a) of the Older Americans Act (OAA), the Virginia Department for Aging and Rehabilitative Services (DARS) is permitted to implement cost sharing for all services funded by the OAA by recipients of the services except for the following which is not permitted by the OAA:

1. Communication, Referral, Information and Assistance (CRIA), Outreach/Public Information and Education (PIE), Care Coordination
2. Ombudsman, Elder Abuse Prevention, Legal Assistance, or other consumer protection services
3. Congregate and Home Delivered Meals
4. Any services delivered through tribal organizations

An Area Agency on Aging (AAA) can request a waiver to the DARS cost sharing policy and receive approval if the AAA can adequately demonstrate that –

1. a significant proportion of persons receiving services under the OAA have incomes below the threshold established in DARS policy; or
2. cost sharing would be an unreasonable administrative or financial burden upon the AAA.

As required in the Virginia Appropriation Act, DARS cannot waive cost sharing for programs provided solely with state general funds that are not used as OAA match funds. It is the intent of the Virginia General Assembly that state general funds continue to be subject to a cost sharing program.

The Area Agency on Aging requests a Cost Sharing Waiver:	
	For all services allowed by the OAA
	For one or more specific services identified below

Using the space below: (1) identify the specific services the AAA is requesting a Cost Sharing Waiver for, if applicable; and (2) provide the reason(s) for the Cost Sharing Waiver request, including a detailed explanation that adequately demonstrates the need for a Cost Sharing Waiver. Submit any supporting documentation for review.

The Span Center is not requesting a Cost Sharing Waiver. Services will be offered at no cost prioritizing those in greatest need. Voluntary donations are accepted.

ALTERNATIVE FEE SCALE WAIVER

Area Agencies on Aging (AAAs) must adhere to the **DARS Sliding Fee Scale** in use with Older Americans Act (OAA) and state general fund cost sharing programs. If the AAA wishes to request an Alternative Fee Scale Waiver, the AAA must complete the sections below.

As required by the OAA, Virginia cannot permit cost sharing by a low-income older individual if the income of such individual is at or below the federal poverty line.

	The AAA requests an Alternative Fee Scale Waiver

State the service(s) that an Alternative Fee Scale Waiver is being requested:

N/A

Provide justification and rationale for the Alternative Fee Scale Waiver request. State if it has been approved by the governing board, when that occurred and/or when the Alternative Fee Scale was last reviewed by the governing board and the current funding source for the service(s). Submit the AAA's proposed Alternative Fee Scale for review.

The Span Center is not requesting an Alternative Fee Scale waiver.

DIRECT SERVICE WAIVER

As required by Section 307(a)(8)(A) and 45 CFR § 1321.65(b)(7), the Area Agency on Aging (AAA) Area Plan shall provide that no supportive services, nutrition services, evidence-based disease prevention and health promotion services, or family caregiver support services will be directly provided by the AAA, unless, in the judgment of the Virginia Department for Aging and Rehabilitative Services (DARS):

1. provision of such services by the AAA is necessary to assure an adequate supply of such services;
2. such services are directly related to the AAA's administrative functions; or
3. such services can be provided more economically, and with comparable quality, by the AAA.

At its discretion, DARS has provided for a categorical approval for all AAAs to directly provide the supportive services of Care Coordination, Communication, Referral, Information and Assistance (CRIA), and Outreach/Public Information and Education (PIE). AAAs should indicate "Yes" under the direct service waiver portion of the service page for Care Coordination, CRIA, and PIE. No additional direct service waiver request is needed for these services.

For all other potential services, DARS will only grant approval for the AAA to provide direct services for a maximum of the Area Plan period. For each new request, the AAA must describe the AAA's efforts to identify service providers prior to a new or renewed waiver's approval.

The AAA must indicate whether it intends to provide a service directly on each service page located in Part 3: Title III Services AND complete a Direct Service Waiver for each service, except for Care Coordination, CRIA and PIE. The Waiver Forms will be included behind each applicable service in Part 3. A blank Direct Service Waiver Form is included on the next page as an example, but the Direct Service Waiver Form is also located in the VDA Providers Portal.

The following factors will be used to consider all Direct Service Waiver requests:

1. **Necessity**: If direct service provision fills a regional service gap. Documentation should include service availability, provider capacity, and geographic coverage.
2. **Administrative Function**: If the services in question are closely linked to the AAA's core administrative responsibilities.
3. **Cost-effectiveness**: Comparison of AAA service delivery versus service provider contracting, assessing efficiency and quality.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Select from Drop Down

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

See Direct Waiver Form for Each Program where the waiver was requested after the program plan page.

PART 3: TITLE III SERVICES

OVERVIEW

Federal Older Americans Act (OAA) regulations (45 CFR § 1321.65(b)(5)) require that the Virginia Department for Aging and Rehabilitative Services (DARS) have policies and procedures regarding Area Agency on Aging (AAA) Area Plan requirements that address the following at a minimum:

The services, including a definition of each type of service; the number of individuals to be served; the type and number of units to be provided; and corresponding expenditures proposed to be provided with funds under the OAA and related local public sources under the AAA Area Plan.

This section is designed to meet the requirements outlined in federal regulations and provide an overview for each projected service the AAA intends to provide. While completing Part 3: Title III Services, refer to the appropriate DARS Service Standards, the Area Plan budget and the information provided in the AAA Area Plan Part 2: Objectives and Strategies.

Unit Type, Total Units, People Served- The unit type as defined in the service standard, number of proposed units to be provided in the plan year and number of proposed people that will be served.

Proposed Expenditure Amount, Funding Source, Match Funding- The proposed expenditure amounts and the funding source for this service and if any of the non-federal funding is being used as Match Funding for federal/OAA funds.

Locality Served- The locations where services will be provided using OAA funds (i.e. cities and/or counties). If a provider is serving all localities, indicate "**ALL**".

Service Provider(s)- The organization/entity actually providing the service whether it be subcontractors or the AAA under an approved Direct Service Waiver.

Entity Type- A service provider that is a For-Profit or Not-For-Profit organization or entity.

Definition of Service- This is a brief general description of the service. This helps explain it to the public who may be unfamiliar with OAA services. The full definition is contained within the DARS Service Standards.

Target Populations- Populations that the AAA will provide services to using OAA funds, with a specific focus on those in Greatest Economic Need (GEN) and Greatest Social Need (GSN). Summarize how the AAA will target OAA services to reach these defined populations (e.g., what action steps or activities will the AAA take to reach individuals with GEN and GSN for the OAA service).

Service Description-A detailed explanation of the service being provided. This includes overall program design and operation, staffing, assessments, program evaluation, monitoring of subcontractors and specifically how the AAA will provide it using OAA funds.

GROUP 1: IN-HOME

Service: Adult Day Center						Direct Service Waiver			
Unit Type	Hours	**Total Units**	11,700	**People Served**	20		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
$15,802.00	Title III-E	
	General Fund- OAA General	X
$100,000.00	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
$115,802.00	**Total Proposed Expenditures**	

Locality Served	Service Provider(s)	Entity Type
PSA 15	Circle Center Adult Day	Not-for-Profit
PSA 15	Hanover Adult Day	Not-for-Profit
PSA 15	Lucy Corr Adult Day	Not-for-Profit
	South Richmond Adult Day	Not-for-Profit
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Adult Day Centers are community-based programs designed to provide social, recreational, and therapeutic activities for older adults who need assistance with daily activities or have health concerns. These centers offer a safe environment where seniors can receive care and companionship during the day, which may provide respite to family caregivers.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)).
Special attention is focused on recipients of care who are at risk of institutionalization and those at risk economically.

Service Description:

The Span Center Staffing:
One full-time and one part-time employee support the In-Home Program. Each team member undergoes a thorough background check and receives comprehensive training to maintain high standards of care. The Caregiver & In-home Support Manager assesses and supervises the staff performance and provides individualized coaching to maintain excellence in service delivery.

Direct Waiver Not Requested:
The Span Center contracts with local adult day care centers that are licensed by the Virginia Department of Social Services and comply with the standards and regulations. Circle Center operates using a hybrid model that integrates both social and medical services, while other providers follow a social services model.

Service Delivery:
The Span Center will provide this service through service agreements (subcontracted) with licensed adult day care (ADC) service providers. ADC providers assist persons who meet criteria and require day time care and supervision when regular caregivers are not available. Recipients of the service receive personal care and supportive services in a supervised, protective, congregate setting. Caregivers receive respite support they need.

Eligibility and Assessment:
Individuals are assessed with a person-centered approach, using the full 12 Page Virginia Uniform Assessment Instrument (UAI) completed with the participant and caregiver, to determine if they meet criteria for adult day care services. Then a care plan is developed. A service agreement is completed between the participant and the service provide and distributed according to licensure standards.

Monitoring, Quality Assurance and Outcome Measurement:
All providers are monitored on-site by the In Home and Respite Program Manager once a year using the DARS monitoring instrument and on an ongoing basis through ongoing communications with person and provider, ADC staff notes, updated UAI, invoices, etc. All program participants will be surveyed upon discontinuation of services around needs being met and service satisfaction. Those results will be used as a quality assurance and improvement tool as well as to ensure program outcomes being met. The program is monitored annually by Chief Programs Officer to ensure compliance with DARS standards.

Alignment with State Plan:
Adult Day Care programs enable older adults to continue living in their homes while promoting active engagement and simultaneously offer caregivers essential respite care.

Service: Checking						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	3000	**People Served**	35	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$3,860.00	Title III-B	
	General Fund- OAA General	X
$22,000.00	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
$25,860.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Checking is a service where trained volunteers or staff make regular visits or phone calls to older adults to check on their well-being, provide reassurance, and offer assistance as needed. This program helps reduce isolation and ensures seniors have a consistent point of contact for support and emergency response.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Special attention is given to persons who are isolated, living alone and at risk of loneliness due to other factors like rural area, lack of transportation or being homebound.

Service Description:

The Span Center Staffing:
The Checking Program is provided through a combination of agency staff and trained volunteers. It is managed by one full time Volunteer Program Manager (VPM) and two part-time staff members.
Direct Waiver Requested: The program is not subcontracted. See Direct Waiver Form.

Service Delivery:
The Span Center will provide "checking calls" through our telephone reassurance program, Tele-Bridges. Agency staff and volunteers call to check on participant's well-being, engage in conversation and allow the program participant time to engage. Program manager "matches" participant to volunteer; ensures continuity in contacts; provides on-going monitoring of participant's service needs and safety status. As person centered approach, the program participant decides the number of calls needed in partnership with the program manager and volunteer. However, we encourage the volunteer telephone reassurance caller to contact the client by telephone 1-5 times a week.
Eligibility and Assessment:
Volunteers are found via website, social media and various on line volunteer recruitment portals. Volunteers enter the program through an application process. The VPM will screen, train, and provide continuous supervision of volunteers. The VPM will also use a designated application form as a screening tool for eligibility in addition to the VA Service - Quick Form (at a minimum.) Participants are typically referred via agency staff are primary for client participation, but referrals may come from other agencies, self-referrals as well as family and friends. Referrals received via the Care Coordination Department will have Part A or full Virginia Uniform Assessment.
Monitoring, Quality Assurance and Outcome Measurement:
The program is monitored annually for compliance with DARS service standards by the VP of Advocacy and Engagement. All participants receive an annual participant agreement assessment to determine satisfaction with checking service, update information, and indicate continued participation in program. Comments are encouraged. Participants are contact staff to give feedback on the service and volunteers as needed. Volunteers are also surveyed annually and recognized at volunteer events. All results for participant and volunteer surveys will be used to as a quality assurance and improvement tool as well as to ensure program outcomes being met.
Alignment with State Plan:
Our Checking Program aligns with statewide strategies by providing consistent, volunteer-led support that helps older adults remain safely in their homes and connected to their communities. Through regular check-in calls, trained volunteers offer social engagement, emotional support, and early identification of needs that may contribute to housing instability or isolation. This program strengthens wrap-around services, supports aging in place, and complements core Older Americans Act (OAA) efforts.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Checking

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

There is a growing need for this service due to the increasing isolation of older adults and the limited availability of family members or caregivers during the day. This program serves as a vital link between isolated seniors and their communities, offering meaningful social connection and emotional support. Currently, few community resources are available to meet this need. Our service leverages trained volunteers, coordinated by our dedicated volunteer services team, to deliver consistent and compassionate outreach. We also collaborate with other local programs that offer in-home friendly visits and telephone check-ins, ensuring alignment with best practices and maximizing the impact of volunteer-based support.

Service: Chore						Direct Service Waiver			
Unit Type	Hours	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-E	
	General Fund- OAA General	X
	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Chore services provide assistance to older adults with household tasks that may be difficult to manage, such as heavy cleaning, yard work and minor repairs. These programs aim to help seniors maintain a safe and healthy living environment while promoting independence and reducing the risk of injury.

Target Populations:

In order to have more fiscal flexibility, The Span Center will provide these services through emergency services and care coordination, working with partner agencies to ensure homes are safe.

Service Description:

Not Applicable.

Service: Homemaker						Direct Service Waiver			
Unit Type	Hours	**Total Units**	2260	**People Served**	28		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$5,229.00	Title III-B	
$8,729.00	Title III-E	
	General Fund- OAA General	X
$79,000.00	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
$92,958.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	At Home Harmony	For Profit
PSA 15	At Home Care Staffing	For Profit
PSA 15	Blessed Hands and Heart	For Profit
PSA 15	Care Advantage	For Profit
PSA 15	Care Med	For Profit
PSA 15	Dedicated Hearts and Hands	For Profit
PSA 15	Family Lifeline	Not-for-Profit
PSA 15	Jewish Family Services	Not-for-Profit
PSA 15	Let Love Lead, LLC	For Profit

Service Definition: Homemaker services offer assistance with household tasks like meal preparation, cleaning, and light housekeeping, helping older adults maintain a comfortable and organized living space. This service is designed to support older individuals who have difficulty with activities of daily living due to physical or cognitive limitations, enabling them to live independently for longer. This service can also provide respite to family caregivers.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement; with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)).

Service Description:

Staffing:
One full-time and one part-time employee support the In-Home Program. Each team member undergoes a thorough background check and receives comprehensive training to maintain high standards of care. The Caregiver & In-home Support Manager assesses and supervises the staff performance and provides individualized coaching to maintain excellence in service delivery. The program works with the Care Coordination team.

Direct Waiver Not Requested:
Services are provided though licensed subcontractor/providers.

Service Delivery:
The Span Center will coordinate Homemaker Services to support persons having difficulty with one or more deficiencies in instrumental activities of daily living due to physical and health impairments, and need assistance to remain in their own home. Special attention is focused on individuals who have the greatest need. Homemaker services will include: light housekeeping and home organization, grocery shopping, and meal preparation. The Span Center will subcontract with licensed home care providers as well as other homemaker contractors in the community. A service agreement is completed between the client and the service provider.

Eligibility and Assessment:
The Span Center Care Coordinators will assess individuals using Part A of Virginia Uniform Assessment Instrument to determine eligibility, and partner with the person to determine service needs - type of service, hours needed. Reassessments will be done annually. A service log is maintained to record the date and duration of service.

Monitoring, Quality Assurance and Outcome Measurement:
All providers are monitored once a year by The Span Center using the DARS monitoring instrument and on an ongoing basis through regular communications with the person and provider, staff notes, updated UAIs, invoices, etc. All program participants will be surveyed upon discontinuation of services around needs being met and service satisfaction. Those results will be used as a quality assurance and improvement tool, as well as to ensure program outcomes are being met. The program is monitored annually by Chief Programs Officer to ensure compliance with DARS standards.

Alignment with State Plan:
In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place.

Service: Personal Care						Direct Service Waiver			
Unit Type	Hours	**Total Units**	4000	**People Served**	50		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
$32,336.00	Title III-E	
	General Fund- OAA General	X
$143,785.00	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
$176,121.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	At Home Harmony	For Profit
PSA 15	At Home Care Staffing	For Profit
PSA 15	Blessed Hands and Heart	For Profit
PSA 15	Care Advantage	For Profit
PSA 15	Care Med	For Profit
PSA 15	Dedicated Hearts and Hands	For Profit
PSA 15	Family Lifeline	Not-for-Profit
PSA 15	JFS	Not-for-Profit
PSA 15	Let Love Lead	For Profit

Service Definition: Personal Care services provide assistance with activities of daily living, such as bathing, dressing, grooming, and toileting. This service is designed to help older adults maintain personal hygiene and comfort while promoting dignity and independence. This service can also provide respite to family caregivers.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1))
Special attention is given to those individuals who are frail and at risk of institutionalization.

Service Description:

Staffing:

One full-time and one part-time employee support the In-Home Program. Each team member undergoes a thorough background check and receives comprehensive training to maintain high standards of care. The Caregiver & In-home Support Manager assesses and supervises the staff performance and provides individualized coaching to maintain excellence in service delivery. The program works with the Care Coordination team.

Direct Waiver Not Requested: Services are provided though licensed subcontractor/providers.

Service Delivery:

The Span Center will provide Personal Care Services to support individuals who are frail and deficient in two or more activities of daily living without substantial human assistance due to impaired physical and/or mental health. Human assistance is defined as needing cues, both verbal and physical as well as supervision of tasks. Personal Care services will include: bathing, dressing, meal prep, mobility support, etc. The Span Center will subcontract with licensed home care providers as well as other homemaker contractors in the community. A service agreement is completed between the client and the service provider.

Eligibility and Assessment:

The Span Center Care Coordination staff will complete the full Virginia Uniform Assessment Instrument to determine eligibility for personal care services and level of service. In a person-centered approach, Care Coordinators will partner with individual, family and caregivers to determine the appropriate level of service. They also complete a plan of care that will enable the persons to set goals and work towards accessing other long-term care supports. Reassessments will be done annually. A service log is maintained to record the date and duration of service.

Monitoring Quality Assurance and Outcome Measurement

All providers are monitored on-site by The Span Center once a year using the DARS monitoring instrument and on an ongoing basis through ongoing communications with person and provider, staff notes, updated UAI, invoices, etc. All program participants will be surveyed upon discontinuation of services around needs being met and service satisfaction. Those results will be used to as a quality assurance and improvement tool as well as to ensure program outcomes being met. The program is monitored annually by Chief Programs Officer to ensure compliance with DARS standards.

Alignment with State Plan:

In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place.

GROUP 2: ACCESS

Service: Care Coordination						Direct Service Waiver			
Unit Type	Hours	**Total Units**	960	**People Served**	192	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$144,589.00	Title III-B	
	Title III-E	
$16,000.00	General Fund- OAA General	X
	General Fund- CCEVP	X
	Voluntary Contributions	
$160,589.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option

Service Definition: Care coordination services refer to the process of organizing and managing various healthcare, social, and support services to meet the needs of older individuals and their caregivers, ensuring they receive the right care at the right time. This service is particularly important for older adults who often have multiple chronic conditions, complex health needs, or face challenges in accessing appropriate care. Care coordination is designed to improve the quality of care, reduce duplication of services and enhance the overall well-being of older adults by providing holistic, seamless support.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1))
Special attention is given to individuals age 60+ who are frail or have physical and/or mental disabilities, multiple chronic health concerns and are at risk of institutional placement.

Service Description:

Staffing:

Our Care Coordination program is supported by a team of eight trained care coordinators. The Care Coordinator Manager assesses and supervises staff performance and provides individualized coaching to maintain optimal service delivery. Each Care Coordinator undergoes thorough background checks and receives comprehensive training to uphold our high standards of service. Ongoing professional development ensures they remain informed about the latest community resources and services. All Care Coordinators are trained using a person centered approach.

Direct Service Waiver Not Required by DARS.

Service Delivery:

The Span Center will provide Care Coordination Services to offer support in identifying, accessing and coordinating necessary services from internal programs and external home and community based organizations. Support for clients may include connecting them with essential services, benefits, and resources, or coordinating care when clients or their caregivers face challenges such as reduced functional capacity or other personal circumstances.

Eligibility and Assessment:

The Span Center provides support to clients who are dependent in two Activities of Daily Living (ADLs) and have significant unmet needs which result in substantive limitations in major life activities. Our focus is on clients with a higher level of dependence involving physical health and/or needing supervision and/or cues. At the initial point of contact, Care Coordinators typically conduct a home visit to complete the Virginia's Uniform Assessment Instrument (UAI). This assessment helps identify the client's needs and capabilities, ensuring that appropriate services are arranged. All assessment data and case notes are documented in our No Wrong Door Database, PeerPlace, allowing tracking of needed information and analysis of the persons served and the impact of the service. A care plan is developed within 15 working days of the completion of the UAI to link the assessment to the delivery of services. This care plan is updated as needed and reassessed at least every six months.

Monitoring Quality Assurance and Outcome Measurement:

Program is monitored by the Program Manager and Chief Programs Officer to ensure data quality and adherence to DARS Service Standards. In addition, program outputs, outcomes and program quality assurance and client satisfaction are captured in our Care Coordination logic model. Client surveys are conducted following closure of the program. Feedback is reviewed by management and used to enhance the quality and effectiveness of our services.

Alignment with State Plan:

In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place.

Service: Care Transitions						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	1200	**People Served**	350	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$361,405.00	Title III-B	
	Title III-D	
	General Fund- OAA General	X
	General Fund- CCEVP	X
	Voluntary Contributions	
$69,200.00	Non Federal Funds	X
$430,605.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Care transitions refer to the process of moving a patient from one care setting to another, such as from a hospital to home, from a nursing home to outpatient care, or between different healthcare providers. The goal is to ensure continuity of care, minimize the risk of complications, and improve the quality of life during these transitions, especially for older adults who may have complex health conditions. The goal of care transitions is to ensure a smooth, safe, and effective move between different levels or types of care, preventing avoidable hospital readmissions, improving health outcomes, and promoting independence and well-being.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)). Additionally, Care Transitions is focused on older adults recently discharged from the hospital. Have multiple complex health conditions, clients at high-risk of readmission, patients with limited support systems.

Service Description:

Staffing:
Our Care Transitions program is supported by five Care Transitions (CT) Coaches. Each team member undergoes a thorough background check and receives comprehensive training to maintain high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services. The Care Transitions Manager assesses and supervises the staff performance and provides individualized coaching to maintain excellence in service delivery.

Direct Service Waiver: Attached

Service Delivery:
Care Transitions (CT) Coaches collaborative with local healthcare providers to receive referrals for older adults preparing for hospital discharges, particularly those managing chronic conditions such as congestive heart failure (CHF). In addition, clients recently discharged from the hospital in the home delivered meals program are also offered the opportunity to participate in this program. The coaches initiate contact through a telephonic visit, helping patients identify strategies to prevent hospital readmission. This is followed by two or three additional phone calls to support the patients' goal of safely remaining at home. The program promotes self-direction and supporting clients to navigate and access barrier-free, high-quality, person-centered long-term support services. The Care Transitions program is grounded in the Coleman Transitions Intervention Model that is based on the four pillars of:
1. medication self-management
2. patient-centered record
3. follow-up with the health care practitioner
4. knowledge of red flags.

The program is designed to reduce hospital readmissions, CT coaches use the Care Transitions model to empower older adults and encourage them to learn self-management skills to ensure their needs are met during the transition of care, particularly from the acute care settings back into the community. The program allows older adults to access services that address functional limitations and promote a proactive approach to managing their health. The goals of care transition programs are to improve transitions from the inpatient hospital settings to other care settings, to improve quality of care, to reduce re-admissions for high-risk individuals, and to document measurable savings to the Medicare program.

Assessment and Eligibility:
Clients referred to the program are typically hospitalized or have been recently discharged. Care Transitions Coaches evaluate each referral to determine eligibility, focusing on the client's residence within the planning district and their current health conditions. The primary goals of the Care Transitions Program are to enhance the continuity of care as individuals move from hospital to home or other care settings, improve overall care quality, reduce hospital readmissions among high-risk populations, and generate measurable cost savings for the Medicare program.

Monitoring Quality Assurance and Outcome Measurement:
To ensure continuous improvement, client satisfaction outcome are conducted regularly. Feedback is reviewed by management and used to enhance the quality and effectiveness of our services. Data is maintained in the PeerPlace system to track needed information and allow analysis of the persons served and the impact of the service. The program is monitored annually by Chief Programs Officer to ensure compliance with DARS standards.

Alignment with State Plan:
In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place. Consistent with the objectives outlined in the state's plan for aging services, this program is committed to enabling older adults to remain in their communities.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Care Transitions

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
X	Services are directly related to the AAA's administrative functions
	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

Our Care Transitions Program has trained health coaches based on the Coleman Model.

This program aligns with The Span Center's mission. By providing this service directly, The Span Center can not only deliver on the Care Transitions Model, but we are also positioned to connect and provide additional long-term support services to both internal and external programs to help improve quality of life for clients by providing services to remain independent at home.

The Span Center also specializes in working with older adults and people with disabilities and are able to use their expertise in case management and community-based resources to ensure smooth transitions from hospital to home. Our trained coaches for this program work directly with local health service provides such as hospital systems and inpatient- rehabilitation hospitals to receive referrals of clients recently discharged from the health care center. This is a cost effective way to help the clients avoid readmission.

Service: Communication, Referral, Information & Assistance						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	15000	**People Served**	10600	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$287,308.00	Title III-B	
$100,993.00	Title III-E	
$100,912.00	General Fund- OAA General	X
	Voluntary Contributions	
$203,561.00	Non Federal	X
$692,774.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option

Service Definition: Communication, Referral, Information and Assistance are activities that provide general information to older individuals, caregivers, or professionals, such as giving contact details for services, informing individuals about appropriate services and connecting them with external resources, and assessing individual service needs and directly linking them to services or supports provided by the agency or subcontractors.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)) and their families and caregivers and person with disabilities aged 18 and over and their families and caregivers.

Service Description:

Staffing:
Communication, Referral, Information and Assistance Program (CRIA) consists of the Program Manager and 5 Intake Specialists all supervised by the Chief Programs Officer. Each team member undergoes a thorough background check and receives comprehensive training to maintain high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services. All Staff have received training on using the Peer Place system. The Program Manager assesses and supervises the staff performance and provides individualized coaching to maintain excellence in service delivery. The CRIA Program works closely with and serves as intake for the Care Coordination Program, who may serve the client addition through a home visit and additional assessments.

Direct Service Waiver Not Required by DARS

Service Delivery:
CRIA is a person-centered information and referral service. CRIA supports clients more effectively by connecting them to both The Span Center's services as well as external home & community-based services. Staff are able to provide up-to-date, accurate, and unbiased information about available resources for older adults, persons with disabilities and their caregivers. The goal is to support individuals in need of services by offering a range of options to assist them in making informed decisions. Such information includes:
1. Housing and Home Modification
2. Nutrition and Food Insecurity
3. Benefits like SNAP or Medicaid
4. In Home and Respite Services
5. Caregiver Support
6. Financial Crisis Information

Via telephone, email, and through on line portals, Intake Specialists provide general information, informing the client about opportunities, services, support and/or resources to meet their needs. Clients are referred internally or to another community partner.

Eligibility and Assessments:
For all general information calls, Intake Specialists log the request using the CRIA Communication Tool in Peer Place. For individuals 60+ or Caregivers, 18+, a CRIA Encounter is used, or Virginia Service-Quick Form is completed. If a client will be internally transferred to another program, The Federal Poverty/VDA Sliding Fee Scale, is used.

Monitoring Quality Assurance and Outcome Measurement:
The Program is monitored by the CRIA and Chief Programs Officer to ensure data quality and adherence to DARS Service Standards. In addition, program outputs, outcomes and program quality assurance and client satisfaction are captured in our CRIA logic model. Feedback is reviewed by management and used to enhance the quality and effectiveness of our services. Data is maintained in the Peer Place system to track needed information and allow analysis of the people served and the impact of the service. Intake specialists monitor the outcome of the referral, and determine the overall effectiveness of the communication, referral and information and assistance services.

Alignment with State Plan:
In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place.

Service: Options Counseling						Direct Service Waiver			
Unit Type	Contacts	**Total Units**		**People Served**		X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	General Fund- CCEVP	X
	Voluntary Contributions	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Options Counseling is an interactive decision-support process that helps individuals make informed choices about long-term services and supports. The individual, or their legal representative, directs the process with the option to include others they choose. The individual remains actively involved throughout the entire Options Counseling process, ensuring their preferences and needs are prioritized in the decision-making.

Target Populations:

We deliver Options Counseling through CCEVP Funding Only. See page 118 of area plan.

Service Description:

Not Applicable. The Span Center offers this program through CCEVP.

Service: Transportation						Direct Service Waiver			
Unit Type	1 Way Trip	**Total Units**	13400	**People Served**	175		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$206,867.00	Title III-B	
	Title III-E	
$52,000.00	General Fund- OAA General	X
$161,113.00	General Fund- Transportation	X
$2,000.00	Voluntary Contributions	
	Fees	
$100,000.00	Other Non Federal	X
$521,980.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
Henrico, Richmond, Chesterfield	VIP Transportation	For Profit
Richmond, Chesterfield Henrico	Winn Transportation	For Profit
Goochland	Winn Transportation	For Profit
Hanover and Powhatan	Cap UP	Not-for-Profit
		Select Option

Service Definition: Transportation is the provision of a means for individuals to travel from one location to another. This service is available to older individuals who are unable to transport themselves or are unwilling due to safety concerns and lack other means of transportation. The service is focused solely on providing transportation and does not include any additional activities.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income,
low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)).
Special attention is given to those at greatest risk of social isolation, malnutrition and food insecurity as well as the transportation disadvantaged.

Service Description:

Staffing:
The IIIB Transportation Program is supported by one FT Nutrition & Transportation Coordinator supervised by the Nutrition and Wellness Programs Manager and VP of Nutrition, Wellness and Transportation. Transportation services are contracted and monitored by the Mobility Manager.

Direct Service Waiver Not Requested:
The Span Center will provide IIIB Transportation through subcontracts with local transportation providers.

Service Delivery:
IIIB Transportation funds are used solely for the transportation to and from the Congregate Nutrition Sites also known as the Friendship Cafes. All IIIB Transportation participants must meet eligibility requirements for the Friendship Cafe. Please note: not all Cafes have transportation available due to funding constraints. Special attention is given to those individuals who lack transportation options to attend the Friendship Cafe. Transportation for field trips to/from Friendship Cafe is also provided, with special authorization from VP. This program supports caregivers by providing transportation for clients to cafés.

Eligibility and Assessment:
Since these are Congregate Meals clients, all clients are assessed using the Cafe Assessment Tool entered into our No Wrong Door database, Peer Place, as a CRIA encounter. The form incorporates information from the Virginia Quick Form, per DARS standard. All participants are assessed annually.

Monitoring Quality Assurance and Outcome Measurement:
All transportation providers are monitored on-site by the Mobility Manager once a year using the DARS Monitoring Instrument and on an ongoing basis as paperwork is received. Bi-annually, clients are surveyed to include program outcomes as well as program satisfaction in alignment with our Logic Model. Analysis is done to ensure high participant satisfaction. The program is monitored annually by VP to ensure compliance with DARS standards.

Alignment with State Plan:
The Span Center, IIIB Transportation Program, aligns with state goals by promoting access to aging and community services for older Virginians with the greatest economic and social needs and supports caregivers. By increasing access to Friendship Cafe attendance, we improve nutritional health and food security while decreasing the risk for malnutrition for older adults by providing nutritionally adequate meals, one-on-one nutrition counseling, and nutrition education.

Service: Assisted Transportation						Direct Service Waiver			
Unit Type	1 Way Trip	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-E	
	General Fund- OAA General	X
	General Fund- Transportation	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Assisted Transportation provides older individuals with transportation services that include assistance with boarding, exiting, and traveling to and from destinations. This service is for individuals who need help due to mobility or other physical limitations but lack other means of transportation.

Target Populations:

The Span Center does not offer this service. Through our Department of Rail and Public Transportation Grant, Ride Connection, we offer transportation to medical appointments where a caregiver rides at no cost.

Service Description:

Not Applicable. The Span Center does not offer this program.

GROUP 3: LEGAL

Service: Legal Assistance						Direct Service Waiver			
Unit Type	Hours	**Total Units**	2000	**People Served**	650		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
$25,000.00	General Fund- OAA General	X
	Voluntary Contributions	
$25,000.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	Central Virginia Legal Aid Society	Type 1
		Select Option
		Select Option
		Select Option

Type 1: AAA contracts with a Legal Aid Program funded by Legal Services Corporation (LSC)
Type 2: AAA contracts with a Legal Aid Program not funded by LSC
Type 3: AAA has an attorney on staff
Type 4: AAA contracts with a private attorney
Type 5: AAA contracts with a Law School Clinical Program

Service Definition: Legal Assistance provides legal advice and representation to older individuals with economic or social needs. This service can include counseling or support from paralegals or law students under an attorney's supervision, and representation by non-lawyers, where permitted by law. In Virginia, it also includes outreach to those with the greatest social or economic need, as well as education, group presentations, and training aimed at protecting the legal rights of older adults, utilizing materials developed under an attorney's supervision.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)).
Special attention is given to those individuals with no alternate access to legal services.

Service Description:

Staffing:

The Span Center Legal Services is supervised by the Vice President of Advocacy and Engagement. Direct Service Waiver Not Requested: The SPAN Center will contract with Central Virginia Legal Aid Society (CVLAS), a Legal Services Corporation provider.

Service Delivery:

The Span Centers offers legal support services through a contract with CVLAS. Clients living in PSA15 are referred to CVLAS for legal support for various reasons, such as: 1. Eviction, foreclosure and other housing concerns 2. Consumer fraud and abuse, contracts, wage claims 3. Wills and Estates. Clients needing more advanced services will be served according to the CVLAS' Goals and Priorities Plan which is updated annually by CVLAS with public input. Those not eligible through CVLAS will be referred for service through the Virginia Lawyer Referral Service. CVLAS submit a quarterly Client Served Spreadsheet to The Span Center that includes the required data elements from the Quick Form for each client, minus client identifying information, such as name and address. The spreadsheet also includes the amount of time spent with each client during the month and the problem code and referral code for each client.

Through a partnership with the law firm of Williams Mullen and the Greater Richmond Bar Foundation, Legal Assistance services are supplemented by pro bono attorneys who assist clients with the preparation of Wills, Durable Powers of Attorney and Advanced Medical Directives also know as Senior Law Day. We do not have a contract with Williams Mullen or Greater Richmond Bar Foundation as they provide this service at no charge.

Eligibility and Assessment:

All clients 60+ will be eligible for advice and brief services by a licensed attorney.

Monitoring Quality Assurance and Outcome Measurement:

The Span Center monitors CVLAS according to DARS standards while ensuring client/legal confidentiality. The Client Served Spreadsheet is reviewed on a quarterly basis by VP to monitor the subcontractor.

Alignment with State Plan:

Increasing access to legal services aligns with the Virginia State Plan for Aging Services by supporting older adults with the greatest economic and social needs. Legal assistance helps protect their rights, promote independence, and ensure access to essential services such as housing, healthcare, and public benefits. This directly supports the Plan's goals of delivering high-quality, person-centered services and reducing disparities, enabling older Virginians to age with dignity and remain in their communities.

GROUP 4: OTHER SERVICES

Service: Assistive Technology/ Durable Medical Equipment (DME)/Personal Emergency Response System (PERS)						Direct Service Waiver			
Unit Type	Devices	Total Units		People Served			Yes		No
	Payments	Total Units		People Served					

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Assistive Technology/Durable Medical Equipment (DME)/Personal Emergency Response Systems (PERS) provide older individuals with specialized devices and equipment to support their independence, safety, and daily living. This includes assistive technology to enhance communication or mobility, durable medical equipment such as wheelchairs, walkers, or oxygen equipment, and personal emergency response systems (PERS) that allow individuals to request emergency assistance quickly. These services aim to improve the quality of life and ensure the safety of older adults by addressing their physical, mobility, and emergency needs.

Target Populations:

The Span Center does not offer this program we coordinate with Virginia Assistive Technology and other local community organizations, like FREE Foundation, to help meet this need.

Service Description:

Not Applicable. The Span Center does not offer this program.

Service: Consumable Supplies						Direct Service Waiver			
Unit Type	Payments	Total Units		People Served			Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Consumable Supplies refers to the provision of essential, disposable items necessary for the health and well-being of older adults. These supplies may include items such as incontinence products, wound care materials, nutritional supplements, and other short-term use products required for daily care and health management. The service ensures that older adults have access to necessary supplies to maintain their independence, comfort, and overall health.

Target Populations:

The Span Center does not offer this program. Our Care Coordination team works with other service providers and donation centers in the area.

Service Description:

Not Applicable. The Span Center does not offer this program.

Service: Emergency Services						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	1725	**People Served**	115	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$90,000.00	Title III-B	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$50,000.00	Other Non Federal	X
$140,000.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Emergency Services provides financial aid and resources, including referrals to public and private agencies, to older individuals facing emergency situations that threaten their health or well-being. The program offers immediate, short-term assistance to help access necessary resources during emergencies.

Target Populations:

Persons who are 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Priority is given to those individuals who are at risk of housing instability and/or risk of homelessness.

Service Description:

Staffing:

Our Care Coordination program administers the Emergency Services Program. There are eight trained care coordinators. The Care Coordinator Program Manager assesses and supervises staff performance and provides individualized coaching to maintain optimal service delivery. Each Care Coordinator undergoes thorough background checks and receives comprehensive training to uphold our high standards of service. Ongoing professional development ensures they remain informed about the latest community resources and services. All Care Coordinators are trained using a person centered approach. Direct Service Waiver Requested: See Attached

Service Delivery:

The program provides immediate and short-term assistance to help clients access resources in an emergency situation that may endanger the health or well-being of older persons. This program provides financial aid and other resources including referrals to other public and private agencies, to persons 60 and older who have an emergency need for help. The Care Coordinator works with the client to determine the scope of the situation and identifying resources and services that are needed. These services can include but are not limited to:

1. Rental or mortgage assistance to prevent a client from losing their home
2. Cleaning of a yard due to overgrown bushes and grass that limits the ability of the client to enter their home safely or puts them at risk of eviction
3. Home repairs and/or modifications needed to due to safety concerns, such as damaged flooring.
4. In-home heaving duty cleaning for individuals with extreme clutter who may be at risk of eviction or cannot access in-home supports due to housing condition.

Eligibility and Assessment:

Clients are screened by Intake Specialists (CRIA Program Staff) as part of an initial assessment and then referred internally via our No Wrong Door database, Peer Place, to our Care Coordination team who will coordinate the service. Care Coordinators complete CRIA2 Encounter as well as other documentation per DARS Service Standard and Federal Poverty Level is assessed. All client data and record of work is maintained in the Peer Place system to track needed information and allow analysis of the persons served and the impact of the service.

Monitoring Quality Assurance and Outcome Measurement:

Emergency Services Program is monitored by the Program Manager and Chief Programs Officer to ensure data quality and adherence to DARS Service Standards. In addition, program outputs, outcomes and program quality assurance and client satisfaction are captured in our logic model. Client surveys are conducted following intervention to ensure outcomes goals are met. Feedback is reviewed by management and used to enhance the quality and effectiveness of our services.

Alignment with State Plan:

In alignment with the state's plan for aging services, this program facilitates the delivery of wrap-around services that can prevent housing instability and homelessness and support aging in place.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Emergency Services

Reason for the Direct Service Waiver request (check all that apply):

X	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

By providing this service directly, we can recreate a more robust person-centered response to clients' needs in each locality. Our Planning Service Area is diverse, and each locality has different needs and supportive services. Care Coordinators (CC) are best able to work directly with the clients to identify needs and offer interventions to ensure the clients' basic needs are met.

Care Coordinators are also positioned to assist with other referrals to both internal and external programs that can ensure safety and well-being. CCs work with the localities to identify other possible resources which include local faith organizations, department of social services, and other nonprofits to identify all options for meeting that need. All records are maintained in our PeerPlace system.

Service: Title III Employment Services						Direct Service Waiver			
Unit Type	Hours	**Total Units**	460	**People Served**	150	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$90,460.00	Title III-B	
$10,000.00	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$100,460.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Employment services assist older individuals obtain part-time or full-time employment opportunities. The service provides comprehensive support, from assessing individual needs to preparing for job placement, ensuring that older individuals are equipped with the skills and knowledge to successfully navigate the job market.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Special attention is given to those at risk of financial or housing instability.

Service Description:

Staffing:
This program is supervised by an Employment Program Manager, under the direction of the Vice President of Advocacy and Engagement. The program is staffed by a part-time Assistant and several Title V enrollees, who serve as Employment Specialists.

Direct Service Waiver Requested: See Attached

Service Delivery:
The Span Center will support individuals age 60 and over as they obtain part-time or full-time employment through education, support and job referral. The SPAN Center solicits job opportunities within the private sector and refers participants to these job openings.
The service is coordinated with Title V of the Older Americans Act and the Workforce Innovation and Opportunity Act. Participants also receive assistance with job seeking skills and referrals for other employment and training programs.

Eligibility and Assessment:
Participants are assessed using the Quick Form and an program assessment tool "intake form" that obtains information on the participant's education, work experience, barriers, interests and aptitudes.

Monitoring Quality Assurance and Outcome Measurement:
The Employment Services Program is monitored by the Program Manager and VP of Advocacy and Engagement to ensure data quality and adherence to DARS Service Standards. Program outputs and outcomes as well as client satisfaction are captured through data quality assurance guidelines and client surveys. All clients are sent a Client Satisfaction Survey annually. The results of those returned are summarized and reviewed for quality assurance and continuous quality improvement.

Client surveys are conducted following intervention to ensure outcomes goals are met.

Alignment with State Plan:
Our program aligns with key strategies to enhance employment opportunities for older adults by collaborating with vocational rehabilitation staff to raise awareness of SCSEP. We ensure individualized, person-centered assessments to support appropriate job placements and promote digital literacy among participants. Additionally, we collaborate with SCSEP delivery partners to adapt to evolving federal technology requirements, ensuring continued program effectiveness and compliance.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Title III Employment Services

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

Employment Services is coordinated with our Senior Community Service Employment Program (Title V) and provides employment services for older adults who are not income eligible for Title V. The VEC traditionally has not adequately served older adults with their services. As a mandated partner, we will continue to coordinate with the Workforce Centers and other community supports to improve the quality and quantity of employment services to older adults.

Service: Medication Management						Direct Service Waiver			
Unit Type	Hours	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Medication Management Services provide support to older individuals in safely and effectively managing their medications. This includes education on the proper use of prescription, over-the-counter (OTC), and herbal medications, as well as the use of devices like pill boxes or timers to ensure adherence to prescribed regimens. The service also involves medication screening, where individuals may be referred to a physician or pharmacist for personalized advice or assistance. Additionally, medication education materials such as brochures and videos are provided to inform older adults about potential side effects, risks of medication interactions, and best practices for medication use.

Target Populations:

The Span Center does not provide this program. Our Care Transitions teams uses the Coleman model to help ensure individuals released from hospitals understand their medications and reviews for conflict. Our Care Coordination team makes referrals to other programs.

Service Description:

Not Applicable. The Span Center does not offer this program.

Service: Money Management						Direct Service Waiver			
Unit Type	Hours	**Total Units**	1250	**People Served**	40	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$13,968.00	Title III-B	
	General Funds- OAA General	X
$83,000.00	General Funds- Community Based	X
	Voluntary Contributions	
	Fees	
$96,968.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Money Management services help eligible older adults make decisions and complete tasks necessary to manage their daily finances. The goal is to enable older adults to stay financially stable, maintain independence, and protect their rights and well-being.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Special attention is given to individuals at risk of financial instability that could lead to loss of housing, abuse and/or financial exploitation.

Service Description:

Staffing:

The Program is staffed by a 25 hour per week Program Coordinator who coordinates the program and manages volunteers. The program is supervised by Volunteer Program Manager under the direction of the Vice President of Advocacy and Engagement. All staff have background checks as well as ongoing training to ensure quality service. Volunteer play a key role in this program.

Direct Service Waiver Requested: See Attached

Service Delivery:

The Money Management Program supports eligible persons in making decisions and completing the tasks necessary to manage their day-to-day finances. The purpose is to help the clients maintain their financial stability, thereby promoting well-being while protecting their interests and rights. Program participants are matched with screened, trained volunteers. Volunteers go through an application process that includes screening, submitting three references as well as a background check. Two police background checks are conducted and document in file. Volunteers go to the home and assist with bill-paying at least once per month. Using a person centered approach, the level of service is tailored to the person's need and ability. Services may include: budgeting, organization of mail, check-writing for client's signature, and check book reconciliation to the bank statement.

Eligibility and Assessment:

The Program works with our Care Coordination team. At a minimum, the Care Coordinator completes Part A of the Virginia Uniform Assessment Instrument (UAI) to determine eligibility, identify if additional supports are needed. When participants enroll in the program, they get, attached to their copy of the letter of agreement, a large-type card with the program manager's name and telephone number. The same information is on the typed letter of agreement. Clients are reassessment annually.

Monitoring Quality Assurance and Outcome Measurement:

The Money Management Program Manager provides oversight of the program, volunteers and participants to ensure compliance with DARS Service Standards. To ensure quality assurance, the monthly Accounting Form is submitted and there is an annual audit that maintains oversight of ongoing work with each participant. Program participants are surveyed yearly satisfaction, alternating between written via mail and phone call. In addition, yearly audits are conducted at the participant's home, both volunteer and participant are asked if there is any way service could be improved.

Alignment with State Plan:

Our Money Management Program directly supports statewide strategies to promote aging in place and prevent housing instability by helping older adults maintain financial stability and independence. Through personalized financial guidance and support, we address critical needs that can lead to homelessness or displacement.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Money Management

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

Access to financial assistance services for low-income adults aged 60 and over is extremely limited in Richmond and the surrounding counties. Few programs offer monthly, in-home support for tasks such as check writing and financial reviews, critical services that help protect older adults from financial exploitation and housing instability. Existing services often charge fees and do not provide regular, in-person visits to help sort bills, review budgets, or negotiate with creditors to reduce fees and charges. Our Money Management Program fills this gap by offering free, personalized support through trained volunteers and a dedicated part-time staff member. This hands-on approach ensures that vulnerable older adults receive the consistent, trustworthy financial guidance they need to remain safe and independent in their homes.

Service: Outreach/Public Information and Education						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	95100	**People Served**		X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$167,635.00	Title III-B	
$170,603.00	Title III-E	
$19,000.00	General Funds- OAA General	X
	Voluntary Contributions	
$357,238.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option

Service Definition: Outreach/Public Information and Education provides information to older adults and the public about available programs, services, and resources for older adults and their caregivers. This includes reaching out to groups of older adults that may or may not be receiving services. The service may also involve creating special campaigns to raise awareness about issues and benefits important to older people.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)).
Priority is given to those individuals at greatest risk of social isolation, malnutrition and food insecurity, financial insecurity as well as the transportation disadvantaged. Special attention will be given to caregivers, older adults with chronic health conditions, individuals living with Dementia. Key partners are also a target population. Educating these secondary audiences is a strategic imperative. They act as crucial conduits, referring clients to the AAA. Informed partners strengthen the local service network and the effectiveness of the "No Wrong Door" system, ensuring older adults connect with needed services efficiently.

Service Description:

Staffing:

We are operating our outreach efforts with a staff of 2 full time employees. Direct Waiver Request is not required by DARS.

Service Delivery:

PIE Strategies and Activities. We will employ a multi-faceted approach to reach our target populations effectively: 1. Information Dissemination: Develop and distribute accessible materials, including brochures, newsletters, resource guides, and fact sheets, ensuring availability in relevant languages for LEP populations. 2. Community Outreach: Conduct presentations and workshops at senior centers, community hubs, faith-based organizations, libraries, and community events, tailoring content to specific audience needs. 3. Digital Engagement: Utilize the agency website, social media channels, and email communications for information sharing and outreach. 4. Media Relations: Engage local media through press releases and public service announcements to broaden reach. 5.Targeted Campaigns: Implement focused campaigns addressing specific needs or programs. 6. Partnerships: Collaborate with healthcare providers, social service agencies, local government, veteran organizations, and community leaders to cross-promote services and reach diverse populations. 7. Culturally Competent Approaches: Ensure materials and outreach methods are culturally sensitive and accessible, utilizing interpretation services and partnerships with trusted community leaders for minority and LEP groups.

Goals and Expected Outcomes

The overarching goals of this PIE plan are to: 1. Increase awareness and understanding of The Span Center's services among all target populations. 2. Improve access to services, particularly for vulnerable and under served groups. 3. Empower older adults and caregivers with information for informed decision-making. 4. Strengthen community partnerships and the local aging network. Expected outcomes include: 1. Increased inquiries and referrals from target populations. 2. Higher utilization rates for key services 3. Improved community understanding of the agency's role and value. 4. Enhanced collaboration with partner organizations.

Monitoring Quality Assurance and outcome Measurement.

The effectiveness of our PIE activities will be monitored through: 1. Tracking the distribution of materials and participation in outreach events. 2. Collecting data on website traffic and engagement. 3. Analyzing referral sources and service uptake data, particularly among target populations. 4. Gathering feedback from clients, caregivers, and community partners. 5. Aggregating and analyzing information on unmet needs identified through PIE activities to inform future planning.

Alignment with State Plan:

By focusing on prioritized target populations and employing diverse, tailored strategies, we aim to fulfill our mandate, support the goals of the Virginia State Plan for Aging Services, and ultimately enhance the quality of life for older adults, adults with disabilities, and caregivers in our community.

Service: Residential Repair and Renovation						Direct Service Waiver			
Unit Type	Homes Repaired	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Residential Repair and Renovation services offer home repairs and maintenance to older adults which helps seniors maintain their homes according to minimum housing standards or adapt their homes to better meet their needs. The service covers essential repairs and modifications to ensure the health and safety. This includes structural repairs, electrical and plumbing work, weatherization, accessibility and security modifications, as well as yard work and home maintenance tasks critical for wellbeing.

Target Populations:

The Span Center is not operating home modifications through RRR in FY2026. In order to have more fiscal flexibility, we will provide home modification and repair support through emergency services and care coordination, working with partner agencies to ensure homes are safe.

Service Description:

Not Applicable

Service: Socialization and Recreation						Direct Service Waiver			
Unit Type	Hours	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	General Funds- OAA General	
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Socialization and Recreation services provide opportunities for older adults to engage in activities that promote social interaction, mental stimulation, and physical well-being. These services aim to reduce isolation, encourage community involvement, and enhance the quality of life by offering recreational programs, social gatherings, and other engaging activities tailored to the interests and abilities of older individuals. The goal is to support emotional health, foster connections with peers, and encourage active living.

Target Populations:

Socialization and recreation programming will be offered through our Tele-Bridges, Friendship Cafe and DPHP - Wellness Programs in FY2026.

Service Description:

Not applicable.

Service: Volunteer Program						Direct Service Waiver			
Unit Type	Hours	**Total Units**	10900	**People Served**	200	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$247,225.00	Title III-B	
$33,000.00	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$50,000.00	Other Non Federal	
$330,225.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: The Volunteer Program connects seniors with meaningful volunteer opportunities. The service includes informing the community about the need for volunteers, developing meaningful opportunities, and match older adults with suitable volunteer placements. The goal is to provide older adults with opportunities to contribute to their community while enhancing their sense of purpose and social engagement.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Special attention is given to those individuals who are at risk of social isolation and in need of engagement activities.

Service Description:

Staffing:

A full-time Volunteer Program Manager oversees and coordinates all volunteer activities, ensuring smooth operations and meaningful engagement. Two part-time Volunteer Program staff support the program. The program is under the direction of the VP of Advocacy and Engagement.

Direct Service Waiver Requested: See Attached

Service Delivery:

The SPAN Center will recruit, train, place and supervise volunteers in the Agency's programs. Programs will include Checking, Care Coordination, Money Management (VMMP), Nutrition Services, Public information and Education (PIE), Ride Connection, SMP, TeleBridges and the Virginia Insurance and Assistance Program (VICAP).

Volunteer positions will include Clerical Assistant, Client Intake, Volunteer Computer Assistant, Data Entry, Friendship Café Activity Assistant, Meals Volunteer, PIE Outreach Volunteer, VMMP Bill Payer, VMMP Monitor, Ride Connection Quality Assurance Volunteer, SMP Presenter through VICAP, Telephone Reassurance Caller (TeleBridges), VICAP counselor, and VICAP program assistant.

The Volunteer Program offers opportunities for service, social connection, and personal growth, along with ongoing support and recognition for all participants. Contact information for program staff is provided to every volunteer, and an open-door policy encourages continuous feedback to enhance the volunteer experience across all programs.

Eligibility and Assessment:

Volunteers are recruited through outreach, online volunteer portals and through agency programming like the Friendship Cafe volunteers. Volunteers complete an application process which includes conducting reference checks and criminal background checks when required. Volunteers are processed via CRIA encounter of Virginia Quick Form.

Monitoring Quality Assurance and Outcome Measurement:

The Volunteer Program Manager provides oversight of the program, volunteers and participants to ensure compliance with DARS Service Standards. Volunteers are surveyed annually to ensure quality assurance and outcome measures. An annual reassessment for Quick Form data mailed to all volunteers and comment/feedback section is included on mailing.

Alignment with State Plan:

Our Volunteer Programs align with statewide strategies by enhancing the capacity of aging services to support older adults in aging safely and independently in their communities. Volunteers play a vital role in delivering wrap-around services that help prevent housing instability and promote well-being. Through partnerships with community organizations, our programs foster collaboration across sectors and extend the reach of core Older Americans Act (OAA) services. By participating in data tracking efforts, our volunteer initiatives contribute to improved service delivery, measurable outcomes, and a stronger, more responsive aging network.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Volunteer Program

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

The Volunteer Program is a vital component of our agency, significantly enhancing the capacity and reach of key services such as Money Management, Legal Assistance, Outreach, the Ombudsman Program, and VICAP. These programs rely heavily on the dedication and support of volunteers to effectively meet the needs of our clients. Without volunteer involvement, many of these services would be limited in scope and impact. The Volunteer Program also collaborates closely with AmeriCorps Seniors Programs, further strengthening our ability to deliver high-quality, community-based support.

GROUP 5: NUTRITION

Service: Congregate Nutrition						Direct Service Waiver			
Unit Type	Meals	**Total Units**	39000	**People Served**	625	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$895,802.00	Title III-C(1)	
	Title III-E	
$111,934.00	NSIP	
$117,724.00	General Funds- OAA General	X
$139,175.00	General Funds- Supplemental Nutrition	X
$6,000.00	Voluntary Contributions	
$1,212.00	Other Local Funding	X
$1,271,847.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Total Congregate Meal Sites:	

Service Definition: Congregate nutrition services provide nutritious meals to older adults at senior centers or other group settings, ensuring that meals meet the latest dietary guidelines. These meals are designed to support the health and well-being of older adults, with adjustments made for any special dietary needs. In addition to providing balanced nutrition, congregate nutrition sites offer opportunities for socialization and recreation, helping to reduce isolation and foster a sense of community.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Special attention is given to individuals that score at risk for malnutrition on the DETERMINE Your Nutritional Health screening tool and/or have limited access to healthy food as well as at risk for social isolation.

Does the AAA provide emergency meals, in the event of unexpected closure of a congregate site?				
X	**Yes**		**No**	If yes, ensure completion of the Grab and Go service pages.

Meal Preparation and Service:

The Span Center's Congregate Meal Program is known in PSA 15 as the Friendship Cafe Program. Meals are prepared by Morrison's Senior Dining for all localities and delivered chilled to the Friendship Cafes. Trained Cafe Specialists reheat meals on site. Bella Sicilia Restaurant is used occasionally to provide hot meals for our Goochland location.

Efforts to provide innovative/modernized congregate nutrition services:

The Friendship Cafes offer a variety of innovative meal services such as culturally inclusive meals, themed events, cafe style settings and meals at local restaurants. Our Registered Dietitian's (RD) efforts have improved meal quality and variety. our RD has also incorporated nutrition education by providing fresh vegetables "to go" with easy recipes for participants to use at home. Socialization during meals improves connection and sense of community.

Nutrition Assessments, Referral and Screening Information:

The process starts with the Friendship Cafe Application once received an appointment at the cafe is setup to conduct the assessment by Span Center staff, using the Friendship Cafe Assessment Tool an enhanced VA Quick Form which includes poverty and reference data, nutrition screening (NSI) and the Virginia Uniform Authorization Form. Client assessment data is documented in the DARS-VDA approved electronic client data base.

Program Evaluation for Effectiveness:

VP of Nutrition, Wellness and Transportation or Nutrition and Wellness Program manager monitors cafes annually. Congregate evaluations are completed using the Monitoring Tool provided by DARS by a ServSafe certified staff member. Client outcome surveys that include program outcome as well as satisfaction that is in alignment with our Logic Model. Surveys are conducted twice a year to participants and also the café specialists. Analysis is done to ensure high participant satisfaction.

Vendors or Subcontractor Monitoring Process and Frequency:

The Program is monitored by the VP of Wellness, Nutrition and Transportation ensure data quality and adherence to DARS Service Standards. Our contracted provider, Morrison's Senior Dining kitchen, is monitored annually using the DARS monitoring tool by a ServSafe certified staff member. We also use Bella Sicilia Restaurant for occasional meals for our Goochland Friendship Cafe. VDH inspection reports are reviewed annually to monitor food safety.

Service Description:

22 Cafes are staffed by 18 paid Cafe Specialists managed by the Nutrition and Wellness Program Manager and supported by Nutrition and Transportation Coordinator and Nutrition Coordinator and the Registered Dietitian all supervised by VP of Nutrition, Wellness and Transportation. In addition to serving healthy meals in a group setting, the program offers opportunities for social engagement and activities. The goal that participants experience decreased food insecurity, reduced social isolation and improved nutritional and physical health in alignment with the state plan.

Nutrition Site Information:				
	Site Name and Street Address	City or County of Site	Days and Hours of Operation	Food Provider
1	Linwood Robinson 700 N. 26th Street	Richmond	Tuesday *	Morrison's Senior Di
2	Charles City Social Center, 13100 The Glebe Ln	Charles City	Mon, Tues, Thurs *	Morrison's Senior Di
3	Powhatan Friendship Cafe, 2253 Rosson Rd	Powhatan	Mon, Tues, Thurs *	Morrison's Senior Di
4	Signs & Wonders FC, 6415 Irongate Dr.	Chesterfield	Monday and Tuesday *	Morrison's Senior Di
5	Market Square, 7300 Taw Street	Chesterfield	Wednesday *	Morrison's Senior Di
6	Deep Run FC, 9900 Ridgefield Pkwy.	Henrico	Tuesday and Thursday *	Morrison's Senior Di
7	New Kent FC, 6160 Pocahontas Trail	New Kent	Tuesday and Thursday *	Morrison's Senior Di
8	CAPUP Senior Center, 1103 Oliver Hill Way	Richmond	Tues, Wed, Thurs *	Morrison's Senior Di
9	Good Shepherd Baptist Church, 1127 N. 28th St	Richmond	Mon, Wed, Thurs *	Morrison's Senior Di
10	Shiloh Baptist Church, 106 S. James St.	Ashland/Hanover	Mon, Tues, Wed, Thurs *	Morrison's Senior Di
11	Western Henrico Cafe 7612 Wanymala Rd.	Henrico	Monday, Wednesday *	Morrison's Senior Di
12	Oakwood Cafe, 3100 Gay Avenue	Henrico	Mon, Tues, Wed, Thurs *	Morrison's Senior Di
13	Montpelier FC, 17203 Mountain Rd.	Hanover	Thursday *	Morrison's Senior Di

14	Korean Cultural/Senior Ctr., 1021 German School Rd	Richmond	Wednesday *	Morrison's Senior Di
15	Monarch Woods FC, 6501 Jahnke Rd.	Chesterfield	Tuesday and Wednesday *	Morrison's Senior Di
16	Bon Air Presbyterian, 9201 W. Huguenot Rd.	Chesterfield	Monday and Thursday *	Morrison's Senior Di
17	Randolph Community Center, 1415 Grayland Ave	Richmond	Tuesday, Wednesday *	Morrison's Senior Di
18	Rockwood Village, 3901 Price Club Blvd.	Chesterfield	Wednesday *	Morrison's Senior Di
19	Guardian Place, 1620 N. Hamilton St.	Richmond	Tuesday and Thursday *	Morrison's Senior Di
20	Mechanicsville Methodist, 7356 Atlee Rd.	Hanover	Tuesday and Wednesday *	Morrison's Senior Di
21	Battery Park Christian, 4201 Brook Rd.	Richmond	Wednesday *	Morrison's Senior Di
22	Battery Park Christian, 4201 Brook Rd.	Goochland	Monday and Friday *	Morrisons/Bella Sicill
23			* all open 9:30 am to 1:00	
24				
25				
26				
27				

Service: Grab and Go Nutrition

Title III Funding Source:	X	**Title III-C(1)**		**Title III-C(2)**

Grab and Go Nutrition funded with Title III-C(1) can be provided (check the applicable scenarios):

X	(A) During disaster or emergency situations affecting the provision of nutrition services and
X	(B) To older individuals who have an occasional need for such meal

For Grab and Go Nutrition funded with Title III-C(2) only, address Grab and Go in the Home Delivered Nutrition service page. **For Title III-C(1) funded Grab and Go Nutrition:**

Address how Grab and Go will enhance and not diminish the congregate meals program. Describe how the agency will monitor the impact on Congregate Nutrition. Provide detailed evidence based on current participant data and program projections:

The AAA attests that it will not exceed the 25% cap on C1 funding for Grab & Go meals for the Area Plan year.

To monitor the impact on the C1 Program, the AAA will:
1) track units and expenditures provided on at least a quarterly basis to ensure the AAA does not exceed the 25% cap;
2) monitor attendance at C1 sites to ensure there are no adverse impacts (e.g., decline in attendance);
3) integrate questions about the experience with Grab & Go Meals into the AAA's satisfaction surveys for C1 participants; and
4) include Grab & Go Meals in the AAA's annual program evaluation process.

Target Populations:

The AAA will target individuals with greatest economic need (GEN) and greatest social need (GSN) for this service.

Eligibility Criteria:

Eligibility for Grab & Go using III-C(1) funds will be those individuals who qualify for the regular III-C(1) program and who are existing or active III-C(1) participants.

Address how the AAA consulted with nutrition and direct service providers, interested parties and the general public on the need for Title III-C(1) Grab and Go:

The AAA has sought and will seek public input in the development of the Area Plan, with specific notice about the Grab & Go Meal provision, through the AAA's public hearing to be held on July 8, 2025 and through the 30-day public comment period from June 20, 2025 to July 18, 2025. We are hosting a special session with our Advisory Council on June 23, 2025. The AAA consulted with the AAA's Registered Dietitian, Cafe Specialists and Friendship Cafe participants in June 2025 who are all in support of the program.

Service Implementation:

The Span Center will offer shelf stable emergency boxes at least twice a year to congregate meal program participants - also known as Friendship Cafe participants. The Span Center will also offer Grab and Go meals prepared a contract food provider, Feed More, our meal contractor or restaurant with direction from our registered dietitian. Meals will be delivered to the cafes and distributed to participants to take home. Friendship Cafe staff will administer this program.

The Program is monitored by the VP of Wellness, Nutrition and Transportation ensure data quality and adherence to DARS Service Standards. The goal that participants experience decreased food insecurity and improved nutritional and physical health in alignment with the state plan.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Congregate Nutrition

Reason for the Direct Service Waiver request (check all that apply):

X	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

Congregate Nutrition - There are currently no service providers in PSA 15 who are able to provide the necessary on-site supervision and programming for all of the congregate meal sites. The Span Center employes Cafe Specialists for the congregate sites. These individuals are responsible for tracking meals, checking food temperatures, serving food, preparing monthly activity calendars, planning and implementing daily activities, scheduling guest speakers, and tracking disease prevention and socialization activities. Meals are provided with a contract with Morrison's Senior Dining.

Service: Home Delivered Nutrition						Direct Service Waiver			
Unit Type	Meals	**Total Units**	168000	**People Served**	1100		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$1,249,042.00	Title III-C(2)	
	Title III-E	
	NSIP	
	General Funds- OAA General	X
$568,073.00	General Funds- Home Delivered Meals	X
	General Funds- Supplemental Nutrition	X
	Voluntary Contributions	
$1,817,115.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	Feed More	Not-for-Profit
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Home Delivered Meals provide eligible clients with nutritious, balanced meals delivered directly to their homes. Meals comply with the latest dietary guidelines. The service accommodates special dietary needs and ensures food safety in handling, preparation, and delivery. This service is intended for homebound individuals who are unable to leave home and attend social activities and does not have access to proper nutrition and transportation.

Target Populations:

Home Bound persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)).

Special attention is given to individuals that score at risk for malnutrition on the DETERMINE Your Nutritional Health screening tool and/or have limited access to healthy food as well as at risk for social isolation.

Types of Home Delivered Meals Served (check all that apply):									
X	**Frozen**	X	**Chilled**		**Shelf Stable**		**Hot**		**Other:**

Meal Preparation and Delivery:

The Span Center contracts with Feed More, a local non-profit Meals on Wheels program to deliver a meal to HDM clients. Meals are prepared in a central kitchen at Feed More. Depending on the situation, meals are either chilled or frozen, with instructions on how to safely store and reheat the meal. Meals are delivered Monday-Friday 10:30am-1:00 pm by either a Feed More staff member or a friendly volunteer.

Emergency Meal Provision- Type and Frequency:

Special circumstances such as inclement weather or recently, ongoing water issues in the Richmond area, require Feed More to make provisions to deliver frozen emergency meals to all HDM clients. In certain circumstances, they will deliver water with the meal.

Nutrition Assessments, Referral and Screening Information:

The CRIA team serves as intake, who review applications from Feed More, self-referrals or from other organizations. A Care Coordinator assesses using: First 4 pages of the Virginia Uniform Assessment Instrument, DETERMINE Your Nutritional Health screening tool, federal poverty level and consent. Annual reassessments are conducted by Nutrition staff and/or Care Coordinators.

Program Evaluation of Effectiveness:

The Span Center conducts surveys once a year, we also review Feed More's customer satisfaction surveys and route surveys to monitor the program. Analysis of survey results are assessed to insure high participant satisfaction with the HDM'S aligning with the state plan goals.

Vendor or Subcontractor Monitoring Process and Frequency:

The VP monitors program ensure data quality and adherence to DARS Service Standards. Feed More is monitored annually, the DARS Monitoring tool, by a ServSafe certified staff member. The Span Center RD reviews menu to ensure compliance to the current Dietary Guidelines for Americans aligning with state plan goals. Meals are spot checked periodically.

Service Description:

In addition to providing home delivered meals to older individuals who are homebound or isolated, this program provides a wellness and safety check, nutrition education quarterly, individual nutritional counseling, social engagement through friendly volunteers and connections to other services. This program is coordinated through a HDM Program assistant and supported by the CRIA and Care Coordination teams who assist referrals, screening and assessments as stated above. The HDM Program Assistant coordinates the service with Feed More - supervised by the VP of Nutrition, Wellness and Transportation. The goal that participants experience decreased food insecurity, reduced social isolation and improved nutritional and physical health in alignment with the state plan.

HOME DELIVERED MEALS INFREQUENT DELIVERY WAIVER

Section 336 of the Older American Act establishes "nutrition projects for older individuals that provide—on 5 or more days a week (except in rural areas where such a frequency is not feasible and a lesser frequency is approved by the State agency) at least 1 home delivered meal per day, which may consist of hot, cold, frozen, dried, canned, or fresh foods and, as appropriate, supplemental foods and any additional meals that [the Area Agency on Aging] elects to provide."

An essential component of the Home Delivered Meal (HDM) program is the social interaction and well-being check that naturally occurs during meal delivery. Within the broader aging network, there are concerns that this vital aspect of the HDM program may be lost when bulk meals are delivered less frequently, particularly in rural areas where participants are often isolated or vulnerable, and/or they may lack other sources of contact. Further, there is also a concern that commercial carriers, like FedEx or UPS, whose primary focus is on package delivery, are not designed to address the social, safety, nutritional, or functional needs of HDM participants. While there are financial constraints that also impact HDM programs, especially in rural areas, commercial delivery of home delivered meals should really only be reserved for the small percentage of participants who are geographically isolated and cannot be reached by regular HDM routes, if applicable.

Not all Area Agencies on Aging (AAAs) are eligible to request a Home Delivered Meals Infrequent Delivery (HDM-ID) Waiver. Agencies eligible to request a HDM-ID Waiver must have at least 50 percent or more of the localities within their planning and service area (PSA) defined as "rural" using the same definition provided in the State Plan for Aging Services Intrastate Funding Formula (IFF).

Eligible AAAs that deliver meals less than weekly to 25 percent or more of their total HDM participants due to feasibility constraints must, in cooperation with any service provider(s), develop and submit a HDM-ID Waiver for DARS review and approval through the Area Plan.

The HDM-ID Waiver must be submitted for review and approval prior to the AAA reducing their delivery frequency to less than weekly and must be updated when significant changes are made to the Area Plan.

Waiver Validity and Expiration: Provided there are no concerns with an AAA's implementation of an approved HDM-ID Waiver, DARS will consider approved HDM-ID Waivers to be valid for the duration of the Area Plan Cycle. Annually, DARS will review rural locality designations during the IFF process to determine if an AAA with an existing HDM-ID Waiver will need to submit a HDM-ID Transition Plan to discontinue its HDM-ID program prior to the start of the next Area Plan Cycle. AAAs that lose their rural qualification for a HDM-ID Waiver in Year 4 of an Area Plan Cycle will have 1 additional FFY (i.e., Year 1 of the new Area Plan Cycle) to continue operating its HDM-ID program, however, the AAA must be in compliance with the HDM requirements by Year 2 of the new Area Plan Cycle.

HOME DELIVERED MEALS INFREQUENT DELIVERY (HDM-ID) WAIVER FORM

The Area Agency on Aging (AAA) requests a HDM-ID Waiver due to the feasibility of providing at least 1 home delivered meal per day on 5 or more days per week in a rural area:

PSA #: -select- Click Here *Select the PSA # from the drop down list then click the button to auto fill the localities within the PSA. Returning to -select- then clicking the button clears the fields.*

Select the localities within the PSA where meals are delivered less than weekly and state the method and frequency of delivery for those localities:			
	Locality	**Method**	**Frequency**
	N/A		

Total number of participants receiving HDMs in the PSA:	
Total number of participants receiving less than weekly delivery:	
Percentage of HDM-ID participants:	

What is the AAA's **specific criteria** for identifying HDM clients who are most vulnerable?

The Span Center is not requesting a HDM infrequent delivery waiver.

Describe the AAA's plan for contact of socially isolated and vulnerable HDM-ID participants: The Span Center is not requesting a HDM infrequent delivery waiver.
How will the AAA provide access to Nutrition Education and Nutrition Counseling for these participants? The Span Center is not requesting a HDM infrequent delivery waiver.
Describe how the AAA will monitor and evaluate the success of HDM-ID implementation. For Waiver Renewals, please also include a summary of the outcomes of the existing HDM-ID implementation for the current or prior Area Plan Cycle. The Span Center is not requesting a HDM infrequent delivery waiver.

For New HDM-ID Waiver Requests or for Renewals of HDM-ID Waiver Requests at the Start of a New Area Plan Cycle: Separately, the AAA should also submit to DARS for review the following documents:

- HDM-ID Plan
- AAA Registered Dietitian Nutrient Analysis/Meal Pattern documentation
- Governing Board and Advisory Council Approved HDM-ID Policy or Minutes from the Governing Board and Advisory Council Meetings that Outlined the HDM-ID Policy
- Current Food Vendor Contract/Agreement (for Renewals of HDM-ID Waivers)
- Commercial Package Delivery Procedures (if applicable)

Registered Dietitian Information			
Total Number of Hours Worked			Full-time Employee
15	Hours per week or		Part-time Employee
	Hours per month	X	Contractor/Consultant

Service: Nutrition Counseling						Direct Service Waiver			
Unit Type	Hours	Total Units	40	People Served	30		Yes	X	No

Proposed Expenditure Amount	Funding Source	Match Funding
$4,000.00	Title III-C(1)	
$4,000.00	Title III-C(2)	
	General Funds- OAA General	X
	General Funds- Supplemental Nutrition	X
	Fees	
$8,000.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	Dietitians On Demand	For Profit
		Select Option
		Select Option
		Select Option

Service Definition: Nutrition Counseling is a personalized, evidence-based service designed to assess, educate, and support older adults, who are at nutritional risk due to factors such as health or nutrition history, dietary intake, chronic illnesses, or medication use. Provided one-on-one by a registered dietitian, this service addresses the unique dietary needs, health conditions, and lifestyle considerations of older adults.

Target Populations:

The target population are adults 60 years and older who attend Congregate Meal sites, also known as Friendship Cafe, or receive Home Delivered Meals and score at risk for malnutrition on the DETERMINE Your Nutritional Health screening tool and/or have limited access to healthy food as well as at risk for social isolation.

Staff Qualifications for Service Delivery:

The Span Center contracts with Dietitians On Demand. The contracted individual for providing nutrition education is a Registered Dietitian (RD).

Screening & Assessment:

All participants attending the Friendship Cafes and Home Delivered Meals program are screened using the evidence-based screening tool: DETERMINE Your Nutritional Health. Individuals who score for being at high risk for malnutrition and/or answer "yes" to question: Without wanting to, I have lost or gained 10 pounds in the last 6 months? are referred to the Registered Dietitian for Nutrition Counseling. These participants are contacted by the RD and receive additional screening using page 6 of the Virginia Uniform Assessment instrument. Based on individual choice, the RD can provide follow-up to assess, identify new concerns as well as document changes over time and improvement in nutrition.

Program Evaluation:

The Program is monitored by the VP of Wellness, Nutrition and Transportation ensure data quality and adherence to DARS Service Standards. For quality assurance and outcome measures, Friendship Cafe participants are given a program evaluation survey bi-annually to include specific questions regarding nutrition counseling, increased knowledges and making healthier choices at home. RD monitors and documents improvements for individuals clients.

Service Description:

Using a person-centered approach, the RD develops a Nutrition Plan through a one-on-one counseling session via telephone that identifies needs, strengths and barriers to nutrition. The goal of the Nutrition Plan is to support individual choice while helping to mitigate the risks of malnutrition and improve nutritional status. RD follow ups as needed to assess, identify new concerns as well as document changes over time and improvement in nutrition. This service is offered free of charge and open to those HDM and Friendship Cafe participants with a high risk of malnutrition. Educational materials are either mailed or emailed. Our goal to improve nutritional health and food security and decrease risk for malnutrition for program participants aligns with the state plan.

Service: Nutrition Education						Direct Service Waiver			
Unit Type	Sessions	Total Units	3500	People Served	475		Yes	X	No

Proposed Expenditure Amount	Funding Source	Match Funding
$31,000.00	Title III-C(1)	
$31,000.00	Title III-C(2)	
	General Funds- OAA General	X
	General Funds- Supplemental Nutrition	X
	Fees	
$62,000.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	Dietitians On Demand	For Profit
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Nutrition education is a program aimed at promoting better health and well-being by providing accurate, culturally sensitive information and instruction on nutrition, physical fitness, and overall health. This service is offered to older adults, caregivers, or both, in either group or individual settings, and is overseen by a registered dietitian or an individual with comparable expertise. The program focuses on reducing hunger, food insecurity, and malnutrition, while encouraging socialization and helping to delay the onset of adverse health conditions.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Priority is given to participants enrolled in the Home Delivered Meals and Congregate Nutrition (Friendship Cafe) Programs.

Staff Qualifications for Service Delivery:

The Span Center contracts with Dietitians On Demand. The contracted individual for providing Nutrition Education is a Registered Dietitian (RD). In an effort to build capacity, the RD trains Cafe Specialists to deliver additional Nutrition Education to all Friendship Cafe participants throughout the year. This education includes a scripted message with supporting materials designed by RD.

Frequency of Service for both Congregate and Home Delivered Participants:

Nutrition Education is offered quarterly, a minimum of 10 hours through monthly newsletters, train the trainer sessions and RD visits to Friendship Cafes. Educational topics are created using feedback from participants and/or risks identified on the nutrition screening tool that affect the majority of the participants. Supplemental materials - like recipes or educational materials are also given. HDM clients receive education through fliers delivered with their meals.
At least once a year the topic will be inclusive of food safety for all programs.

Annual Education Plan Accommodations for Older Adult Learners:

Materials are large type with font no less than 12 point, adequate white space and dark print. All materials will be written using plain language and simple, direct wording. After a topic is presented, written notes are provided for later reference. During live presentations, the RD will encourage dialogue, questions and feedback so that clarification can be offered and comprehension can assessed.

Program Evaluation:

The Program is monitored annually by VP ensure data quality and adherence to DARS Service Standards. For quality assurance and outcome measures, Friendship Cafe and Home Delivered participants are given a program evaluation survey bi-annually to include specific questions regarding nutrition education, increased knowledge and making healthier choices at home.

Service Description:

The RD will plan and direct all in-person and train the trainer sessions for Nutrition Education as well as any written educational materials. All content will be consistent with the Dietary Guidelines for Americans. All educational materials will be accurate, culturally sensitive, regionally appropriate and consider personal preference. The program participants will be provided nutrition education information quarterly. When appropriate, RD will work with Feed More's RD, our contractor for HDM. Our goal to improve nutritional health and food security and decrease risk for malnutrition for program participants aligns with the state plan.

GROUP 6: DISEASE PREVENTION/HEALTH PROMOTION

Service: Disease Prevention/Health Promotion						Direct Service Waiver			
Unit Type	Sessions	**Total Units**	6750	**People Served**	375	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
$37,768.00	Title III-D	
$10,000.00	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$47,200.00	Other Non Federal Funds	
$94,968.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Disease Prevention/Health Promotion programs use evidence-based strategies to enhance health, prevent disease, and improve quality of life in aging populations. These programs are designed to address the unique health challenges faced by older adults, such as chronic diseases, mobility issues, and mental health concerns, by promoting healthier behaviors, increasing physical activity, improving nutrition, and encouraging social engagement.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas. (OAA Section 306(a)(1)). Priority is given to individuals with chronic conditions, mobility and/or high fall risk concerns, and social isolation.

List the specific evidence-based services provided:

Chronic Disease Self-Management Program, Chronic Pain Self-Management Program, Diabetes Self-Management Program, Matter of Balance - Falls Prevention Program, Walk with Ease for Arthritis Program, Tai Chi for Arthritis and Falls Prevention Program

Program Staffing:

The DPHP Program is coordinated through a Master Trainer/Health & Wellness Coordinator, a Span Center; Trained volunteers - Leaders and Coaches. The DPHP program is supervised by the VP of Nutrition, Wellness and Transportation.

Service Locations:

DPHP Programs are offered throughout PSA15. The Span Center hosts sessions at local libraries, community centers, parks and recreation centers, churches, physician's offices, medical centers and rehabilitation centers. Externally we partner with health systems, the YMCA and 55+ communities. Internally, we partner with various programs, including The Friendship Cafe.

Participation Tracking:

Staff track attendance and upon completion of the program administers participant evaluation forms. Upon completion of programs, participants and given a certificate. Participants are entered into the NWD technology, Peer Place, enrolling in DPHP where units are captured.

Screening:

Individuals must self-identify as being able to participate in programs on their own. A Physical Activity Readiness Form (Par Q) is required for specific programs. The Par Q is a self-screening tool used by fitness trainers and coaches to determine the safety or possible risks of exercising based on your health history, current symptoms and risk factors.

Assessments:

The Span Center enrolls participants via a CRIA encounter or Virginia Service Quick Form which includes federal poverty level.

Service Description:

All our DPHP programs are evidence-based programs and facilitated by a trained staff member of volunteers. They help participants manage their chronic condition, develop strategies to prevent falling, improve wellbeing, encourage exercise, proper medication use, communicate with their health professionals, understand and improve nutrition, and how to address feelings of sadness, anger, fear and frustration. is designed to reduce the fear of falling and encourage activity and make changes to reduce fall risk at home and exercise to increase strength and balance. These programs align with the state plan to deliver evidence-based programs that encourage healthy, active, and engaged lives.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Disease Prevention/Health Promotion

Reason for the Direct Service Waiver request (check all that apply):

X	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

The Span Center provides its own wellness programming. Although there are multiple health systems in our area, there programs are fragmented and location based and does not serve PSA15. Our trained and certified staff can support wellness efforst across the PSA 15 and provide services within each locatlity.

Service: Health Education and Screening						Direct Service Waiver			
Unit Type	Hours	Total Units		People Served			Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$ 0.00	Total Proposed Expenditures	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Health Education and Screening services are designed to promote the well-being of older adults by providing essential information and assessments to support their health needs. Health education offers targeted information or materials on age-related diseases, chronic conditions, prevention, self-care, and independence, focusing on prevention, diagnosis, treatment, and rehabilitation. Health screening services include comprehensive assessments to determine an individual's current health status, aiming to detect or prevent common illnesses in older adults. These services may also include counseling, follow-up, and referrals to ensure optimal care and support for the individual's health and wellness.

Target Populations:

The Span Center does not offer education and screening services as a stand alone service. Nutrition and wellness programming is offered through DPHP, Friendship Cafe and through other programs.

Service Description:

Not Applicable.

GROUP 7: NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM: ADDITIONAL SERVICES

Service: Individual Counseling						Direct Service Waiver			
Unit Type	Hours	Total Units	450	People Served	200	X	Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
$ 115,067.00	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
$ 15,000.00	Other Non Federal	
$130,067.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Individual counseling provides personalized support to individuals caring for older relatives. This service offers guidance on managing caregiving stress, preventing burnout, improving communication with the care recipient, and accessing resources. Delivered by a trained professional, it aims to enhance caregiver well-being and resilience, helping them balance their own needs with those of the person they care for.

Target Populations:

Caregivers who are informal providers of in-home and community care to an individual who is 60 or older or an individual who is less than 60 and has a diagnosis of early onset dementia.

Grandparents or relative caregivers (related by blood, marriage, or adoption), 55 or older, who provide informal care to a child not more than 18 or an individual 19-59 who has a severe disability. (OAA Section 373(c)(2))

Service Description:

Staffing:

The agency employees a full-time Caregiver and In-Home Support Manager who supervises a full-time Caregiver Support Coordinator. Staff work collaboratively to ensure the needs of both the caregiver and care recipient are addressed in a comprehensive care plan. Staff undergoes a thorough background check and receives comprehensive training to maintain high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services.

Direct Service Waiver Requested: See Attached

Service Delivery:

Individual Counseling helps identify a need for assistance for caregivers and care partners regarding training, support, respite care, and system navigation. These supportive services enhance a caregiver's ability to provide informal care for as long as appropriate. A person-centered trauma informed (PCTI) approach is used when working with the caregivers. Caregivers may be supported on an ongoing basis for as long as they desire to accommodate the changing needs and emotions associated with a lengthy caregiving journey. Care can be provided by family caregivers, grandparents, or other older individuals who are relative caregivers. Caregivers are referred by internal staff, other agencies, friends/family of self-referral.

Individual Counseling can be provided via phone, email or face-to-face in their home or at another location that provides the caregiver comfort and privacy. The sharing of information empowers caregivers to make decisions, connect with needed resources, recognize the value of self-care, and resolve concerns relating to caregiving roles. When calls are received, active listening skills are used to assess the concerns of the callers, and they are encouraged to identify their distress and needs during the conversation. The information gathered is used to identify possible options and resources with the caller within a person-centered care framework.

Outreach to caregivers is a critical component to this program. Outreach efforts include:

1) collaboration with other organizations that also support caregivers
2) local governments and aging network
3) community and caregiver events.

Eligibility and Assessment:

Individuals self-identify as a caregiver and are enrolled in the program per DARS standards. A CRIA encounter or the Virginia Service Quick Form and Federal Poverty Level is completed per participant.

Monitoring Quality Assurance and Outcome Measurement:

The program is monitored annually by the Chief Programs Officer to ensure compliance with DARS standards. Quality assurance and outcomes are measured via a survey to determine if they found this service helpful and would recommend it to others.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Individual Counseling

Reason for the Direct Service Waiver request (check all that apply):

	Providing services by the AAA is necessary to assure an adequate supply
X	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

National Family Caregiver Support Program (NFCSP) provides a multifaceted support system that helps families sustain their efforts to care for an older individual or child or a relative with severe disabilities. These support services, which do not supplant the role of the family as caregiver but enhances their ability to provide informal care for as long as appropriate, shall be provided to family caregivers, grandparents, or other older individuals who are relative caregivers.

The Span Center provides individual counseling to caregivers to reduce caregivers' burden. The Caregiver Support program staff that provides this counseling are uniquely qualifed to support caregivers through their knowledge of the bio-psycho-social impacts of aging, are trained in person-centered trauma-informed practices, have in-depth knowledge of resources and supports available to caregivers in the community, and are able to quickly connect caregivers directly to the services provided by The Span Center that will support their caregiving journey (eg. Caregiver Training, Home Delivered Meals, In-home Care, Insurance Counseling, Transportation Services, etc.) The quality and efficiency of individual counseling services cannot be matched by entieies outside of the agency.

Service: Support Groups						Direct Service Waiver			
Unit Type	Sessions	**Total Units**		**People Served**			**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Support Groups provide a supportive environment for caregivers to connect, share experiences, and receive emotional support. Facilitated by a trained professional, these groups offer a space to discuss caregiving challenges, share coping strategies, and gain practical advice from others in similar situations. The goal is to reduce caregiver stress, prevent burnout, and promote emotional well-being through peer support and community resources.

Target Populations:

The Span Center supports caregivers through individual counseling, training and respite and does not request IIIE federal funding for Support Groups.

Service Description:

Not applicable. The Span Center does not offer this program.

Service: Caregiver Training						Direct Service Waiver			
Unit Type	Hours	Total Units	350	People Served	250	X	Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
$74,381.00	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
$33,100.00	Other Non Federal	
$107,481.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Caregiver Training provides caregivers with the knowledge and skills needed to deliver effective care. This service covers essential topics such as managing medical conditions, assisting with daily activities, understanding safety protocols, communication techniques, and coping with the emotional challenges of caregiving. Delivered by healthcare professionals or trained instructors, the training aims to enhance the caregiver's confidence, competency, and ability to provide high-quality care while promoting their own well-being.

Target Populations:

Caregivers who are informal providers of in-home and community care to an individual who is 60 or older or an individual who is less than 60 and has a diagnosis of early onset dementia.
Grandparents or relative caregivers (related by blood, marriage, or adoption), 55 or older, who provide informal care to a child not more than 18 or an individual 19-
59 who has a severe disability. (OAA Section 373(c)(2))

Service Description:

Staffing:

The agency employees a full-time Caregiver and In-Home Support Manager who supervises a full-time Caregiver Support Coordinator. Staff work collaboratively to ensure the needs of both the caregiver and care recipient are addressed in a comprehensive care plan. Staff undergoes a thorough background check and receives comprehensive training to maintain high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services.

Direct Service Waiver Requested: See Attached

Service Delivery:

The Span Center's Caregiver Training Program helps caregivers: increase their knowledge of how to best interact with and provide care for as long as possible as well as empowers caregivers to make decisions and solve problems related to their caregiving roles. The Span Center offers many programs to caregivers to engage as they can and choose.

1) Evidence-based education program called "Powerful Tools for Caregivers" (PTC). PTC is offered virtually at no charge several times throughout the year. This evidence-based curriculum will be facilitated by two trained class leaders, who are The Span Center employees or partners. The program is evaluated by surveys at the end of the six-week class series.

2) Caregiver educational webinars throughout the year, focusing on a variety of topics important to caregivers, including but not limited to legal documents for caregivers, community resources, stress management, dementia communication and advance planning. Webinars are hosted by Caregiver Support staff and occasionally subject matter experts. Online Surveys will be administered immediately following the webinars to gauge effectiveness of webinars as well as to inform future webinar topics.

3) In-Person or Virtual Topics Training throughout the year may be offered in-person or virtually, addressing topics such as behavioral issues, family dynamics, living situations, and caregiver self-care. Training will be offered on-site, and throughout the community in libraries, rec centers, etc. to provide service throughout the planning district. As funding is available, transportation and respite care may be made available for caregivers needing these services to assure they are able to attend the training.

Eligibility and Assessment:

Individuals self-identify as a caregiver and are enrolled in the program per DARS standards. A CRIA encounter or the Virginia Service Quick Form and Federal Poverty Level is completed per participant. Income and age are not factors for participating in the training. The ages of participants ranged from 22 to 84 years old. Referrals to the program include self-referral, care coordinators, other agencies, outreach by The Span Center or a family member or friend.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Caregiver Training

Reason for the Direct Service Waiver request (check all that apply):

X	Providing services by the AAA is necessary to assure an adequate supply
	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

National Family Caregiver Support Program (NFCSP) provides a multifaceted support system that helps families sustain their efforts to care for an older individual or child or a relative with severe disabilities. These support services, which do not supplant the role of the family as caregiver but enhances their ability to provide informal care for as long as appropriate, shall be provided to family caregivers, grandparents, or other older individuals who are relative caregivers.

The Span Center Caregiver Training programs reduce caregivers' burden by providing education on topics that are essential for caregivers.

The Caregiver Support program staff that faciliates the Caregiver Training are uniquely qualified to support caregivers through their knowledge of the bio-psycho-social impacts of aging, are trained in person-centered trauma-informed practices, have in-depth knowledge of resources and supports available to caregivers in the community, and are able to quickly connect caregivers directly to the services provided by The Span Center that will support their caregiving journey (eg. Caregiver Individual Counseling, Home Delivered Meals, In-home Care, Insurance Counseling, Transportation Services, etc.). Training can include disease specific communication techniques, healthcare systems navigation, practical skills, accessing community resources and self-care education.

Service: Respite Voucher						Direct Service Waiver			
Unit Type	Vouchers	**Total Units**	5	**People Served**	5		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
$2,500.00	Title III-E	
	General Funds- OAA General	X
	General Funds- Community Based	X
	Voluntary Contributions	
	Fees	
$2,500.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option

Service Definition: A Respite Voucher is designed to provide temporary relief to caregivers by providing the opportunity to take a break from their caregiving duties by providing financial assistance or vouchers that can be used to pay for respite care services.

Target Populations:

Caregivers who are informal providers of in-home and community care to an individual who is 60 or older or an individual who is less than 60 and has a diagnosis of early onset dementia.
Grandparents or relative caregivers (related by blood, marriage, or adoption), 55 or older, who provide informal care to a child not more than 18 or an individual 19-59 who has a severe disability. (OAA Section 373(c)(2))

Service Description:

Staffing:
The agency employees a full-time Caregiver and In-Home Support Manager who supervises a full-time Caregiver Support Coordinator. Staff work collaboratively to ensure the needs of both the caregiver and care recipient are addressed in a comprehensive care plan. Staff undergoes a thorough background check and receives comprehensive training to maintain high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services.

Direct Service Waiver Not Requested:
This is The Span Center's sole consumer/self-directed program.

Service Delivery:
This self-directed program provides reimbursement to a caregiver providing care and/or supervision to another person diagnosed with chronic disease or disability. The caregiver is responsible for hiring a provider of their choosing to provide the respite care on a temporary basis. Reimbursement is limited to $595 per family. The caregiver must provide sufficient proof of payment that services have been rendered prior to receiving reimbursement. The Span Center will allow partial reimbursements when the caregiver requests this option instead of the full respite amount of $595.

The Span Center Caregiver Respite Voucher also includes reimbursement to Grandfamilies and Kinship Caregivers for the cost of childcare or recreational camps so that caregivers can rest and recharge. To be eligible for this program, caregivers must live in PSA15, be a kinship caregiver raising a minor child, and must have custody of that child.

Eligibility and Assessment:
Caregivers are enrolled via CRIA Encounter/Virginia Caregiver Form which includes federal poverty level. Part A of Virginia Uniform Assessment Instrument and/or current documentation of diagnosis from a medical professional will be used to determine eligibility and assess need.

Monitoring Quality Assurance and Outcome Measurement:
The program is monitored annually by the Chief Programs Officer to ensure compliance with DARS standards. Quality assurance and outcomes are measured via survey after completion of the program. Caregivers are asked to complete a survey to rate satisfaction with the process and outcomes.

Alignment with State Plan:
Caregiver Training improves access to all resources and services that support all caregivers and help them provide a high quality of care for their loved ones.

Service: Institutional Respite						Direct Service Waiver			
Unit Type	Hours	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	General Funds- Community Based	X
	Voluntary Contributions	
	Fees	
		X
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option

Service Definition: Institutional Respite is a type of respite care that is provided in a specialized facility or institution, rather than in the home or community setting. This form of respite care allows caregivers to temporarily place their loved one in a residential care facility where trained staff provide supervision, assistance with daily activities, and healthcare support. The facility may be a nursing home or a dedicated respite care facility.

Target Populations:

The Span Center does not provide this program as focus is on in-home respite as that is reflective of what we hear during listening sessions as a priority.

Service Description:

Not Applicable. The Span Center does not provide this program.

Service: Other (Respite Services)						Direct Service Waiver			
Unit Type		Total Units		People Served			Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	
	General Funds- Community Based	
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: A respite service that does not fall into the previously defined respite service categories. This includes non-traditional services that provide relief or are respite specific to an individual caregiver's situation.

Target Populations:

The Span Center prioritizes in-home, adult day, voucher respite services with available funding. We do offer caregiver support counseling to access other programs that may benefit a caregiver.

Service Description:

Not Applicable. The Span Center does not offer this service.

Service: Financial Consultation						Direct Service Waiver			
Unit Type	Hours	Total Units		People Served			Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
$0.00	Total Proposed Expenditures	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option

Service Definition: Financial consultation offers expert guidance in managing the financial aspects of caregiving, including budgeting, long-term care costs, insurance options, and estate planning. The service helps caregivers navigate complex financial decisions, alleviate financial stress, and secure their financial future while ensuring the well-being of their loved ones. It includes support with healthcare expenses, tax planning, and understanding financial assistance programs. The goal is to empower caregivers to make informed, sustainable financial choices as they manage caregiving responsibilities.

Target Populations:

The Span Center does not offer this program. We do connect caregivers with resources to assist.

Service Description:

The Span Center does not offer this program.

Service: Direct Payments						Direct Service Waiver			
Unit Type	Payments	**Total Units**		**People Served**			**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	General Funds- Community Based	X
	Voluntary Contributions	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Direct Payments are used for programs are services that are outside of traditional OAA services. It may be paid in cash or by voucher.

Target Populations:

The Span Center provides respite support to caregivers via the voucher program.

Service Description:

Not Applicable. The Span Center does not offer this program.

Service: Other Supplemental Services						Direct Service Waiver			
Unit Type		Total Units		People Served			Yes		No

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	General Funds- Community Based	X
	Voluntary Contributions	
	Fees	
$0.00	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Other Supplemental Services include gap filling services provided to caregivers on a limited basis to compliment care provided by caregivers.

Target Populations:

We do not offer this program. The Span Center Care Coordinators, Care Transitions Team and Caregiver Support Team work with caregivers to fill gaps using existing community resources.

Service Description:

Not Applicable. The Span Center does not offer this program.

PART 4: TITLE VII SERVICES

GROUP 8: ELDER ABUSE PREVENTION

Forego completion of this page if all Title VII- Elder Abuse Prevention funding is budgeted for the Long-Term Care Ombudsman Program. If all Title VII- Elder Abuse Prevention funds are used for the Long-Term Care Ombudsman Program, complete the service page in Group 9: Long-Term Care Ombudsman.

Service: Elder Abuse Prevention					
Unit Type	Contacts	**Total Units**	320	**People Served**	150

Proposed Expenditure Amount	**Funding Source**
$34,485.00	Title III-B
	Title VII- Elder Abuse Prevention
$4,000.00	General Funds- OAA General
	Voluntary Contributions
$38,485.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
		Select Option
		Select Option
		Select Option

Service Definition: Elder Abuse Prevention aims to protect older adults from abuse, neglect, and exploitation through education, early intervention, and support. These services include raising awareness, providing counseling, safety assessments, and facilitating community partnerships to ensure a coordinated response.

Target Populations:

Per DARS Guidelines: See Ombudsman Program Page, 108.

Forego completion of this page if all Title VII- Elder Abuse Prevention funding is budgeted for the Long-Term Care Ombudsman Program. If all Title VII- Elder Abuse Prevention funds are used for the Long-Term Care Ombudsman Program, complete the service page in Group 9: Long-Term Care Ombudsman.

Service Description:

Per DARS Guidelines: See Ombudsman Program Page, 108.

Forego completion of this page if all Title VII- Elder Abuse Prevention funding is budgeted for the Long-Term Care Ombudsman Program. If all Title VII- Elder Abuse Prevention funds are used for the Long-Term Care Ombudsman Program, complete the service page in Group 9: Long-Term Care Ombudsman.

GROUP 9: LONG-TERM CARE OMBUDSMAN

Service: Long-Term Care Ombudsman Program	
Service Details (Indicate how the AAA ensures ombudsman coverage):	
X	The AAA operates this service for this PSA only.
	The AAA arranges for another AAA to provide this service for this jurisdiction. *(If this is the case, forego the remainder of this service page after naming the AAA below.)*
Identify the other AAA contracted to provide this service:	N/A
	The AAA provides this service for one or more other PSAs.
Identify the other PSA(s) for which the agency provides this service:	N/A

Proposed Expenditure Amount	Funding Source
$122,381.00	Title III-B
$11,527.00	Title VII- Elder Abuse Prevention
$58,339.00	Title VII-Long-term Care Ombudsman
$39,000.00	General Funds- OAA General
$41,309.00	General Funds- Ombudsman
$19,362.00	Dept. of Medical Asst. Services (DMAS) Ombudsman
	Supplemental Local or Regional Funding
$100,000.00	Other Non Federal
$391,918.00	**Total Proposed Expenditures**

In compliance with Section 306(a)(9) of the OAA, in the upcoming program year the Area Agency on Aging must expend on the Ombudsman program not less than the total amount of Title III (Section 304 (d)(1)(D) and Title VII funds expended FFY 2019.

Check this box to attest that the above statement is true: X

Service Definition: The Office of the State Long-Term Care Ombudsman Program oversees a network of local program representatives that advocate for long term care recipients across multiple settings. These trained advocates work at the community (PSA) level to protect the health, safety, welfare and rights of long-term care recipients. Program representatives investigate and resolve complaints for individuals who reside in nursing facilities and assisted living facilities, and other settings where they receive community based long term services and supports. In addition, Ombudsman representatives provide information and guidance to help individuals access needed services, understand their rights, and navigate the long-term care system.

Eligible Populations: Residents of long-term care facilities. (OAA Section 711(6)); individuals who receive home and community based long-term care services through adult day centers, home care organizations, hospice providers, DBHDS, area agencies on aging and any other non-profit or proprietary agencies (Code of Virginia, § 51.5-182).

Number of long-term care beds:	10,000
Number of assigned staff to program:	3.8
% FTE per each staff person assigned:	3 at 100% and 1 at 80%

Volunteer Recruitment and Management (if applicable):

The program will utilize administrative volunteers to assist with clerical work. The SPAN Center Volunteer Services Department will support the recruitment and on-boarding of all agency volunteers. See Volunteer Program plan pages 68-69.

All host entities (AAAs) providing Ombudsman Program services are required to carry out specific duties (set forth in 45 CFR Part 1324 (Subpart A § 1324.17-19), which include ensuring access to conflict-free ombudsman program services; providing consumers with information and assistance regarding long-term care; investigating and resolving long-term care complaints; and appropriately documenting program activities.

In regard to these required program duties, describe 3 primary (specific) goals for your ombudsman activities this year:

1. Expand Presence in Assisted Living Facilitates

Increase visits to Assisted Living Facilities by 10% by expanding The Span Center's capacity, enhancing service delivery, responsiveness, and outreach in long-term care settings.

2. Expand Presence in Skilled Care Facilities

To better serve residents in long-term care, The SPAN Center will increase its visibility and engagement within facilities, by increasing Routine Access visits by 25%. This includes conducting more Residents' Rights Trainings to educate residents and empower them to advocate for themselves. Additionally, the Center will increase the frequency of routine access visits, allowing staff to build stronger relationships with residents, identify concerns early, and provide timely support and intervention.

3. Strengthen Relationships with Facility Staff

Recognizing the importance of collaboration, The SPAN Center aims to foster stronger partnerships with facility staff through enhanced outreach and educational opportunities, by developing at least 3 joint initiatives during the year. This includes offering regular communication to build trust, improve mutual understanding, and promote a shared commitment to resident well-being. These efforts will help create a more supportive environment for residents and ensure smoother coordination between The SPAN Center and facility personnel.

PART 5: STATE GENERAL FUND SERVICES

Service: State Funded Home Delivered Nutrition					
Unit Type	Meals	**Total Units**		**People Served**	

Proposed Expenditure Amount	Funding Source
	General Funds- Home Delivered Meals
	General Funds- Supplemental Nutrition
	Fees
$0.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option

	The AAA acknowledges that this service requires the use of a sliding fee scale and cannot utilize any OAA or NSIP funding to support this service.

Service Definition: Home Delivered Meals provide eligible clients with nutritious, balanced meals delivered directly to their homes. Meals comply with the latest dietary guidelines. The service accommodates special dietary needs and ensures food safety in handling, preparation, and delivery. This service is intended for homebound individuals who are unable to leave home and attend social activities and does not have access to proper nutrition and transportation.

Target Populations:

The Span Center currently only utilizes IIIC federal funding or Home Delivered Nutrition Programs.

Types of Home Delivered Meals Served (check all that apply):											
	Frozen		**Chilled**		**Shelf Stable**		**Hot**		**Other:**		

Service Description:

Not applicable.

CARE COORDINATION FOR ELDERLY VIRGINIANS PROGRAM

Only complete this page if no Title III funding is budgeted for Care Coordination. If Title III funding is used, complete the Care Coordination service page under Group 2: Access instead.

Service: Service Coordination Level 2					
Unit Type	Hours	**Total Units**		**People Served**	

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
	General Fund- OAA General	X
	General Fund- CCEVP	X
	Voluntary Contributions	
$0.00	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
		Select Option
		Select Option
		Select Option

Service Definition: Care coordination services refer to the process of organizing and managing various healthcare, social, and support services to meet the needs of older individuals and their caregivers, ensuring they receive the right care at the right time. This service is particularly important for older adults who often have multiple chronic conditions, complex health needs, or face challenges in accessing appropriate care. Care coordination is designed to improve the quality of care, reduce duplication of services and enhance the overall well-being of older adults by providing holistic, seamless support.

Target Populations:

The Span Center delivers Care Coordination through IIIB federal OAA funding.

Service Description:

Not applicable.

Service: Service Coordination Level 1					
Unit Type	Hours	**Total Units**		**People Served**	

Proposed Expenditure Amount	Funding Source
	General Fund- OAA General
	General Fund- CCEVP
	Voluntary Contributions
	Fees
$0.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option

This service requires the use of a sliding fee scale

Service Definition: Care coordination services refer to the process of organizing and managing various healthcare, social, and support services to meet the needs of older individuals and their caregivers, ensuring they receive the right care at the right time. This service is particularly important for older adults who often have multiple chronic conditions, complex health needs, or face challenges in accessing appropriate care. Care coordination is designed to improve the quality of care, reduce duplication of services and enhance the overall well-being of older adults by providing holistic, seamless support.

Target Populations:

The Span Center delivers Care Coordination through IIIB federal OAA funding.

Service Description:

Not applicable.

Service: Senior Outreach to Services (SOS)					
Unit Type	Referrals	**Total Units**		**People Served**	

Proposed Expenditure Amount	Funding Source
	General Fund- CCEVP
	Voluntary Contributions
$0.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option

Service Definition: Senior Outreach to Services (S.O.S.) is a service coordination model designed to provide mobile, short-term interventions that connect seniors to community-based supports and services. Through proactive outreach and assistance, seniors are reached and offered a face-to-face interview to assess their needs and identify available services to help them live independently in the community.

Target Populations:

The Span Center offices short term interventions through Information and Referral not SOS.

Service Description:

Not applicable.

Only complete this page if no Title III funding is budgeted for Options Counseling. If Title III funding is used, complete the Option Counseling Service page under Group 2: Access instead.

Service: Person-Centered Options Counseling					
Unit Type	Hours	**Total Units**	2250	**People Served**	675

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
$13,770.00	General Fund- OAA General	X
$57,823.00	General Fund- CCEVP	X
	Voluntary Contributions	
$71,593.00	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Person-Centered Options Counseling is an interactive decision-support process that helps individuals make informed choices about long-term services and supports. The individual, or their legal representative, directs the process with the option to include others they choose. The individual remains actively involved throughout the entire Options Counseling process, ensuring their preferences and needs are prioritized in the decision-making.

Target Populations:

Persons 60 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)) or person with disabilities aged 18.

Special attention is given to those individuals who are at risk of chronic conditions, social isolation, financial or housing instability and/or have had a recent transition that has destabilized their situation.

Service Description:

Staffing:

Our Options Counseling program is supported by eight trained care coordinators trained as Person Centered Options Counselors (OC) via No Wrong Door Training Platform. The program is supervised by a Program Manager under the Chief Program Officer. Each team member undergoes thorough background checks and receives comprehensive training to uphold our high standards of care. Ongoing professional development ensures they remain informed about the latest community resources and services.

Direct Service Waiver Requested: See Attached

Service Delivery:

Often the need for Options Counseling is triggered by a situation event, such as death of a spouse. Options Counseling is an interactive decision support process, whereby individuals receive support in making long term support service (LTSS) choices in the context of their unique preferences, strengths, needs, values, and circumstances. The Care Coordinator (CC) will support the client in developing an individual action plan. Staff work to understand the client's preferences, needs, values and circumstances. Information about options and services is provided to help the client make informed decisions that best meet their needs. The CC makes referrals, assists with application processes. Once support is in place the CC will follow up a minimum of two times with the client to determine if goals are met. Required data is maintained in the Peer Place system to track needed information and allow analysis of the persons served and the impact of the service.

Eligibility and Assessment:

Intake Specialists from the CRIA Program team receive client calls about services and programs. After an initial assessment, a CRIA Encounter is created, and client is referred to a CC. The client can be offered options counseling based on the person circumstance or the client can request the service.

Monitoring Quality Assurance and Outcome Measurement:

The program is monitored by the Program Manager and Chief Programs Officer to ensure data quality and adherence to DARS Service Standards. In addition, program outputs, outcomes and program quality assurance and client satisfaction are captured in our Options Counseling logic model. All Options Counseling clients are given a DARS standard survey to determine outcomes especially around client . Feedback is reviewed by management and used to enhance the quality and effectiveness of our services.

Alignment with State Plan:

In alignment with the state's plan for aging services, this program is designed to help older adults remain in their communities. It serves as one of the key wraparound supports that promote aging in place. Consistent with the objectives outlined in the state's plan for aging services, this program is committed to enabling older adults to remain in their communities.

DIRECT SERVICE WAIVER FORM

The Area Agency on Aging (AAA) requests a Direct Service Waiver for:

Options Counseling

Reason for the Direct Service Waiver request (check all that apply):

X	Providing services by the AAA is necessary to assure an adequate supply
X	Services are directly related to the AAA's administrative functions
X	Services can be provided more economically, and with comparable quality, by the AAA

Provide justification for this request. Include any efforts the AAA made to locate a service provider, details regarding the costs of services in the planning and service area (PSA) and any other information relevant for consideration. Include information regarding governing board review and approval. All records related to this request must be maintained for monitoring purposes.

Trained Options Counselors are working directly with clients to empower them to take needed actions by exploring their circumstances, values and preferences. The goal is to improve their quality of life and to learn how to be self- sufficient in securing resources for themselves. This program provides a supportive and encouraging approach to help the clients to be involved in improving their well-being. Often needed services or programs can be accessed through our system or through collaborative efforts with our community partners.

Only complete this page if no Title III funding is budgeted for Care Transitions. If Title III funding is used, complete the Care Transitions Service page under Group 2: Access instead.

Service: Care Transitions					
Unit Type	Contacts	**Total Units**		**People Served**	

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
	General Fund- OAA General	X
	General Fund- CCEVP	X
	Voluntary Contributions	
$0.00	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition: Care transitions refer to the process of moving a patient from one care setting to another, such as from a hospital to home, from a nursing home to outpatient care, or between different healthcare providers. The goal is to ensure continuity of care, minimize the risk of complications, and improve the quality of life during these transitions, especially for older adults who may have complex health conditions. The goal of care transitions is to ensure a smooth, safe, and effective move between different levels or types of care, preventing avoidable hospital readmissions, improving health outcomes, and promoting independence and well-being.

Target Populations:

We deliver CT through IIIB federal OAA funding as well as private funding - other service pages.

Service Description:

Not applicable.

Service: AmeriCorps Seniors Foster Grandparent Program (FGP)					
Unit Type	Hours	**Total Units**	36540	**People Served**	45

Proposed Expenditure Amount	**Funding Source**
$281,176.00	CNCS dba AmeriCorps/AmeriCorps Seniors
$25,312.00	Empty Plate Luncheon, Fundraising
$19,106.00	In Kind- Other
$325,594.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
City of Richmond and Henrico	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

The AmeriCorps Seniors Foster Grandparent Program (FGP) is an intergenerational program that engages low-income Americans 55 and older in providing one-on-one mentoring, tutoring, and

Eligible Populations:

FGP serves two distinct poplulations: 1) older adults age 55 and older that meet AmeriCorps Seniors requirments for enrollment in the program, including meeting income requirements and passing a National Service Criminal History Check; 2) children or youth with special and/or exceptional needs.

Service Description:

The AmeriCorps Seniors Foster Grandparent Program (FGP) supports children and youth that may need support academically, emotionally, mentally, physically, or socially in child development centers, preschools, private or public schools, and after-school or summer programs. The FGP volunteers receive a modest stipend and other benefits. FGP is a federally-funded grant with funds provided by AmeriCorps Seniors. The SPAN Center is the grantee of this renewable 3-year grant and the program is supported by a full-time program manager.

Service: AmeriCorps Seniors Retired and Seniors Volunteer Program

Unit Type		Total Units		People Served	

Proposed Expenditure Amount	Funding Source
N/A	
$0.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Eligible Populations:

Service Description:

Effective July 1, 2025, The Span Center will no longer operate the AmeriCorps Seniors RSVP program. Due to ongoing federal budget challenges and a need to realign our efforts to better meet the changing needs of our community, we believe this is the most responsible path forward.

RSVP has been part of our organization since 2001, and we are incredibly proud of the impact the program has made within our community. We are deeply grateful to our RSVP Host Stations and RSVP Volunteers. Each playing a vital role in the program's success by in enriching the lives of countless individuals, strengthening community and making a meaningful difference.

We understand this change may raise questions, and we are committed to working with our RSVP Host Stations and Volunteers to ensure a smooth transition. Our Host Stations will continue their work and the volunteers may choose to continue to volunteer there or join us for other opportunities at The Span Center.

PART 6: OTHER AAA SERVICES

Service: Community Guardiandship and Conservator Program					
Unit Type	Persons	**Total Units**	15	**People Served**	15

Proposed Expenditure Amount	**Funding Source**
	VCUHS
$0.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:
The Community Guardian Program serves vulnerable individuals 55 and older referred primarily by Virginia Commonwealth Health System by providing legal decision-making, including healthcare, finances and daily living needs

Eligible Populations:
Residents must live in PSA15 and be 55 or older, indigent, incapacitated and no one else willing, able or suitable to serve as guardian.

Service Description:
Our Community Guardianship Program provides court appointed guardianshipn services for adults who lack the capacity to make decisions and are at risk of harm. They coordinate direct and indirect supports to meet the essential requirements for physical and emotional health and personal welfare of persons declared to be incapacitated by the court. They make regular visits, attend care planning meetings and regularly scheduled meeting are held with the Chief Program Officer to review status and appropriateness for the program. Additionally, the program supports 24 hour on call for crisis intervention. The program is supported by 2 part-time staff.

PART 6: OTHER AAA SERVICES

Service: Public Guardiandship and Conservator Program					
Unit Type	Persons	**Total Units**	50	**People Served**	50

Proposed Expenditure Amount	**Funding Source**
$250,000.00	STATE- DARS
$250,000.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

The Public Guardian Program serves vulnerable individuals (18+) by providing legal decision-making, including healthcare, finances and daily living needs. Public Guardians are contracted by the

Eligible Populations:

Residents of the City of Richmond, Henrico, Chesterfield, Hanover, Charles City, New Kent, Powhatan and Goochland. Must be 18 or older, indigent, incapacitated and no one else willing, able or suitable to serve as guardian.

Service Description:

Our Public Guardianship Program provides court appointed public guardian services for adults who lack the capacity to make decisions and are at risk of harm. They coordinate direct and indirect supports to meet the essential requirements for physical and emotional health and personal welfare of persons declared to be incapacitated by the court. They make monthly visits, attend PCP planning meetings and conduct Multi-disciplinary Panel Meetings to review each individual's plan annually. Additionally, the program supports 24 hour on call for crisis intervention. The SPAN Centers PGP is supported by 3 full time staff.

PART 6: OTHER AAA SERVICES

Service: Elder Justice Model					
Unit Type		**Total Units**		**People Served**	

Proposed Expenditure Amount	**Funding Source**
$110,000.00	2-Year Grant initiative from
$110,000.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	See Below	Not-for-Profit
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Pilot of a new program addressing housing instability through a care team approach.

Eligible Populations:

This model addresses emergency and transitional housing needs and integrates support services for older adults (ages 60+), including those with disabilities, who have experienced abuse, neglect, or exploitation.

Service Description:

Its goal is to establish, pilot, and evaluate an innovative, decentralized elder justice model serving the greater Richmond Region. Key partners include: VCU Gerontology, Virginia Center on Aging, CARITAS, Department for Aging and Rehabilitative Services (DARS), Homeward, The SPANCenter's role includes providing care coordination and launching a new volunteer program using a care team approach. The overall initiative aims to create long-term systems-level change through six key outcomes: Housing Strategy-Establish a person-centered-trauma-informed, housing strategy with a continuum of partners. Cross-Sector Service Protocol-Develop a service coordination protocol for elders experiencing mistreatment and homelessness. Electronic Referral Process-Develop an electronic referral process between homeless and aging services providers. Volunteer Care Team Model-Develop a volunteer care team model to provide social and practical supports.
Workforce Support-Boost workforce support and training to decrease moral injury and moral distress. Replicable Blueprint-Develop a replicable blueprint of a decentralized elder justice shelter model and protocols.

PART 6: OTHER AAA SERVICES

Service: Care Transitions - Grant Funded Programs					
Unit Type	Persons	**Total Units**	1200	**People Served**	350

Proposed Expenditure Amount	**Funding Source**
	UnitedWay
	Bon Secours
	Sheltering Arms
$0.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Care transitions helps to ensure a smooth, safe, and effective move between different levels or types of care, preventing avoidable hospital readmissions, improving health outcomes and well being.

Eligible Populations:

Persons 55 and older with low-income, greatest economic need, greatest social need, risk of institutional placement, with particular attention to low-income, low-income minority, limited English proficiency, and residing in rural or geographically isolated areas (OAA Section 306(a)(1)).

Service Description:

Our Care Transitions (CT) program relies on CT Coaches collaborative with local healthcare providers to receive referrals for older adults preparing for hospital discharges, particularly those managing chronic conditions. In addition, clients recently discharged from the hospital in the home delivered meals program are also offered the opportunity to participate in this program. The Care Transitions program is grounded in the Coleman Transitions Intervention Model that is based on the four pillars of: 1. medication self-management 2. patient-centered record 3. follow-up with the health care practitioner 4. knowledge of red flags. The program is designed to reduce hospital readmissions, CT coaches use the Care Transitions model to empower older adults and encourage them to learn self-management skills to ensure their needs are met during the transition of care, particularly from the acute care settings back into the community. The program allows older adults to access services that address functional limitations and promote a proactive approach to managing their health. The goals of care transition programs are to improve transitions from the inpatient

PART 6: OTHER AAA SERVICES

Service: Care Transitions- VAAA Cares with Bay Aging					
Unit Type	Persons	**Total Units**	1000	**People Served**	480

Proposed Expenditure Amount	**Funding Source**
	VAAACares
$0.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Care transitions helps to ensure a smooth, safe, and effective move between different levels or types of care, preventing avoidable hospital readmissions, improving health outcomes and well being.

Eligible Populations:

Anyone enrolled in the designated managed care organization with VAAACares that qualifies based on medical conditions.

Service Description:

Our Care Transitions (CT) program relies on CT Coaches collaborative with local healthcare providers to receive referrals for older adults preparing for hospital discharges, particularly those managing chronic conditions. In addition, clients recently discharged from the hospital in the home delivered meals program are also offered the opportunity to participate in this program. The Care Transitions program is grounded in the Coleman Transitions Intervention Model that is based on the four pillars of: 1. medication self-management 2. patient-centered record 3. follow-up with the health care practitioner 4. knowledge of red flags. The program is designed to reduce hospital readmissions, CT coaches use the Care Transitions model to empower older adults and encourage them to learn self-management skills to ensure their needs are met during the transition of care, particularly from the acute care settings back into the community. The program allows older adults to access services that address functional limitations and promote a proactive approach to managing their health. The goals of care transition programs are to improve transitions from the inpatient

Service: Senior Community Service Employment Program (Title V)					
Unit Type	Participant	**Total Units**	35	**People Served**	35

Proposed Expenditure Amount	**Funding Source**
$359,393.00	Federal
$35,939.00	In- Kind (supervisory time)
$395,332.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
Petersburg	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

The SCSEP, or Title V helps low-income, unemployed older adults find employment by providing paid training and supportive services. While having a disability is not an eligibility factor, those with

Eligible Populations:

Participants must be at least 55, unemployed, and have a family income of no more than 125% of the federal poverty level. Enrollment priority is given to veterans and qualified spouses, then to individuals who are over 65, have a disability, have low literacy skills or limited English proficiency,

Service Description:

The Senior Community Service Employment Program (SCSEP) is a community service and work-based job training program for older Americans, authorized under the Older Americans Act. The program provides training for low-income, unemployed seniors. SCSEP participants gain work experience in a variety of community service activities at non-profit and public facilities, including schools, hospitals, day-care centers, and senior centers. Participants work an average of 20 hours a week, and are paid the federal minimum wage. This training serves as a bridge to unsubsidized employment opportunities for participants.

Service: Senior Cool Care Program

Unit Type	units	Total Units	65	People Served	65

Proposed Expenditure Amount	Funding Source
$7,500.00	Dominion
$7,500.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:
Senior Cool Care is a public-private partnership sponsored by Dominion Energy and administered by the Virginia Department for Aging and Rehabilitative Services that helps low-income older citizens in Virginia keep cool during summer months. The program runs May 1 through the last working day in

Eligible Populations:
Adults must be 60 or older, be at or below 150% of the poverty level, and need additional cooling at home.

Service Description:
The program provides single room fans, window air conditioners and now portable air conditioners to elderly Virginians who live within Dominion Energy's service area and who meet eligibility requirements. For those individuals who contact the office to request a fan or air conditioner, our Information and Referral Intake staff will conduct a screening with the client to verify they are eligible. Once determining that they are eligible, they will coordinate a pick up date and time for the client to get the needed fan or air conditioner.

Service: Senior Farm Market Fresh Program

Unit Type	Card	Total Units	2700	People Served	900

Proposed Expenditure Amount	Funding Source
$0.00	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
All	The Span Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

The Seniors Farmers Market Nutrition Program vouchers provide fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs through farmers markets and roadside stands.

Eligible Populations:

Low-income seniors, generally defined as individuals who are at least 60 years old and who have household incomes of not more than 185% of the federal poverty income guidelines.

Service Description:

Farm Market Fresh provides low-income seniors with access to locally grown fruits, vegetables and herbs from local farmers. The Nutrition and Wellness Program Manager supervises this program. Individuals submit an application online or by mail. Once approved, the individual will receive a digital voucher worth $50.00 to use at participating farmers markets. This program not only supports older adults but aids in the development of new and additional farmers markets, roadside stands, and community support agricultural programs. We will expand our marketing and outreach of the program to increase participation.

Service: Supplemental Nutrition Assistance Program (SNAP) Benefit Counseling

Unit Type	Hours	**Total Units**	250	**People Served**	700

Proposed Expenditure Amount	**Funding Source**
$34,454.93	State
$34,454.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The Span Center	Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:
SNAP Counseling offers information and education as well as application support to connect individuals to SNAP - a public assistance program designed to alleviate hunger and malnutrition by increasing the purchasing power of low income households.

Eligible Populations:
The Span Center will target individuals with greatest economic need (GEN) and greatest social need (GSN) for this service. Priority given to those in greatest risk of malnutrition, limited access to healthy food and/or food insecure.

Service Description:

The Span Center delivers person-centered SNAP counseling through our Care Coordination Team of 8 Care Coordinators (CC.) The program is supervised by the Care Coordination Program Manager and Chief Program Officer. CC will provide information on SNAP to those applying for our services. If requested, the CC will complete either the on line eligibility pre-screening tool or use a paper pre-screening guide to determine potential eligibility for interested individuals.

Outreach staff will distribute of SNAP materials at community events and presentations.

A CRIA Encounter or Virginia Quick Service Form will be used to enroll participants. SNAP information and those assisted with an application will be tracked using PeerPlace and reported to VDSS monthly.

Service: Transportation - Ride Connection Program					
Unit Type	1-way Trip	**Total Units**	3500	**People Served**	700

Proposed Expenditure Amount	**Funding Source**
$215,000.00	Department of Rail and Public Transportation - VA
$215,000.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	VIP	For Profit
PSA 15	Diamonds and Jewels	For Profit
PSA 15	On the Way	For Profit
PSA 15	Brighter Solutions	For Profit
PSA 15	Creme Dela Creme	For Profit
		Select Option

Service Definition:

Ride Connection provides mobility assistance for older adults (age 60+) and persons with disabilities (aged 18+) who are transportation disadvantaged so they may continue to live a healthy and socially

Eligible Populations:

Older adults age 60+ and persons with disabilities aged 18+ living and traveling withing PSA15 with a focus on those in greatest economic and social need.

Service Description:

Ride Connection provides ride counseling, referral services and rides to eligible persons who contact us via our hot line. Individuals who do not receive a transportation benefit through their insurance, live inside our service area and do not have access to public transportation are eligible for 2 round-trip rides per client per month, exempting Chesterfield County residents (who are referred to Chesterfield Mobility Services), and Hanover County residents (who are referred to Hanover DASH). We fulfill these ride requests through the utilization of 5 private contracted, for-profit transportation providers who specialize in human services transportation (ambulatory and paratransit). Clients are entered into PeerPlace (The Span Center's database) and RideScheduler (the software we use to schedule client rides). Currently, Ride Connection is managed in Mobility Manager with 1 FT and 1 PT Transportation Specialist. All providers are monitored on-site yearly by the Mobility Manager using a DARS approved monitoring tool. The program is supervised by the VP of Nutrition, Wellness and Transportation.

Service: Virginia Insurance Counseling and Assistance Program					
Unit Type	Contacts	**Total Units**	2300	**People Served**	N/A

Proposed Expenditure Amount	**Funding Source**
$76,971.00	SHIP- Federal
$105,534.00	MIPPA- Federal
$25,000.00	State
$207,505.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

VICAP is Virginia's State Health Insurance Assistance Program (SHIP), administered and funded through the Administration for Community Living (ACL). VICAP provides free, unbiased, confidential

Eligible Populations:

Medicare beneficiaries including persons turning 65 or over, persons with disabilities, persons with ESRD, and persons with ALS.

Service Description:

The Virginia Insurance Counseling and Assistance Program is part of a national network of programs that offers free, unbiased, confidential counseling and assistance for people with Medicare. Counseling topics include Original Medicare, Part D, Medicare Advantage, Medigap, Medicaid, Low Income Subsidy (LIS), Medicare Savings Programs (MSP), billing and claims, appeals and more.

Service: Senior Medicare Patrol					
Unit Type	Persons	**Total Units**	1500	**People Served**	1500

Proposed Expenditure Amount	**Funding Source**
$8,000.00	Health Care Fraud and Abuse Control Act (HCFAC)
$8,000.00	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 15	The SPAN Center	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

The Senior Medicare Patrol (SMP) Program Coordinators assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report healthcare fraud, errors, and abuse through outreach,

Eligible Populations:

Medicare beneficiaries and their caregivers.

Service Description:

The Senior Medicare Program (SMP) utilizes trained volunteers to educate Medicare beneficiaries and their caregivers about Medicare and Medicaid fraud and to empower them to identify, report and prevent healthcare fraud and abuse.

Area Plan Summary
Proposed Budget for October 1, 2025
through September 30, 2026

Agency: Senior Connections - Capital Area Agency on Aging, Inc. PSA # 15

Projected Resources and Spending	Title III-B	Title III-C(1)	Title III-C(2)	Title III-D	Title III-E	Title VII - EA	NSIP	Title VII - OMB
Estimated Unencumbered Cash on Hand on 10/1/25	123,200	385,532	128,143	2,874	32,582			
FY'26 Obligation	1,469,873	778,960	1,308,491	34,894	504,875	11,527	111,934	58,339
FY'26 Transfers	223,820	(152,459)	(71,361)					
Total Resources	1,816,893	1,012,033	1,365,273	37,768	537,457	11,527	111,934	58,339
Total Proposed Spending FY'26	1,816,893	1,012,033	1,365,273	37,768	537,457	11,527	111,934	58,339
Proposed Carryover into FY'27	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0

Projected Resources and Spending	OAA General	Community Based	Transportation	Home Delivered Meals	Supplemental Nutrition	CCEVP	GF OMB
Estimated Unencumbered Cash on Hand on 10/1/25							
FY'26 Obligation (Oct 1, 2025 - Jun 30, 2026)	327,721	333,523	120,835	426,055	104,361	43,367	30,602
FY'26 Transfers (Oct 1, 2025 - Jun 30, 2026)							
FY'27 Obligation (Jul 1, 2026 - Sep 30, 2026)	79,773	111,174	40,278	142,018	34,794	14,456	10,327
FY'27 Transfers (Jul 1, 2026 - Sep 30, 2026)							
Total Resources	407,495	444,697	161,113	568,073	139,155	57,823	41,309
Total Proposed Spending FY'26*	424,406	427,765	161,113	568,073	139,155	57,823	41,309
Balance prior to ReAllocation of Undesignated Funds	(16,911)	16,912	0	(1)	(0)		0
Reallocation Requested of Undesignated Funds **	16,911	(16,912)					
Proposed Carryover into FY'27	(0)	0	0	(1)	(0)		0

Projected Resources and Spending	DMAS OMB
Estimated Unencumbered Cash on Hand on 10/1/25	
FY'26 Obligation	19,362
Total Resources	19,362
Total Proposed Spending FY'26	19,362
Proposed Carryover into FY'27	(0)

- The allocation of "Undesignated Funds" must be done during the initial budget period at the beginning of the area plan year.
- Federal regulations prohibit the movement of Title III-D & E funds, which also restrict the movement of matching state funds.
- CCEVP and Ombudsman funds are restricted as well. You cannot reallocate funds from CCEVP or Ombudsman, however you may add undesignated funds to any service.
- *All undesignated funds budgeted for a service will be added to the "OAA General" funding source. In the event that "OAA General" is not an available funding source for that service, then the funds will be added to "CCEVP".
- **If you are moving Undesignated funds from funding source "OAA General" to "Undesignated OAA General" then a reallocation of funds will not be necessary. The balances that are shown on this line represent amounts that are moving from different funding sources.

05/09/25

The allocations are estimations and projections made using the information from the current award documents. The funds are based on the best data available and used to forecast the future year budget and resource allocation.

Spending Requirements Review

	A	B	C	D	E	F	G	H
1	**Agency:**	**Senior Connections - Capital Area Agency on Aging, Inc.**			**PSA:**	**15**		
2								
3	**Requirement**			**Agency Status**		**Requirement**		**Agency Status**
4	**Minimum Adequate Proportion**					**Title III-E**		
5	Access (minimum 15%)		1,000,169	55.0%		Prep & Admin Spending (10% or less)		3.2%
6	In-Home (minimum 5%)		9,089	0.5%		Prep & Admin Federal Share (75% or less)		63.5%
7	Legal (minimum 1%)		25,000	1.4%		Services Federal Share (75% or less)		59.7%
8								
9	**Title III-B Preparation and Administration**					**Title III-E Categories**		
10	Spending (10% or less)		178,943	4.2%		Respite Services		56,667
11	Federal Share (75% or less)		178,943	71.3%		Supplemental Services		
12	Non-Federal Share (25% or more)		72,000	28.7%				
13								
14	Title III and Title III-E Preparation and Administration							
15	using OAA General Fund (5% or less)		9,000	2.2%		Funds Spent on Grandparents		
16						% Spent on Grandparents (10% or less)		
17	FY 2019 Title III-B Expenditures in the LTC		Current YR D/E	Yr 2019				
18	Ombudsman Program Comparison		91,032	31,349				
19						Enter Title III-B general fund expenditures used to match non OAA funds or used for services under a non OAA allowed sliding fee scale.		
20	**Title III-B Services**							
21	Federal Share (85% or less)		1,678,031	56.6%				
22	Non-Federal Share plus State Share (15% or more)		926444	33.3%				
23	State Share (5% or more)		522,883	20.9%				
24						Enter Title III-C1 general fund expenditures used to match non OAA funds.		
25	**Title III-C1 Services**							
26	Federal Share (85% or less)		930,802	78.4%				
27	Non-Federal Share plus State Share (15% or more)		256,899	21.6%				
28	State Share (5% or more)		256,899	21.6%				
29						Enter Title III-C2 general fund expenditures used to match non OAA funds.		
30	**Title III-C2 Services**							
31	Federal Share (85% or less)		1,284,042	69.3%				
32	Non-Federal Share plus State Share (15% or more)		568,073	30.7%		**CCEVP Tab (if yellow go to tab)**		
33	State Share (5% or more)		568,073	30.7%		Care Coordination Level 2		
34						Care Coordination Level 1		
35			**10/1/25-**	**7/1/26 -**		Care Transitions		
36	**State Transfers (40% or less)**		**6/30/26**	**9/30/26**		Senior Outreach to Services (S.O.S.)		
37	Community Based Transfers					Options Counseling Services		
38	Transportation Transfers							
39	Home Delivered Meal Transfers							
40	Total Transfers Equal Zero					**Undesignated Funds**		
41				**10/1/25-**		Match Required (Title III-B, C1, C2)		627,763
42	**Federal Transfers**			**9/30/26**		Match Met		1,409,855
43	Title III-B (30% or less)			-15.2%		Undesignated Funds		782,092
44	Title III-C(1) (25% or less to C(2), 10% or less to B)			19.6%				
45	Title III-C(2) (25% or less to C(1), 10% or less to B)			5.5%		Total Undesignated Funds Budgeted to OAA General *		10,912 **
46	Total Transfers Equal Zero					Total Undesignated Funds Budgeted to CCEVP *		
47								
48								
49								
50		• The allocation of "Undesignated Funds" must be done during the initial budget period at the beginning of the area plan year.						
51	5/6/2025							
52		• Federal regulations prohibit the movement of Title III-D & E funds, which also restrict the movement of matching state funds.						
53								
54		• CCEVP and Ombudsman funds are restricted as well. You cannot reallocate funds from CCEVP or Ombudsman, however you may add undesignated funds to any service.						
55								
56		• "All undesignated funds budgeted for a service will be added to the "OAA General" funding source. In the event that "OAA General" is not an available funding source for that service, then the funds will be added to "CCEVP".						
57								
58								
59		• **If you are moving Undesignated funds from funding source "OAA General" to "Undesignated OAA General" then a reallocation of funds will not be necessary. The balances that are shown on this line represent amounts that are moving from other funding sources.						
60								
61								
62								

Title III
(Except III-E)

	A	B	C	D	E	F	G	H
1	PSA:	15						
2			This row is left available for your internal comments. For example, some agencies use it to indicate internal ac					
3	**Planned Expenditures**		**In-Home Services**					
4	**Funding Source**		**Adult Day Care**	**Checking**	**Chore**	**Homemaker**	**Personal Care**	**Care / Service Coordination Level 2**
5	**Older Americans Act**							
6		Title III-B		3,860		5,229		144,589
7		Title III-C(1)						
8		Title III-C(2)						
9		Title III-D						
10		Title VII - Ombudsman						
11		Title VII - Elder Abuse						
12	**Other Funds**							
13		Voluntary Contributions						
14		Other Non-Federal						
15		Fees						
16	**Other Federal**							
17		DMAS - Ombudsman						
18		Other Local Federal Funding						
19		NSIP*						
20	**General Funds**							
21		OAA General						16,000
22		Community Based		22,000		29,000		
23		Transportation						
24		Home Delivered Meals						
25		Supplemental Nutrition						
26		GCEVP*						
27		Ombudsman						
28	**Undesignated Funds to OAA General***							
29	**Undesignated Funds to GCEVP***							
30	**Total Cash**			25,860		34,229		160,589
31	**In-Kind Amount**							
32	**Service Data:**							
33	Planned Number of Units			3,000		660		960
34								
35	Unit Defined as:		Hours	Contacts	Individual Hours	Individual Hours	Individual Hours	Individual Hours
36	Unit Cost			$8.62		$51.86		$167.28
37	Planned Persons Served			35		8		192
38								
39								
40	*All undesignated funds budgeted for a service will be added to the "OAA General" funding source. In the event that "OAA General" is not an av							
41								
42	05/06/25							

Title III
(Except III-E)

	A	B	I	J	K	L	M	N	O
1	PSA:	15							
2			ount numbers.						
3	Planned Expenditures		Access Services						
4	Funding Source		Service Coordination Level 1	Care Transitions	S.O.S.	Communication Referral & I&A	Options Counseling	Transportation	Assisted Transportation
5	Older Americans Act								
6		Title III-B		361,405		287,308		208,867	
7		Title III-C(1)							
8		Title III-C(2)							
9		Title III-D							
10		Title VII - Ombudsman							
11		Title VII - Elder Abuse							
12	Other Funds								
13		Voluntary Contributions						2,000	
14		Other Non-Federal		69,200		203,561		100,000	
15		Fees							
16	Other Federal								
17		DMAS - Ombudsman							
18		Other Local Federal Funding							
19		NSIP							
20	General Funds								
21		OAA General				84,000	13,770	52,000	
22		Community Based							
23		Transportation						161,113	
24		Home Delivered Meals							
25		Supplemental Nutrition							
26		CCEVP					57,823		
27		Ombudsman							
28	Undesignated Funds to OAA General*					16,912			
29	Undesignated Funds to CCEVP*								
30	Total Cash			430,605		591,781	71,593	521,980	
31	In-Kind Amount								
32	Service Data:								
33	Planned Number of Units			1,200		14,500	1,000	13,400	
34									
35	Unit Defined as:		Individual Hours	Contacts	Referrals	Contacts	Hours	1-Way Trips	1-Way Trips
36	Unit Cost			$356.84		$40.81	$71.59	$38.95	
37	Planned Persons Served			350		10,500	300	175	
38									
39									
40	*All undesignated funds budgeted for a allable funding source for that service, then the funds will be added to "CCEVP".								
41									
42	05/08/25								

Title III
(Except III-E)

	A	B	P	Q	R	S	T	U	V	W
1	PSA:	15								
2										
3	Planned Expenditures		Nutrition					Disease Prevention		
4	Funding Source		Congregate Meals	Home Delivered Meals	State Funded Home Delivered Meals	Nutrition Counseling	Nutrition Education	Other "EB" Disease Prevention	CDSME	Falls Prevention
5	Older Americans Act									
6		Title III-B								
7		Title III-C(1)	895,802			4,000	31,000			
8		Title III-C(2)		1,249,042		4,000	31,000			
9		Title III-D						37,768		
10		Title VII - Ombudsman								
11		Title VII - Elder Abuse								
12	Other Funds									
13		Voluntary Contributions	6,000							
14		Other Non-Federal						47,200		
15		Fees								
16	Other Federal									
17		DMAS - Ombudsman								
18		Other Local Federal Funding	1,212							
19		NSIP	111,934							
20	General Funds									
21		OAA General	117,724					10,000		
22		Community Based								
23		Transportation								
24		Home Delivered Meals		568,073						
25		Supplemental Nutrition	139,175							
26		CCEVP								
27		Ombudsman								
28	Undesignated Funds to OAA General*									
29	Undesignated Funds to CCEVP*									
30	Total Cash		1,271,847	1,817,115		8,000	62,000	94,968		
31	In-Kind Amount									
32	Service Data:									
33	Planned Number of Units		39,000	168,000		40	3,500	6,750		
34										
35	Unit Defined as:		Eligible Meals	Meals	Non NSIP Meals	Hours	Sessions	Sessions	Sessions	Sessions
36	Unit Cost		$32.61	$10.82		$200.00	$17.71	$14.07		
37	Planned Persons Served		625	1,100		30	475	375		
38										
39										
40	*All undesignated funds budgeted for a s									
41										
42	05/09/25									

Title III
(Except III-E)

	A	B	X	Y	Z	AA	AB
1	PSA:	15					
2							
3	Planned Expenditures						
4	Funding Source		Health Education Screening	Assistive Technology/ DME / PERS - Devices	Assistive Technology/ DME / PERS - Payments	Consumable Supplies	Emergency
5	Older Americans Act						
6		Title III-B					90,000
7		Title III-C(1)					
8		Title III-C(2)					
9		Title III-D					
10		Title VII - Ombudsman					
11		Title VII - Elder Abuse					
12	Other Funds						
13		Voluntary Contributions					
14		Other Non-Federal					50,000
15		Fees					
16	Other Federal						
17		DMAS - Ombudsman					
18		Other Local Federal Funding					
19		NSIP					
20	General Funds						
21		OAA General					
22		Community Based					
23		Transportation					
24		Home Delivered Meals					
25		Supplemental Nutrition					
26		CCEVP					
27		Ombudsman					
28	Undesignated Funds to OAA General*						
29	Undesignated Funds to CCEVP*						
30	Total Cash						140,000
31	In-Kind Amount						
32	Service Data:						
33	Planned Number of Units						1,725
34							
35	Unit Defined as:		Individual Hours	Devices	Payments	Payments	Contacts
36	Unit Cost						$81.16
37	Planned Persons Served						115
38							
39							
40	*All undesignated funds budgeted for a t						
41							
42	05/06/25						

Title III
(Except III-E)

	A	B	AC	AD	AE	AF	AG	AH
1	PSA: 15							
2								
3	**Planned Expenditures**		**Other Services**					
4	**Funding Source**		**Employment**	**Medication Management**	**Money Management**	**Outreach/ Public Information/ Education**	**Residential Repair & Renovation**	**Socialization & Recreation**
5	**Older Americans Act**							
6		Title III-B	90,460		13,968	187,635		
7		Title III-C(1)						
8		Title III-C(2)						
9		Title III-D						
10		Title VII - Ombudsman						
11		Title VII - Elder Abuse						
12	**Other Funds**							
13		Voluntary Contributions						
14		Other Non-Federal						
15		Fees						
16	**Other Federal**							
17		OMAS - Ombudsman						
18		Other Local Federal Funding						
19		NSIP						
20	**General Funds**							
21		OAA General	10,000			19,000		
22		Community Based			83,000			
23		Transportation						
24		Home Delivered Meals						
25		Supplemental Nutrition						
26		CCEVP						
27		Ombudsman						
28	**Undesignated Funds to OAA General***							
29	**Undesignated Funds to CCEVP***							
30	**Total Cash**		100,460		96,968	186,635		
31	**In-Kind Amount**							
32	**Service Data:**							
33	Planned Number of Units		460		1,250	95,000		
34								
35	Unit Defined as:		Individual Hours	Individual Hours	Individual Hours	# of Activities	Homes Repaired	Individual Hours
36	Unit Cost		$218.39		$77.57	$1.96		
37	Planned Persons Served		150		40			
38								
39								
40	*All undesignated funds budgeted for a s							
41								
42	05/08/25							

Title III
(Except III-E)

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP
1	PSA:	15								
2										
3	Planned Expenditures			Legal	Elder Rights		Incentive	Administration	Grand Total	
4	Funding Source		Volunteer Programs	Legal Assistance	Elder Abuse Prevention	Local LTC Ombudsman	Incentive Program	Preparation & Administration	Total	
5	Older Americans Act									
6		Title III-B	247,225	25,000	34,485	122,381		16,481	1,816,893	
7		Title III-C(1)						81,231	1,012,033	
8		Title III-C(2)						81,231	1,365,273	
9		Title III-D							37,768	
10		Title VII - Ombudsman				58,339			58,339	
11		Title VII - Elder Abuse				11,527			11,527	
12	Other Funds									
13		Voluntary Contributions							8,000	
14		Other Non-Federal	50,000			100,000		63,000	662,961	
15		Fees								
16	Other Federal									
17		DMAS - Ombudsman				19,362			19,362	
18		Other Local Federal Funding							1,212	
19		NSIP							111,934	
20	General Funds									
21		OAA General	33,000		4,000	39,000		9,000	407,494	
22		Community Based							134,000	
23		Transportation							161,113	
24		Home Delivered Meals							568,073	
25		Supplemental Nutrition							139,175	
26		CCEVP							57,823	
27		Ombudsman				41,309			41,309	
28	Undesignated Funds to OAA General*								18,912	
29	Undesignated Funds to CCEVP*									
30	Total Cash		330,225	25,000	38,485	391,918		250,943	6,651,201	
31	In-Kind Amount									
32	Service Data:									
33	Planned Number of Units		10,900	2,000	320					
34										
35	Unit Defined as:		Individual Hours	Individual Hours	Contacts		# of Incentives			
36	Unit Cost		$30.30	$12.50	$120.27					
37	Planned Persons Served		200	650	150					
38										
39										
40	*All undesignated funds budgeted for a t									
41										
42	05/06/25									

Title III - E

	A	B	C	D	E	F	G	H
2			This row is left available for your internal comments. For example, some agencies use it to indicate internal account numbers					
3	Planned Expenditures		Individual Counseling	Support Groups	Caregiver Training	Care / Service Coordination Level 2	Information and Assistance	Outreach/ Public Information/ Education
4	Funding Source		Individual Counseling	Support Groups	Caregiver Training	Care / Service Coordination Level 2	Communication Referral & I&A	Outreach/ Public Information/ Education
5	Older Americans Act							
6		Title III-E	115,067		74,381		100,993	170,603
7	Other Funds							
8		Voluntary Contributions						
9		Other Non-Federal	15,000		33,100			
10		Fees						
11	Other Federal							
12		Other Local Federal Funding						
13		NSIP						
14	General Funds							
15		OAA General						
16		Community Based						
17		Transportation						
18		Home Delivered Meals						
19		Supplemental Nutrition						
20	Undesignated Funds to OAA General *							
21	Total Cash		130,067		107,481		100,993	170,603
22	In-Kind Amount							
23	Service Data:							
24	Planned Units of Service		450		350		400	100
25	Unit Defined as:		Hours	Sessions	Hours	Individual Hours	Contacts	# of Activities
26	Unit Cost		$289.04		$307.09		$252.48	$1,706.03
27	Planned Persons Served with a Caregiver		200				100	Est. Audience Size
28	Planned Caregivers Served		200		250		100	6,000
29	Planned Number of Caregivers Benefited		200		250		100	
30								
31	*All undesignated funds budgeted for a service will be added to the "OAA General" funding source. In the event that "OAA General" is not an available funding							
32	5/6/2025							

Title III - E

	A	B	I	J	K	L	M	N
2								
3	Planned Expenditures		Respite Voucher	Respite Services				
4	Funding Source		Respite Voucher	Adult Day Care (Out of Home)	Homemaker (In-Home)	Personal Care (In-Home)	Institutional Respite (Out of Home Overnight)	Other
5	Older Americans Act							
6		Title III-E	2,500	15,802	8,729	32,336		
7	Other Funds							
8		Voluntary Contributions						
9		Other Non-Federal						
10		Fees						
11	Other Federal							
12		Other Local Federal Funding						
13		NSIP*						
14	General Funds							
15		OAA General						
16		Community Based		100,000	50,000	143,785		
17		Transportation						
18		Home Delivered Meals						
19		Supplemental Nutrition						
20	Undesignated Funds to OAA General *							
21	Total Cash		2,500	115,802	58,729	176,121		
22	In-Kind Amount							
23	Service Data:							
24	Planned Units of Service		5	11,700	1,600	4,000		
25	Unit Defined as:		# of Vouchers	Individual Hours	Individual Hours	Individual Hours	Individual Hours	Define Here
26	Unit Cost		$500.00	$9.90	$36.71	$44.03		
27	Planned Persons Served with a Caregiver		5	20	20	50		
28	Planned Caregivers Served		5		20	50		
29	Planned Number of Caregivers Benefited		5	20	20	50		
30								
31	*All undesignated funds budgeted for a sa source for that service, then the funds will be added to "CCEVP".							
32	5/6/2025							

Title III - E

	A	B	O	P	Q	R	S	T
2								
3	Planned Expenditures							
4	Funding Source		Assistive Technology/ DME / PERS - Devices	Assistive Technology/ DME / PERS - Payments	Chore	Consumable Supplies	Financial Consultation	Congregate Meals
5	Older Americans Act							
6		Title III-E						
7	Other Funds							
8		Voluntary Contributions						
9		Other Non-Federal						
10		Fees						
11	Other Federal							
12		Other Local Federal Funding						
13		NSIP						
14	General Funds							
15		OAA General						
16		Community Based						
17		Transportation						
18		Home Delivered Meals						
19		Supplemental Nutrition						
20	Undesignated Funds to OAA General *							
21	Total Cash							
22	In-Kind Amount							
23	Service Data:							
24	Planned Units of Service							
25	Unit Defined as:		Devices	Payments	Individual Hours	Payments	Individual Hours	Eligible Meals
26	Unit Cost							
27	Planned Persons Served with a Caregiver							
28	Planned Caregivers Served							
29	Planned Number of Caregivers Benefited							
30								
31	*All undesignated funds budgeted for a se							
32	5/6/2025							

Title III - E

	A	B	U	V	W	X	Y	Z
2								
3	**Planned Expenditures**		**Supplemental Services**					
4	**Funding Source**		**Home Delivered Meals**	**Homemaker**	**Personal Care**	**Residential Repair & Renovation**	**Transportation**	**Assisted Transportation**
5	**Older Americans Act**							
6		Title III-E						
7	**Other Funds**							
8		Voluntary Contributions						
9		Other Non-Federal						
10		Fees						
11	**Other Federal**							
12		Other Local Federal Funding						
13		NSIP						
14	**General Funds**							
15		OAA General						
16		Community Based						
17		Transportation						
18		Home Delivered Meals						
19		Supplemental Nutrition						
20	**Undesignated Funds to OAA General ***							
21	**Total Cash**							
22	**In-Kind Amount**							
23	**Service Data:**							
24	Planned Units of Service							
25	Unit Defined as:		Meals	Individual Hours	Individual Hours	Homes Repaired	1-Way Trips	1-Way Trips
26	Unit Cost							
27	Planned Persons Served with a Caregiver							
28	Planned Caregivers Served							
29	Planned Number of Caregivers Benefited							
30								
31	***All undesignated funds budgeted for a se**							
32	5/6/2025							

Title III - E

	A	B	AA	AB	AC	AD	AE
2							
3	Planned Expenditures				Incentive Program	Administration	
4	Funding Source		Direct Payments	Other Supplemental Services	Incentive Program	Preparation & Administration	Total Title III-E
5	Older Americans Act						
6		Title III-E				17,040	537,457
7	Other Funds						
8		Voluntary Contributions					
9		Other Non-Federal				9,794	57,694
10		Fees					
11	Other Federal						
12		Other Local Federal Funding					
13		NSIP					
14	General Funds						
15		OAA General					
16		Community Based					293,785
17		Transportation					
18		Home Delivered Meals					
19		Supplemental Nutrition					
20	Undesignated Funds to OAA General *						
21	Total Cash					26,840	889,136
22	In-Kind Amount						
23	Service Data:						
24	Planned Units of Service						
25	Unit Defined as:		# of Payments	Define Here	# of Incentives		
26	Unit Cost						
27	Planned Persons Served with a Caregiver						
28	Planned Caregivers Served						
29	Planned Number of Caregivers Benefited						
30							
31	*All undesignated funds budgeted for a se						
32	5/6/2025						