DARS | Virginia Department for Aging and Rehabilitative Services

DIVISION FOR AGING SERVICES

The Area Plan for Aging Services

Fiscal Years 2024-2027

Agency: Central Virginia Alliance for Community Living, Inc. (CVACL)

Mailing Address: P. O. Box 1390, Lynchburg, VA 24505

Local Telephone: (434) 385-9070

Toll Free Number: (866) 255-6868

Fax: (434) 385-9209

Email: cvacl@cvcl.org

PSA #: 11

Counties:
Amherst
Appomattox
Bedford
Campbell

Cities:
Lynchburg

Third Year of the Area Plan:

October 1, 2025 through September 30, 2026

Virginia Department for Aging and Rehabilitative Services

TABLE OF CONTENTS

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 **Central Virginia Alliance for Community Living, Inc.** 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

Our Mission: Central Virginia Alliance for Community Living, Inc. (CVACL) supports older adults and individuals with disabilities to live with dignity in accordance with their own personal choice.

Our Vision: All individuals regardless of age or disability maintain independence, dignity, equal rights, and a meaningful life based on their individual choices.

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:**

A Board of Directors and an Advisory Council help provide direction and input to all programs offered by Central Virginia Alliance for Community Living (CVACL) throughout the year.

CVACL began additional outreach to interested parties for this Area Plan in early June, notifying our Advisory Council members of upcoming public comment and public hearing dates and reaching out to constituents for presentations and feedback sessions.

Our plan for public input:
June 20, 2025 - Draft Area Plan published online, advertised on social media, emailed to 889 readers, including Advisory Council members and Board of Directors.
June 23, 2025 - Presented to Bedford and Moneta congregate site participants.
June 25, 2025 - Presented to Appomattox and Lynchburg congregate site participants.
June 26, 2025 - Presented to Altavista and Campbell Cafe congregate site participants.
June 27, 2025 - Presented to Bedford Area Resource Council.
July 17, 2025 - Presented at public hearing during CVACL Open House.

Detailed notes will be taken on feedback provided and incorporated as feasible.

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 2025	
Source	**Amount**
Department for Aging and Rehabilitative Services	
Older Americans Act (include Nutrition Services Incentive Program or NSIP)	1,369,989
State General Funds	646,622
Virginia Insurance Counseling and Assistance Program (VICAP); including State Health Insurance Assistance Program (SHIP) and Medicare Improvements for Patients and Providers (MIPPA)	91,396
Respite Care Initiative	
Dominion Energy Senior Cool Care	4,000
U.S. Dept. Of Agriculture – Senior Farmers Market Nutrition Program (USDA-SFMNP)	1,368
Supplemental Nutrition Assistance Program (SNAP) Outreach	
Senior Community Service Employment Program (SCSEP)	
Other State Government Sources	
Dept. of Rail and Public Transportation (DRPT)	188,000
Dept. of Medical Assistance Services (DMAS)	5,952
Dept. of Social Services (VDSS)	
Dept. of Behavioral Health and Developmental Services (DBHDS)	
Virginia Housing (formerly Virginia Housing Development Authority)	551,266
Dept. of Education (VDOE)	
Other Federal Government Sources	
AmeriCorps	
U.S. Centers for Medicare and Medicaid Services (CMS)	
Veterans Administration	
Senior Medicare Patrol (SMP)	8,000
Department of Energy (DOE)	127,398
Department of Energy (BIL)	199,866

Local Government Sources	
Jurisdictional Funding	135,148
Jurisdictional Funding - Bedford Ride	59,500
Private Sources	
APCO/AEP/Old Dominion	156,000
United Way	85,000
Centra Health	60,000
Centra Foundation Bedford Ride	35,000
Bay Aging	80,000
Bedford Community Health Foundation - Bedford Ride	35,000
Greater Lynchburg Community Foundation	6,000
Genworth - Care Transitions	15,000
Senior Cool Care - Donation	4,364
Other Sources	
Contributions/In-Kind	120,000
Charges/Fees	12,000
Investment Earnings	5,000
Other Income	
Community Donations - Bedford Ride	75,000
Community Donations - Agency	25,000
Fundraising	20,000
Rental Income - Blue Ridge Regional Food Bank	80,400
Total Projected Revenues	4,202,269

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	7065	US Census Bureau
Poverty as further defined by the state		
Greatest Social Need (GSN)		
Physical and mental disabilities	11,785	US Census Bureau
Language barriers	340	US Census Bureau
Cultural, social, or geographical isolation, including due to:		
Racial and ethnic status	16,900	US Census Bureau
Native American identity	265	US Census Bureau
Religious affiliation	280	Association of Religion Data Archives
Sexual orientation	3920	Centra Community Health Needs Assessment
Gender identity or sex characteristics	1420	Centra Community Health Needs Assessment
HIV status	710	Centra Community Health Needs Assessment
Chronic conditions	19,750	Centra Community Health Needs Assessment
Housing instability	20	VA Dept of Housing and Community Dev.
Food insecurity	3905	Weldon Cooper Center at UVA
Lack of access to reliable and clean water supply	60	VDH / American Community Survey
Lack of transportation	3550	Centra Community Health Needs Assessment
Utility assistance needs		
Interpersonal safety concerns	4975	Centra Community Health Needs Assessment
Rural location	36,935	US Census Bureau
Any other status that threatens the capacity of the individual to live independently		

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.

Planning and Service Area (PSA) 11 serves a substantial older adult population, accounting for 27.7% of the total regional population. Economic vulnerability is a prominent concern, with approximately 10% of the age 60+ population living at or below the federal poverty level, and 5.5% of older adults receiving food stamps/SNAP benefits, suggesting food insecurity and limited financial resources.

PSA11 is also characterized by multiple intersecting factors of social disadvantage, including health, disability, minority status, sexual orientation, gender identity, geography, and safety:
- One in six of our older adult population reports having physical and/or mental disabilities, affecting their ability to live independently and access services.
- Chronic health conditions impact 27.8% of older adults, increasing demand for health and support services.
- Racial and ethnic minorities comprise a significant segment of the population, with almost one in four individuals identified as part of a racial or ethnic minority group.
- Specific identity groups with potential service barriers include our 5.5% of the older adult population that identifies as LGBTQ+ and the 2% that identify as gender non-conforming. While HIV-positive older adults make up only 1% of the older adult population, they may require specialized health and social services.
- Transportation challenges affect 5% of older adults, limiting access to healthcare, social services, and community engagement.
- Interpersonal safety concerns (people who do not feel safe where they are living) are estimated to impact 7% of older individuals, indicating a need for protective and legal services to prevent or assist with elder abuse and exploitation.
- Despite being centered around a city, 52% of older adults in our region live in areas that are geographically or functionally rural, with related barriers such as fewer service providers and increased isolation.

The PSA has a highly diverse and vulnerable aging population, with significant pockets of older adults facing economic hardship, health-related limitations, and social isolation, compounded by geographic challenges.

Data was obtained and/or extrapolated from reports from the US Census Bureau, Weldon Cooper Center for Public Service at the University of Virginia, Centra Health's Community Needs Assessment, the Virginia Department of Housing and Community Development, the Association of Religion Data Archives, and the US Administration for Community Living. Virginia Department of Health was able to provide data on housing without adequate plumbing, but specific information on access to clean water or utility assistance is unavailable. Where other age-specific data was not available, numbers were extrapolated based on percentage of population over age 60.

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.

PeerPlace CRIA2 Unmet Needs for Services Report

1. Home Delivered Meals
   Unmet need in units: 11,303 meals
   Unserved: 45 individuals
   Underserved: 51 individuals

2. Personal Care
   Unmet need: 4,640 hours
   Unserved/waiting list: 10 people
   Underserved/not received assessed hours needed: 1 person

3. Transportation
   Unmet need: 102 trips
   Unserved: 0 individuals
   Underserved: 1 person

Recognizing the scale and impact of identified gaps, these services have been prioritized in our goals, objectives, and funding allocation discussions.

The unmet needs data highlight a growing demand that outpaces our current funding levels. As a result, we will continue to actively pursue additional resources, including grant opportunities and local partnerships, while exploring cost-efficiency measures.

While funding limitations remain a key challenge, incorporating this unmet need data ensures that our planning remains responsive, realistic, and grounded in the lived experiences of older adults in our community. The Area Plan reflects a commitment to not only maintain current service levels but to seek strategic solutions to close these service gaps over time.

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: 2880

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

Looking at US Census Bureau data and Administration for Community Living data, and cross-comparing those of racial and/or ethnic minority with those living at or below the poverty level, an estimated 2,880 individuals fall into this category within PSA11.

CVACL has received referrals for, assessed, and assisted 378 low-income minority individuals with their needs in the last year.

Each individual has met with a trained Care Manager who has completed the Virginia Uniform Assessment Instrument (UAI) to help determine their specific needs and to help develop and implement a person-centered care plan to meet those service needs.

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.

Objectives in the previous federal fiscal year concentrated on promoting access to aging and community services for older Virginians with the greatest economic and social needs, as well as bolstering awareness of and increase access to person-centered long-term services and supports (LTSS).

These efforts included, among others:
- a dedicated public relations manager, who regularly attends events in outlying areas in the city and four surrounding counties. This position liaises with independent living facilities, parks and recreation services, and other groups that serve seniors and adults living with disabilities.
- meetings that have led to opportunities to work with the Monacan Indian Nation, ensuring local Native Americans know of available services.

Every referral was addressed in a timely manner.

As an agency, we provided high-quality core Older Americans Act (OAA) programs according to individuals' needs and delivered evidence-based programs that encourage healthy, active, and engaged lives.

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:

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.

The development of this Area Plan has been guided by ongoing assessments of unmet needs and identification of populations experiencing the Greatest Economic Need (GEN) and Greatest Social Need (GSN), which has validated our existing service structure, highlighting consistent satisfaction with service delivery.

Input from agency clientele, Advisory Council, and the public at large has been instrumental in shaping goals for the upcoming fiscal year. Unmet needs assessments and public input have highlighted a growing demand for additional caregiver support programming, home-delivered meals, and personal care services, particularly among older adults with limited mobility or without nearby support networks. While the AAA recognizes the strong interest in other supportive services—such as adult day care, chore, and homemaker services—current funding constraints limit the ability to expand in these areas. Nevertheless, this feedback has helped guide our priorities and reinforced the importance of advocating for additional resources to address these critical gaps.

To help address these unmet needs, CVACL is actively exploring future grant opportunities and potential partnerships with community-based organizations and local governments. These efforts aim to expand capacity for high-demand services where current funding is insufficient. By leveraging external resources and collaborative initiatives, CVACL remains committed to responding to the evolving needs of older adults and their caregivers throughout the region.

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).

Generally, all CVACL services are available in all areas of PSA 11, with the exception of some Housing/Weatherization programs in Lynchburg City or Campbell County that are served by Lynchburg Community Action Group (LynCag). Funding is distributed within the PSA according to individual needs for services.

If, following the Case Management Team determination of an individual's unmet need, a service is not available, the appropriate Program Manager/Director will accept a referral but place the individual on a waiting list. Services with waiting lists may include Personal Care, Congregate Meals, Meals on Wheels for Seniors, and Transportation.

Clients are removed from the waiting list by the highest need score, with special emphasis given to low-income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.

Care Coordination and Care Transitions clients are given first priority, as well as those individuals with the greatest economic and social need.

Proximity to an opening on the schedule or route will also be a determining factor.

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.

Central Virginia Alliance for Community Living, Inc. (CVACL) coordinates with local mental health providers and community-based organizations through a collaborative approach to increase awareness and understanding of mental health disorders among older adults. These partnerships support comprehensive community education and outreach efforts, with a focus on reducing stigma and connecting individuals to appropriate services.

CVACL utilizes the No Wrong Door (NWD) portal to facilitate timely referrals to appropriate mental health and community organizations, ensuring that individuals are connected with the resources that best meet their needs.

To promote continuity of care, CVACL operates a Multi-Disciplinary Team (MDT) that includes representatives from all internal departments as well as external partner agencies. This integrated team approach ensures coordinated care planning, efficient communication, and person-centered service delivery. In addition, CVACL provides ongoing staff training and in-service sessions focused on mental health disorders, early identification of symptoms, and culturally competent approaches to support. This training enhances the capacity of staff to recognize, respond to, and refer individuals experiencing mental health challenges.

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.

Central Virginia Alliance for Community Living, Inc. (CVACL) collaborates with the Virginia Assistive Technology System (VATS) to expand access to assistive technology for older adults. CVACL uses the NWD system to facilitate timely and accurate referrals to VATS, ensuring that older adults are connected to appropriate assistive technology resources based on their individual needs. In partnership with VATS, CVACL supports access to hands-on demonstrations of assistive devices, allowing older adults to explore and try out tools such as mobility aids, medication management systems, and communication supports. CVACL coordinates with VATS to organize and participate in community outreach events, including health fairs and caregiver expos. These events raise awareness about the availability and benefits of assistive technology, especially among underserved or rural populations.

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.

In a state of emergency and/or disaster relief, CVACL partners with Fire and Rescue, Police departments, local Departments of Social Services, and other organizations to streamline assistance to those most in need of meals, transportation, support, and advocacy. CVACL works with the Central Virginia Planning District Commission (CVPDC), Monacan Indian Nation, Genworth, and other community partners throughout the region.

As an example of proactive preparedness, CVACL's community partner, Genworth, has supplied bags and emergency items to give to our clients to help keep these older adults confident, calm, and secure at home until relief plans can be executed.

CVACL is again reviewing our Contingency of Operations Plan (COOP) and Emergency Plan with updated service efforts, current management and staff roster, current efforts in the region for safety and security, and provider services in case of an emergency or disaster relief situation.

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.

Central Virginia Alliance for Community Living, Inc. (CVACL) embraces the directive and regulations from the Administration for Community Living (ACL) to serve American Indians. The Monacan Indian Nation Headquarters, Elder Center, and a number of Tribal Elders and their Caregivers are located and reside within PSA 11, the district in which CVACL provides service delivery.

To accomplish effective partnership, communication, and quality service delivery, CVACL will:
- conduct outreach activities and ensure ongoing communication with Tribal leaders determine a means for identify needs; assessing service delivery and enhancing the provision of services and supports to the Monacan Indian Nation.
- offer ongoing targeted coordination with the Monacan Indian Nation to support the delivery of IIB services and supports
- where eligibility is evident and need presents, coordinate with the Monacan Indian Nation to provide additional services funded outside the Older Americans Act.
- will support and provide access to CVACL Programs and service delivery to any American Indian residing within the planning district that should present for services and supports.
- will offer members of the Monacan Indian Tribe leadership an opportunity to be involved in the governance and input for program operations.

CVACL staff will endeavor to understand the culture and structure relevant to tribal relations and will offer a culturally sensitive, person-centered and trauma informed approach to service delivery CVACL will specifically:
1. Coordinate meetings with the Monacan Indian Nation Elder Center monthly and will offer assessments and program information as needed for Elders.
2. Will include the members of the Elder Center in annual and periodic activities (Such as the CVACL Annual Senior Dance; CVACL Congregate Picnics; Holiday Activities; etc.)
3. Will offer ongoing periodic educational sessions related to CVAC's service delivery
4. Will work with the tribal community to provide open, supportive, and culturally sensitive assessment for members of the tribal community.
5. Will provide outreach and coordinating to offer specific programmatic services that fall outside the Older Americans Act funding, such as:
   - Elves for Elders
   - Virginia Insurance Counseling and Assistance Program (VICAP)
   - Weatherization and Housing Programs
   - Senior Medicare Patrol - Scam Alerts
   - Disease Prevention / Health Education and Wellness Programming - Dealing with Dementia, Falls Talk, Bingocize, Navigating Dementia, etc.
6. CVACL will offer the Monacan Indian Nation Tribal Chief a seat on the Board of Directors and the Elder Center Director a position on the CVACL Advisory Council. CVACL will offer an Elder for the member Monacan Indian Nation a position on the CVACL Advisory Council.
7. CVACL will include the Monacan Indian Nation in email newsletters and any information disseminated to the general public.
8. CVACL will participate in DARS annual Tribal Convenings.

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						
Checking	X					
Chore						
Homemaker						
Personal Care	X					
Group 2: Access						
Care Coordination	X					
Care Transitions	X					
Communication, Referral, Information & Assistance	X				X	X
Options Counseling	X					
Transportation	X					X
Assisted Transportation	X				X	X
Group 3: Legal Assistance						
Legal Assistance	X					
Group 4: Other Services						
Assistive Technology/Durable Medical Equipment (DME)/Personal Emergency Response System (PERS)						
Consumable Supplies	X					
Emergency Services	X					
Title III Employment Service						
Medication Management						
Money Management						
Outreach/Public Information & Education (PIE)	X				X	
Residential Repair and Renovation						
Socialization & Recreation	X					
Volunteer Program	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						
Support Groups						
Caregiver Training					X	
Respite Voucher						
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
State General Fund Services						State GF
State Funded Nutrition Services						
State Funded Home Delivered Nutrition						
Care Coordination for Elderly Virginians Program						
Service Coordination 2						X
Service Coordination 1						X
Senior Outreach to Services						
Person Centered Options Counseling						X
Care Transitions						X

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.

Central Virginia Alliance for Community Living, Inc. (CVACL) offers a number of services which address these concerns, including in-home services (social isolation, physical health conditions), access services (all), other services such as congregate nutrition sites (hunger, malnutrition, social isolation, physical health conditions), nutrition services (all), disease prevention/health education (social isolation, physical and mental health conditions), elder abuse prevention (all), long-term care ombudsman (all), and the Care Coordination for Elderly Virginians Program (all).

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.

Personal Care
Home Delivered Nutrition

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	
Community Action Agency (CAA)	
DRPT Transportation	
Emergency Services	
Foster Grandparents	
Home Repair/Modification	X
U.S. Housing and Urban Development (HUD) Housing	
Low Income Home Energy Assistance Program (LIHEAP)	X
Managed Care Services	X
Medicaid Transportation	
Options Counseling	
Program for All-Inclusive Care for the Elderly (PACE)	
Virginia Public Guardianship & Conservator Program	
Retired Senior Volunteer Program (RSVP)	
Senior Community Service Employment Program (SCSEP; OAA Title V)	
Senior Companions	
Senior Cool Care	X
Senior Farmers' Market Nutrition Program	X
Senior Medicare Patrol	X
Supplemental Nutrition Assistance Program (SNAP) Benefit Counseling	
Virginia Insurance Counseling and Assistance Program (VICAP)	X
Weatherization	X
Other-Bedford Ride Transportation	X
Other-New Freedom Transportation	X
Other-Weatherization Readiness Fund (WRD)	X
Other-Weatherization Deferral Repair (WDR)	X
Other-Emergency Home Accessibility Repair Program (EHARP)	X
Other-Supplemental Utility Weatherization - APCo Wx. ODEC Wx	X
Other-Bipartisan Infrastructure Law (BIL)/Infrastructure Investment and Jobs Act (IIJA)	X
Other - Navigating Dementia Self-Management Program	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.
	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: _____

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

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.

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:

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.

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
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.

CVACL is requesting a Direct Services Waiver for the following services due to the fact that no other agency in PSA 11 provides the service and CVACL is the only provider for this service:

Assisted Transportation
Care Transitions
Caregiver Training
Checking
Disease Prevention
Emergency Services
Options Counseling

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**		**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	**Total Proposed Expenditures**	

Locality Served	**Service Provider(s)**	**Entity Type**
		Select Option
		Select Option
		Select Option
		Select Option
		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:

Service Description:

Service: Checking						Direct Service Waiver		
Unit Type	Contacts	**Total Units**	2,314	**People Served**	160	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
5,000	Title III-B	
	General Fund- OAA General	X
12,000	General Fund- Community Based	X
	Voluntary Contributions	
	Fees	
17,000	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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 with greatest economic need, with particilar attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

Checking service provided by the Central Virginia Alliance for Community Living (CVACL) is designed to support older adults and individuals with disabilities, particularly those who are frail, isolated, or living alone. This service aims to ensure their physical and emotional well-being through regular contact, as deemed eligible by an assessment. To qualify for the Checking service, individuals undergo an assessment process facilitated by a CVACL Care Manager. This assessment utilizes the Uniform Assessment Instrument (UAI), a standardized tool mandated by DARS. CVACL conducts phone calls or in-home visits, to individuals enrolled in the Checking service. These calls or in-home visits serve as a friendly check-in to assess their well-being and provide reassurance.CVACL will conduct regular systematic analysis of the persons served and the impact of the service.

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	**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:

Service Description:

Service: Homemaker						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	**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
		Select Option

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:

Service Description:

Service: Personal Care						Direct Service Waiver		
Unit Type	Hours	**Total Units**	2,652	**People Served**	14	**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
19,000	Title III-B	
	Title III-E	
	General Fund- OAA General	X
119,229	General Fund- Community Based	X
	Voluntary Contributions	
4,000	Fees	
142,229	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	Karis Care	For Profit
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

CVACL Personal Care services are designed to assist individuals aged 60 and older who have difficulty performing Activities of Daily Living (ADLs) such as bathing, dressing, eating, toileting, grooming, transferring in and out of bed or chair, and walking. These services aim to support individuals in living independently and may also provide respite for family caregivers. Services provided are determined based on the individual needs as identified in the assessment in the Uniform Assessment Instrument evaluation. A care plan is developed identifying service components to be provided to the individual.

Personal Care services are delivered through contracts with licensed home health care agencies. These agencies are required to be registered in the State of Virginia. A service agreement is completed between the individual, CVACL and the identified contractor, enumerating the services to be provided.

Monitoring of the program is conducted on a monthly basis through the review of Shift/Visit reports provided by the Personal Care/Home Health agencies. Service providers are monitored annually. Additionally, a regular systematic analysis of the individuals served and the impact of the service is conducted to ensure effectiveness and quality of care.

Personal Care services in Virginia are structured to provide essential support to older adults, enabling them to live independently and safely in their homes. Through contracted providers, service agreements, and a robust monitoring and evaluation system, these services aim to meet the individual needs of clients while adhering to state regulations and ensuring quality care of individuals residing at home.

GROUP 2: ACCESS

Service: Care Coordination						Direct Service Waiver			
Unit Type	Hours	**Total Units**	185	**People Served**	13	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
14,000	Title III-B	
	Title III-E	
	General Fund- OAA General	X
5,000	General Fund- CCEVP	X
	Voluntary Contributions	
19,000	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Individuals served shall be dependent in two (2) or more activities of daily living (ADLs) and have significant unmet needs.

Service Description:

CVACL employs a comprehensive approach in the evaluation and assessment of an individual's needs for services. Individuals served shall be dependent in two (2) or more activities of daily living (ADLs) and have significant unmet needs. A Care Manager completes an assessment, using the full Uniform Assessment Instrument (UAI), a standardized tool mandated by Virginia's Department for Aging and Rehabilitative Services (DARS), to determine the care needs of individuals. The Care Manager then evaluates individual's service provisions and individual needs and coordinates service referrals and provisions by a variety of agencies/organizations. Components of service shall include a comprehensive service delivery model that encompasses the following key components:

1 - Outreach and Intake: Engaging with individuals to inform them about available services and initiating the intake process.
2 - Screening and Assessment: Conducting a thorough evaluation using the UAI to determine the individual's functional status, including their ability to perform Activities of Daily Living (ADLs) such as bathing, dressing, eating, toileting, grooming, transferring, and walking.
3 - Care Planning: Developing an individualized care plan based on assessment findings, identifying specific service needs and goals.
4 - Service Referral and Delivery: Connecting individuals to appropriate services and ensuring their delivery in a timely and effective manner.
5 - Service Monitoring: Regularly reviewing the implementation of the care plan to ensure services are meeting the individual's needs.
6 - Reassessment: Conducting formal evaluations at least every six months to assess changes in the individual's condition and adjust the care plan accordingly.
7 - Transition Planning: Assisting individuals in transitioning to more intensive care options, such as intensive in-home care, personal care, adult day care, or institutional care, when necessary.

These components are designed to provide a holistic and responsive service delivery system that adapts to the evolving needs of older adults.

CVACL staff maintains monthly contact with the individual and/or caregiver being served to monitor the implementation of the care plan. If the individual's needs have changed, then the care plan is adjusted at any time to meet those needs. Reassessments must be completed at least every six months. CVACL will conduct a regular systematic analysis of the persons served and the impact of the service. This ongoing evaluation process ensures that services remain responsive and effective in meeting the needs of older adults and individuals with disabilities.

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

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-B	
	Title III-D	
	General Fund- OAA General	X
	General Fund- CCEVP	X
	Voluntary Contributions	
	Centra Grant	
	Total Proposed Expenditures	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	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 with greatest economic need, with particilar attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently. Persons at greatest risk of readmission to a hospital within 30 days of discharge.

Service Description:

TAKE CHARGE is a current program that partners with Centra Health and other providers to address Care Transitions of high-risk patients from hospital/facility to home with a goal of reducing readmissions, improving patient response to health care issues, and increasing the knowledge and education of patients in regard to chronic and acute medical conditions. The program seeks to impact patient response to health issues through education and behavioral changes. The program has involved multidisciplinary collaboration with Centra staff and leadership to ensure the integrity and quality development of the components of service.

The Program operates according to the Coleman Care Transitions Intervention Model and is currently managed by a Director of Social Service Programs with a MA in Counseling Psychology. Direct service staff are a RN, Lead CTI Coach, and a CTI Coach.

The priority of the program is to serve frail and high-risk individuals identified and referred by Centra and other providers. The program addresses the many needs documented among individuals transitioning from hospital to home or other transition in health care. The Take Charge Care Transitions Intervention Program will accept referrals for individuals transitioning within health care settings with a focus on empowering individuals to take charge of their health by understanding and managing their health conditions to their best ability. The program will support individuals in maintaining individual independence and quality of life. A secondary goal is to avoid admissions and readmissions to hospitals and other health care facilities. The program anticipates serving the uninsured and the underinsured individuals who are at high risk of readmission or admission to health care facilities and lack the resources to respond.

The program will involve:
- specific health related education;
- support with accessing and following through with medical care;
- support with accessing resources needed for medical equipment and emergency medications;
- medication management strategies based on individual health care needs,
- assessment of social determinants impacting health care and support in addressing them;
- assessment for connection with community based services; and
- referral for follow up and support services with CVACL care management programs.

The program will utilize a three-pronged approach to providing service to individuals referred. Service Delivery is based in the individual's home or residential facility. All referrals from the hospital will receive initial assessment at the hospital, if at all possible, followed by home visits and implementation of an individual plan for service delivery. The service delivery plan will involve 30-day CTI coaching and follow-up model.

Service: Communication, Referral, Information & Assistance						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	2,230	**People Served**	1,380	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
122,000	Title III-B	
69,500	Title III-E	
32,709	General Fund- OAA General	X
11,000	Voluntary Contributions	
235,209	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

CVACL offers a comprehensive Communication, Information and Referral (CRIA) service designed to educate individuals, individuals with disabilities and/or caregivers as to the services available within the community and the methods of access in order to promote the individual's holistic well-being and encourage ongoing independence by providing tailored information and facilitating connections to appropriate services. The individual's needs are determined based on the individual's request and/or agency assessment. Aspects include individual assessments, individual education, and referral assistance. Also, it will include the collection and maintenance of data/information of community resources and service providers.

CVACL's CRIA service encompasses the following components:
1 - Information Dissemination: Providing general information to individuals, caregivers, and community members about available services.
2 - Personalized Assistance: Offering additional support to older adults and caregivers by identifying and connecting them to services that meet their specific needs.
3 - Service Access Guidance: Educating individuals and caregivers on how to access services, including understanding eligibility requirements and application processes.

To determine service needs, CVACL utilizes either the Virginia Service – Quick Form (a streamlined assessment tool used to gather essential information for service determination) or the Uniform Assessment Instrument (UAI) (a comprehensive assessment tool consisting of multiple pages). If an individual requires only a referral, the Virginia Service – Quick Form is sufficient. For more complex needs, the UAI is completed to ensure comprehensive service planning

CVACL utilizes the No Wrong Door (NWD) Tools Application to facilitate referrals to service referrals. With the individual's consent, CVACL staff can make referrals and request additional assistance through this system.

Follow-up is conducted with a minimum of 10% of external referrals, involving the individual or caregiver and the referred agency, to ensure service effectiveness and satisfaction.

CVACL maintains a comprehensive database of community resources and service providers, which is regularly updated to ensure accurate and current information. This database supports the CRIA service by enabling staff to provide timely and relevant information to individuals seeking assistance.

By providing personalized information and facilitating connections to appropriate resources, CVACL aims to enhance the well-being and independence of older adults and individuals with disabilities.

Service: Options Counseling						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	145	**People Served**	20	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
10,000	Title III-B	
15,000	General Fund- CCEVP	X
	Voluntary Contributions	
25,000	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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:

All persons regardless of age, disability or veteran status shall be served by Person-Centered Options Counseling. Organizations shall have a knowledge of services and supports for all persons and provide Person-Centered Options Counseling (PC-OC) to further assist individuals in locating the services and supports needed.

Service Description:

Person-Centered Options Counseling is a decision-support process whereby individuals, with support from family members, caregivers and/or significant others, are supported in their deliberations to make informed long-term support choices in the context of the individual's preferences, strengths, needs, values, and individual needs. It involves respecting the rights of individuals to control and make decisions about their own lives. It is a process, not an event. It may include multiple contacts over a short-term period, or maybe ongoing over a longer period of time. The Person-Centered Options Counselor may have multiple contacts over a short-term period, or maybe ongoing over a longer period of time, depending on the individual's choice and the care plan.

CVACL Agency staff who deliver Person-Centered Options Counseling must have training in the statewide Person-Centered Options Counseling curriculum. Counselors collaborate with individuals, their families, caregivers, and significant others to explore long-term support options and develop an Individual care plan that reflects the individual's goals and desired outcomes. At present, CVACL employs two Person-Centered Options Counselors. Once Person-Centered Options Counseling services are terminated, an Options Counseling Individual Survey is sent to each CVACL individual, within 10 working days, to gain insight concerning their satisfaction with the Person-Centered Options Counseling supports that they received.This feedback is used to assess service effectiveness and identify areas for improvement.

CVACL's Person-Centered Options Counseling services are designed to empower individuals to make informed decisions about their long-term care options. By adhering to statewide training standards and actively seeking client feedback, CVACL ensures that services are responsive to the unique needs and preferences of each individual.

Service: Transportation						Direct Service Waiver			
Unit Type	1 Way Trip	**Total Units**	5,502	**People Served**	50		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
70,000	Title III-B	
	Title III-E	
30,491	General Fund- OAA General	X
47,525	General Fund- Transportation	X
5,000	Voluntary Contributions	
	Fees	
153,016	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	AAA
		Select Option
		Select Option
		Select Option
		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, who are assessed for and wish to attend CVACL's congregate nutrition site programs.

Service Description:

CVACL plans to provide transportation to both ambulatory and non-ambulatory (but not stretcher bound) seniors, age 60 and older, who lack the ability or means to transport themselves, and have no one in the community to assist them, to and from the CVACL nutrition sites and living within the transportation radius from the nutrition center. Included in this service are occasional trips to the grocery store, local shopping, all-site parties, and other trips as deemed appropriate. These services will be provided depending on the availability of vehicles, drivers, volunteers, weather conditions, site capacity, budget constraints, and days sites are open. This service will be provided based on site calendars. Individuals must be physically and mentally able to attend the sites and must be approved for transport following their assessments. Individuals are assessed using the Virginia UAI. Service provided is in compliance with Service Standards, Title III Regulations, and OAA.

Staffing involved in this project include: the Nutrition Program Director, Director of Transportation, Transportation Coordinator, full and part time drivers, Director of Finance, Care Managers and some administrative employees. Drivers all receive training, driver record check, and background check.

The program is evaluated by way of verifying driver daily schedules, ride completions (units of service), and occasional ride-alongs by a driver supervisor.

Service: Assisted Transportation						Direct Service Waiver			
Unit Type	1 Way Trip	**Total Units**	2,048	**People Served**	110		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
89,000	Title III-B	
31,800	Title III-E	
48,447	General Fund- OAA General	X
	General Fund- Transportation	X
	Voluntary Contributions	
7,000	Fees	
58,000	United Way	
234,247	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	AAA
		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:

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.

Service Description:

Central Virginia Alliance for Community Living (CVACL) plans to provide non-emergency transportation (Dial-A-Ride) to both ambulatory and non-ambulatory (but not stretcher bound) seniors 60 years of age or older, door through door, for individuals living in their own homes who lack the ability or means to transport themselves to medical appointments and for other services (such as pharmacies, grocery stores, and other human service appointments) that promote continued independent living. Spouses or necessary escorts may accompany eligible participants. Escorts may be required to accompany individuals if individuals need extra assistance. Individuals cannot be carried or lifted by drivers and individuals in wheelchairs cannot be taken up or down steps.

Individuals are assessed using the Virginia UAI. Transportation arrangements may be requested after individuals have been assessed and approved for transportation services.

Ride requests should be made as far in advance as possible, but in no case with less than two working days lead time. We do not provide emergency transportation. Rides are provided on a first come, first served basis and requests are accepted as driver and vehicle availability, schedules, destinations, and budgets allow. Generally, rides are provided only to destinations within the planning district we serve (PSA 11). Service is in compliance with Service Standards, Title III Regulations, and the Older Americans Act.

Staffing involved in this project include: the Director of Transportation, Transportation Coordinator, three full time drivers, one part time driver, Director of Finance, Care Managers, and some administrative employees. The vast majority of trips are provided by CVACL drivers. A limited number of trips are provided by service delivery accessed through a non-contracted service provided by Greater Lynchburg Transit Company (GLTC) and paid on the individual's behalf based on GLTC's rate. The GLTC trips are monitored monthly via billing and customer interaction.

The program is evaluated by way of verifying driver daily schedules, ride completions (units of service), and occasional ride-alongs by driver supervisor. Drivers all receive training, driver record checks, and background checks.

GROUP 3: LEGAL

Service: Legal Assistance						Direct Service Waiver			
Unit Type	Hours	**Total Units**	50	**People Served**	20		**Yes**	X	**No**

Proposed Expenditure Amount	Funding Source	Match Funding
5,000	Title III-B	
	General Fund- OAA General	X
	Voluntary Contributions	
5,000	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	Virgina 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 with greatest economic need, with particilar attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

CVACL contracts with the Virginia Legal Aid Society (VLAS) to provide essential legal assistance to older adults in our Service Area. This partnership aims to enhance the legal well-being of seniors, particularly those facing financial constraints. This collaboration ensures that older adults have access to vital legal resources, promoting their rights and well-being.

To determine eligibility for legal assistance, CVACL Care Managers conduct assessments using either the Virginia Service-Quick Form or Part A of the Uniform Assessment Instrument (UAI). These tools help identify individuals who may benefit from services such as Simple Wills and Powers of Attorney.

Public information/education, training, and group presentations are also provided to increase community knowledge and awareness of legal related issues and protect the legal rights of older adults. VLAS also engages in public education to raise awareness about legal issues affecting older adults.

CVACL monitors this service on a monthly basis when VLAS submits detailed reports to CVACL outlining the services rendered. Following the conclusion of services, CVACL solicits feedback from clients to assess client satisfaction and identify areas for improvement.

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	**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:

Service Description:

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	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	AAA
		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:

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.

Service Description:

Oral Nutrition Supplements (ONS), such as Ensure, are provided to individuals that have been determined according to a Nutritional Screening Instrument (NSI) with a need for supplemental nutrition and are recommended by a physician, accompanied with a signed prescription.

ONS (Ensure) will be delivered once monthly as 30 8oz units. ONS is not counted as a meal but is tracked.

Service: Emergency Services						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	50	**People Served**	30	X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
500	Title III-B	
	General Funds- OAA General	X
1,000	Voluntary Contributions	
	Fees	
1,500	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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 60 and with greatest economic need, with particilar attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

To provide short-term and/or immediate support to individuals facing personal, family, or community emergencies. Assistance is tailored to meet urgent needs resulting from crisis such as homelessness, the loss of income, severe weather, or public health concerns.

All individuals requesting emergency assistance will undergo an assessment process conducted by a CVACL care manager. Eligibility is determined by completing either the Virginia Quick Form or the Uniform Assessment Instrument (UAI), to identify the individual's immediate needs and determine appropriate support or referrals.

Requests for emergency assistance may include:
- Basic Needs: Food, clothing, hygiene supplies
- Medical Support: Medications, eyeglasses, hearing aids, medical equipment
- Housing & Utilities: Assistance with electric bills, heating oil
- Information & Referrals: Connection to appropriate community resources and services

CVACL conducts regular and systematic analyses of the individuals served and the overall impact of emergency services. This ongoing evaluation helps ensure services are effective, responsive, and aligned with community needs and the mission of CVACL.

Service: Title III Employment Services						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	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		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:

Service Description:

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	**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:

Service Description:

Service: Money 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
	General Funds- Community Based	X
	Voluntary Contributions	
	Fees	
0	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		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:

Service Description:

Service: Outreach/Public Information and Education						Direct Service Waiver			
Unit Type	Contacts	**Total Units**	3,237	**People Served**		X	**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
52,500	Title III-B	
42,200	Title III-E	
	General Funds- OAA General	X
2,500	Voluntary Contributions	
97,200	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

Central Virginia Alliance for Community Living, Inc. (CVACL) is committed to providing the public with accurate and accessible information about the services we offer. Information is disseminated through a variety of methods, including brochures, handouts, public service announcements, educational programs, and public speaking engagements. CVACL also participates in and promotes health and information fairs, and share updates via television segments, social media platforms, and the agency website.

Information about CVACL's services is available by emailing cvacl@cvcl.org; by calling our office using our toll-free number during regular business hours, Monday through Friday, 8:30 a.m.-4:30 p.m.; by visiting our website at www.cvacl.org; or by following our social media channels:
Facebook - https://www.facebook.com/cvallianceforcommunityliving
Instagram - https://www.instagram.com/cvacl/
LinkedIn - https://www.linkedin.com/company/central-virginia-alliance-for-community-living-inc.

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	**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:

Service Description:

Service: Socialization and Recreation						Direct Service Waiver			
Unit Type	Hours	**Total Units**	2,645	**People Served**	70		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
10,000	Title III-B	
	General Funds- OAA General	
	Voluntary Contributions	
	Fees	
10,000	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA11	CVACL	AAA
		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:

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.

Service Description:
Socialization and recreation at CVACL's congregate nutrition sites are implemented by trained site managers.

Physical activities provided at congregate sites are adapted from evidence-based programs such as Bingocize and Geri-Fit. Cognitive activities are provided using materials from Stronger Memory and Goodwin Living Foundation. Arts activities come from a variety of resources, including Amherst Glebe Arts Response (AGAR), which has provided virtual/streamed jazz concerts and in person painting classes.

Referrals for congregate site participation come from the community, DSS, hospitals, individuals, and caregivers.

Service: Volunteer Program						Direct Service Waiver			
Unit Type	Hours	**Total Units**	517	**People Served**	18		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
2,100	Title III-B	
	General Funds- OAA General	
	Voluntary Contributions	
	Fees	
		X
2,100	**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
		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:
Adults who wish to serve older adults and adults with disabilities.

Service Description:
Volunteer opportunities will be advertised to the community by way of website, newsletter, Facebook, newspaper, radio, and television. Presentations will be conducted at civic clubs, church groups, businesses, and events to recruit volunteers.

New volunteers are provided with orientation and training. Volunteers are managed by a program supervisor that also monitors their work.

Volunteers are used to assist the public in the Virginia Insurance Counseling and Assistance Program, delivering meals, providing transportation, office work, and special projects.

Each volunteer fills out an application. A criminal background check is conducted on all volunteers, and a drug screen and driver record check are performed where appropriate.

GROUP 5: NUTRITION

Service: Congregate Nutrition						**Direct Service Waiver**			
Unit Type	Meals	**Total Units**	2,913	**People Served**	70		**Yes**		**No**

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
214,028	Title III-C(1)	
	Title III-E	
	NSIP	
42,452	General Funds- OAA General	X
	General Funds- Supplemental Nutrition	X
500	Voluntary Contributions	
4,000	United Way	
260,980	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
PSA11	CVACL	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.

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:

Meals at congregate sites are frozen and reheated to 165F on site. Each meal provides one-third of the US Recommended Daily Allowance for intake of nutrients, as required. An appropriate single shelf-stable meal is provided to our individuals for use during site closings and holidays that fall on a regularly scheduled site day. Each congregate site is monitored at least monthly by the Nutrition program coordinator or the Program Director. Congregate site meal preparation and programming is observed and documented on a Congregate Site Checklist. Any observed deficiencies are noted and promptly corrected.

Efforts to provide innovative/modernized congregate nutrition services:

At least semi-annually, a congregate site survey is completed by participants to gain information such as meal satisfaction, at-home meal consumption, impact of service on the individual, and additional programming suggestions. All suggestions are evaluated for popularity and feasibility while adhering to provided standards and regulations. Recent improvements to meals include the addition of fresh salads during the summer growing season, when fresh vegetables are available.

Nutrition Assessments, Referral and Screening Information:

Referrals for congregate participation come from the community, DSS, hospitals, individuals, and caregivers. Once the referral is received, a trained care manager conducts an assessment using the Virginia Uniform Assessment Instrument or Virginia Service-Quick Form and completes the Nutritional Health Screening Checklist on each potential individual. Any individual with an assessed need for nutrition services will be referred to our Registered Dietitian Nutritionist (RDN), given additional information, and closely monitored for further social and dietary needs.

Program Evaluation for Effectiveness:

Congregate site programming is evaluated monthly at calendar submission by the Nutrition Program Director. As previously mentioned, at least semi-annually a congregate site survey is completed by participants to gain input on meal satisfaction, at-home meal consumption, impact of service on the individual, and additional programming suggestions.

Vendors or Subcontractor Monitoring Process and Frequency:

GA Foods produces the meals, which are distributed by Blue Dog Associates, Inc.

GA Foods will be monitored monthly online via health department inspections from their jurisdiction. Blue Dog Associates, Inc., is monitored on site semi-annually with a checklist provided by CVACL.

Service Description:

Each congregate site is managed by a part-time trained Site Manager, who implements the nutrition programming and appropriate exercise programs. Congregate Site Managers may also be assisted by approved and trained volunteers. CVACL employs one part-time Congregate Site Manager Coordinator to oversee site program operations and to offer training as needed. Congregate site participants receive opportunities for fellowship, social and recreational activities, and cognitive exercises, in addition to enjoying a nutritious meal together.

Nutrition Site Information:				
	Site Name and Street Address	City or County of Site	Days and Hours of Operation	Food Provider
1	Lynchburg/Amherst @ 501 12th St.	Lynchburg	Mon, Wed, Fri / 9am-1pm	GA Foods/Blue Dog
2	Lynne M Burnham Center @ 103 Avoca Ln.	Altavista	Tue, Thu / 9am-1pm	GA Foods/Blue Dog
3	Appomattox @ 220 Community Ln.	Appomattox	Mon, Wed, Fri / 9am-1pm	GA Foods/Blue Dog
4	Campbell Cafe @ 616 Old Rustburg Rd.	Campbell County	Tue, Thu / 10am-1pm	GA Foods/Blue Dog
5	Bedford @ 1257 County Farm Rd.	Bedford	Mon / 9am-1pm	GA Foods/Blue Dog
6	Moneta @ 1050 Hendricks Store Rd.	Bedford County	Tue / 9am-1pm	GA Foods/Blue Dog
7				
8				
9				
10				
11				
12				
13				

14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				

Service: Grab and Go Nutrition

Title III Funding Source:		**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):

	(A) During disaster or emergency situations affecting the provision of nutrition services and
	(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:

Grab and Go meals preemptively address food insecurity should an emergency need arrive, including natural disasters, unexpected closure of a congregate site, or unexpected illness of a site participant. By providing shelf-stable meals twice a year, eligible clients are assured there is always something to eat on hand. With this infrequent delivery, participants remain encouraged to continue attending their congregate site meal program regularly.

CVACL attests that it will not exceed the 25% cap on Title III-C(1) funding for Grab & Go meals for the Area Plan year.

To monitor the impact on the C1 Program, CVACL 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:

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.

Eligibility Criteria:

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

CVACL sought public input in the development of the Area Plan, with specific notice about the Grab & Go Meal provision, through the AAA's public hearing held on July 17, 2025, and through the 30-day public comment period held on June 20-July 20, 2025.

CVACL consulted with the AAA's Registered Dietitian, AAA Advisory Council, and the AAA's nutrition services provider. The AAA further sought the input of C1 participants and their families. In receiving input from these entities, the AAA noted... [wide support, mixed support, no support, etc.].

Service Implementation:

CVACL's Grab & Go program will be implemented by the distribution of shelf stable meals (provided by GA Foods via Blue Dog Associates) on a semi-annual basis: once in early spring and once in early fall. The service can also be utilized by congregate site participants on special need basis.

Service: Home Delivered Nutrition						Direct Service Waiver			
Unit Type	Meals	**Total Units**	88,000	**People Served**	450		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
390,435	Title III-C(2)	
	Title III-E	
21,718	NSIP	
30,790	General Funds- OAA General	X
167,553	General Funds- Home Delivered Meals	X
40,597	General Funds- Supplemental Nutrition	X
3,000	Voluntary Contributions	
23,000	United Way	
677,093	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	AAA
		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:

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.

Types of Home Delivered Meals Served (check all that apply):

X	**Frozen**	X	**Chilled**		**Shelf Stable**	X	**Hot**		**Other:**

Meal Preparation and Delivery:
Home-delivered meals are frozen or chilled "Mom's Meals" from PUR Foods, LLC. All meals are heated to 165F before delivery and consumption.

The quality assurance process and policies for Mom's Meals and distributor Nourish Care Cold-Chain Management: Meals are packaged frozen and have a 72-hours delivery window from shipment to refrigerator. The meals are held throughout delivery at temperatures that ensure product safety and quality, typically 28-41F.

Emergency Meal Provision- Type and Frequency:
CVACL's Grab & Go program provides shelf stable meals on a semi-annual basis to ensure a meal is available in case of emergency. The service can also be utilized by congregate site participants on special need basis.

Nutrition Assessments, Referral and Screening Information:
Referrals for Home Delivered Meals come from the community, DSS, hospitals, individuals, and caregivers. Once the referral is received, a trained care manager conducts an assessment using the Virginia Uniform Assessment Instrument and completes the Nutritional Health Screening Checklist on each potential individual to determine eligibility for the program.

Program Evaluation of Effectiveness:
Home Delivered Meals program is evaluated quarterly at menu submission by the Registered Dietary Nutritionist (RDN) and Nutrition Program Director. At least semi-annually, a survey is completed by all Home Delivered Meal recipients to gain information such as meal satisfaction, in-home meal consumption, impact of service on the individual, and additional programming suggestions.

Vendor or Subcontractor Monitoring Process and Frequency:
Pur Foods LLC is monitored semi-annually via online Health Department inspection from that jurisdiction.

Service Description:
Hot home-delivered and chilled meals are provided to individuals who are assessed as homebound and unable to attend a congregate nutrition site. The assessment is provided by CVACL Care Manager using the Virginia Uniform Assessment Instrument (UAI). Based on the assessment the individual may be referred to our RDN on staff for further evaluation and assistance, either through Nutritional Counseling and/or to other community resources.

Currently, CVACL refers those in need of additional food sources to local food banks, pantries, and DSS for possible SNAP benefits. Approved individuals may receive five (5) meals minimum per week depending on assessed need. Hot home delivered meals are delivered by paid part-time staff on a weekly basis; chilled home delivered meals are delivered by Pur Foods/Mom's Meals on a weekly basis.

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**

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?

Describe the AAA's plan for contact of socially isolated and vulnerable HDM-ID participants:
How will the AAA provide access to Nutrition Education and Nutrition Counseling for these participants?
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.

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**
	Hours per week or		**Part-time Employee**
10	**Hours per month**	X	**Contractor/Consultant**

Service: Nutrition Counseling									**Direct Service Waiver**	
Unit Type	Hours	**Total Units**	60	**People Served**	40		**Yes**		**No**

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
500	Title III-C(1)	
2,500	Title III-C(2)	
	General Funds- OAA General	X
	General Funds- Supplemental Nutrition	X
	Fees	
3,000	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	AAA
		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:

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.

Staff Qualifications for Service Delivery:

Registered Dietitian Nutritionist (RDN) licensed by the Virginia Department of Health Professions

Screening & Assessment:

The "Determine Your Nutritional Health" Nutrition Screening checklist developed and distributed by the Nutrition Screening Initiative must be completed during assessment and reassessment for both Congregate and Home Delivered Meal services. This screening can be self-administered or conducted by anyone that interacts with older adults. It highlights the warning signs of poor nutritional status.

A score of 11 or higher, and a "YES" answer to question 9 ("without wanting to, I have lost or gained 10 pounds in the last 6 months") requires a referral to the RDN on staff. If the participant accepts the referral for Nutrition Counseling, the RDN must complete or review the completed page 6 of the Uniform Assessment Instrument.

Program Evaluation:

Home Delivered and Congregate Meals Program are evaluated semi-annually by the RDN and Nutrition Program Director. At least semi-annually, a survey is completed by all Nutrition program participants to gain information such as meal satisfaction, in-home meal consumption, impact of service on the individual, and additional Nutritional information. This survey provides the opportunity to contribute feedback on nutrition counseling services received or needed, in addition to regular staff touchpoints.

Service Description:

Based on assessment, the RDN determines individual participant nutrition needs, develops and implements a nutrition plan, evaluates the participant's outcomes, and maintains documentation. Counseling may be provided to the participant and/or caregiver at a congregate site, in home, at the office, or by phone. Written instruction and/or handouts are provided as needed. Nutrition Counseling sessions are documented in DARS-approved participant database within the program notes.

All Congregate and Home Delivered Meal participants of CVACL will receive written information at orientation on the availability of the Nutrition Counseling service for those deemed high-risk.

Service: Nutrition Education						Direct Service Waiver			
Unit Type	Sessions	**Total Units**	500	**People Served**	900		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
2,000	Title III-C(1)	
7,500	Title III-C(2)	
	General Funds- OAA General	X
	General Funds- Supplemental Nutrition	X
	Fees	
9,500	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	AAA
		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.

Staff Qualifications for Service Delivery:

Registered Dietitian Nutritionist (RDN) or Nutrition staff under RDN guidance

Frequency of Service for both Congregate and Home Delivered Participants:

Nutrition education is provided to congregate site participants 1 to 3 times a week in person and/or with handouts. Home Delivered Meal recipients receive twice monthly educational handouts.

Annual Education Plan Accommodations for Older Adult Learners:

An annual Nutrition Education Plan will be designed by the RDN and Nutrition Program Director. The goal is to improve the overall community health in older adults using specific and targeted nutrition education. Each segment of the nutrition education plan will be tailored to the most prevalent nutritional problems facing older adults. Nutrition education will be directed towards prevention of nutritional deficiencies. All nutrition information will be designed to meet all older adults at all levels of education.

Program Evaluation:

Home Delivered/Congregate Meals programs are evaluated semi-annually by the RDN and Nutrition Program Director. At least semi-annually, a survey is completed by all Nutrition program participants to gain information such as meal satisfaction, in-home meal consumption, impact of service on the individual, and additional nutritional information, including education. All surveys will be kept on file tracking purposes.

Service Description:

The RDN develops or reviews and approves nutrition information (handouts and/or presentations) and develops an annual nutrition education plan. Each congregate site will present at least 15 minutes of nutrition education at each convening. The information used will be approved by the RDN. The nutrition education will be presented by the RDN, trained congregate site manager, or a trained volunteer. The education information will be monitored using the congregate site monthly calendar.

Nutrition education for Home Delivered Meals will be in the form of handouts delivered with the home delivered meals twice monthly. Only approved information by the RDN on staff will be approved for distribution. All nutrition education information will be monitored by the Nutrition Program Director and kept on file for program purposes.

GROUP 6: DISEASE PREVENTION/HEALTH PROMOTION

Service: Disease Prevention/Health Promotion						Direct Service Waiver			
Unit Type	Sessions	**Total Units**	239	**People Served**	29		**Yes**		**No**

Proposed Expenditure Amount	Funding Source	Match Funding
3,400	Title III-B	
15,932	Title III-D	
	General Funds- OAA General	X
	Voluntary Contributions	
	Fees	
19,332	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

List the specific evidence-based services provided:

FallsTalk
Healthy IDEAS
Care Transitions Intervention
Bingocize
Geri-Fit
Walk with Ease

Program Staffing:
FallsTalk and Healthy IDEAS are conducted by staff within Social Services department, all of whom have a four-year Human Services Degree. Care Transitions Intervention is conducted by staff within the Social Services department and/or a Registered Nurse. These programs are supervised by the Director of Social Services Programs. Bingocize, Geri-Fit, and Walk with Ease are conducted by a staff member with specific program training and experience as an adult trainer, Activity Director at an Adult Day Care, and former Exercise Leader with the American College of Sports Medicine.

Service Locations:
Programs are provided throughout the CVACL Service Area, including at participant sites, congregate nutrition sites, and at CVACL's administrative office community room, as appropriate.

Participation Tracking:
Individual units are tracked in the DARS-approved client database for each participant receiving the service. A session is one event that lasts a day or part of a day.

Screening:
FallsTalk program is designed to be implemented by professional social services staff after assessing for falls risk behaviors and conditions. Services provided are determined based on the individual's needs as identified in the Uniform Assessment Instrument (UAI). Healthy IDEAS individuals are screened for this program based on their needs as identified in the Uniform Assessment Instrument (UAI).

Assessments:
FallsTalk program begins with a personal interview to discuss his/her unique situation. Intervention consists of initial and follow-up interviews with a trained facilitator, with three weekly and then monthly check-in calls. Healthy IDEAS begins with a one-on-one conversation. The presence and severity of depressive symptoms determines the scope and duration of the intervention, with components/steps delivered over 3 to 6 months through a minimum of three in-person visits in the client's home and five or more telephone contacts. Exercise programs are self-assessed.

Service Description:
- FallsTalk is an evidence-based program to address one of the most significant threats to independence among individuals over 50 and individuals with disabilities. Additionally, the outcome of preventing falls is significant to cost savings for healthcare. The program increases falls prevention behaviors and falls self-management skills, as well as improving recognition of falls threats (personal traits and circumstances that could cause a fall) and self-efficacy.
- Healthy IDEAS (Identifying Depression, Empowering Activities, for Seniors) is an evidence-based depression program for older adults. Healthy IDEAS helps detect depression and to reduce the severity of depressive symptoms in older adults, and to empower at-risk older adults to address care concerns so they can remain at home. Depressive symptoms are identified, included in the individual's care plan, and monitored over time.
- Evidence-based group exercise programs build strength and endurance while providing education to prevent falls or self-manage diseases like arthritis, while providing opportunities for socialization.

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	**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:

Service Description:

GROUP 7: NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM: ADDITIONAL SERVICES

Service: Individual Counseling						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	
0	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		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:

Service Description:

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

Proposed Expenditure Amount	Funding Source	Match Funding
	Title III-E	
	General Funds- OAA General	X
	Voluntary Contributions	
0	**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:

Service Description:

Service: Caregiver Training						Direct Service Waiver			
Unit Type	Hours	**Total Units**	10	**People Served**	10	X	**Yes**		**No**

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

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	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; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Service Description:

Dealing with Dementia (DWD) is a four-hour workshop, paired with a comprehensive reference book, the Dealing with Dementia Guide. CVACL is continuing to work with Rosalynn Carter Institute on Caregiving (RCI) to provide support for caregivers, both personal and professional, of individuals who are living with dementia, Alzheimer's, and/or memory loss. The evidence-informed program teaches participants how to use the Dealing with Dementia Guide provided by RCI (considered the best reference material available in the field), how to access resources, and how to manage the different challenges with caregiving. Those challenges can include financial, medical, behavioral, and, very importantly, self-care issues.

CVACL currently has one staff employee certified through the Rosalynn Carter Institute on Caregiving (RCI) to facilitate these workshops.

Service: Respite Voucher						Direct Service Waiver			
Unit Type	Vouchers	**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	**Total Proposed Expenditures**	

Locality Served	Service Provider	Entity Type
		Select Option
		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:

Service Description:

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	**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:

Service Description:

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	**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:

Service Description:

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	**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:

Service Description:

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	**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:

Service Description:

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	**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:

Service Description:

PART 4: TITLE VII SERVICES

GROUP 8: ELDER ABUSE PREVENTION

Forego completion of this page if <u>all</u> 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**		**People Served**	

Proposed Expenditure Amount	**Funding Source**
	Title III-B
	Title VII- Elder Abuse Prevention
	General Funds- OAA General
	Voluntary Contributions
	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:

Service Description:

GROUP 9: LONG-TERM CARE OMBUDSMAN

Service: Long-Term Care Ombudsman Program	
Service Details (Indicate how the AAA ensures ombudsman coverage):	
	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:	
	The AAA provides this service for one or more other PSAs.
Identify the other PSA(s) for which the agency provides this service:	

Proposed Expenditure Amount	Funding Source
10,000	Title III-B
3,408	Title VII- Elder Abuse Prevention
24,016	Title VII-Long-term Care Ombudsman
	General Funds- OAA General
17,005	General Funds- Ombudsman
5,952	Dept. of Medical Asst. Services (DMAS) Ombudsman
4,903	Supplemental Local or Regional Funding
65,284	**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:	3477
Number of assigned staff to program:	1
% FTE per each staff person assigned:	100

Volunteer Recruitment and Management (if applicable):

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:

During FFY 2026, our program will assess and develop a plan to meet the needs for training within PSA11 facilities.

During FFY 2026, our program will complete all documentation in Ombudsman PeerPlace within 48 business hours.

During FFY 2026, our program will work to increase outreach and program access for the Ombudsman by surveying facilities for feedback and suggestions for Ombudsman Service Delivery.

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	**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:

Types of Home Delivered Meals Served (check all that apply):

	Frozen		**Chilled**		**Shelf Stable**		**Hot**		**Other:**	

Service Description:

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	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Individuals must be dependent in two (2) or more Activities of Daily Living (ADLs) and have significant unmet needs that result in substantive limitations in major life activities.

Service Description:

The CVACL Care Manager is responsible for completing a full Uniform Assessment Instrument (UAI) to assess individuals' needs and determine appropriate service referrals. Care management involves comprehensive coordination with various agencies and organizations and includes the following components:

- Outreach, Intake, and Screening
- Assessments and Reassessments (at least every six months)
- Care Planning (as needs change)
- Service Referrals and Delivery
- Ongoing Service Monitoring

CVACL ensures monthly contact with the individual or informal caregivers to monitor care plan implementation. If an individual's needs change, the care plan is revised accordingly. When necessary, individuals may transition to more intensive services such as in-home care, personal care, adult day care, or institutional care services.

Additionally, CVACL conducts a regular, systematic analysis to evaluate the outcomes and impact of services provided.

Service: Service Coordination Level 1					
Unit Type	Hours	**Total Units**	208	**People Served**	10

Proposed Expenditure Amount	Funding Source
	General Fund- OAA General
7,500	General Fund- CCEVP
	Voluntary Contributions
	Fees
7,500	**Total Proposed Expenditures**

Locality Served	Service Provider	Entity Type
PSA 11	CVACL	AAA
		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:

Persons 60 and with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Individuals must be dependent in one (1) or more Activities of Daily Living (ADLs) and must require either mobility assistance (either human or mechanical) or suffer from a cognitive impairment, such as Alzheimer's disease or related disorder.

Service Description:

The CVACL Care Manager is responsible for completing a full Uniform Assessment Instrument (UAI) to assess individuals' needs and determine appropriate service referrals. Care management involves comprehensive coordination with various agencies and organizations and includes the following components:

- Outreach, Intake, and Screening
- Assessments and Reassessments (at least every six months)
- Care Planning (as needs change)
- Service Referrals and Delivery
- Ongoing Service Monitoring

CVACL ensures monthly contact with the individual or informal caregivers to monitor care plan implementation. If an individual's needs change, the care plan is revised accordingly. When necessary, individuals may transition to more intensive services such as in-home care, personal care, adult day care, or institutional care services.

Additionally, CVACL conducts a regular, systematic analysis to evaluate the outcomes and impact of services provided for all individuals served.

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

Proposed Expenditure Amount	Funding Source
	General Fund- CCEVP
	Voluntary Contributions
0	**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:

Service Description:

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**		**People Served**	

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

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	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:

All persons regardless of age, disability or veteran status are served by Person-Centered Options Counseling. CVACL shares knowledge of services and supports for all persons and provides Person-Centered Options Counseling (PC-OC) to assist individuals in locating the services and supports needed.

Service Description:

Person-Centered Options Counseling (PC-OC) is a decision-support process whereby individuals, with support from family members, caregivers and/or significant others, are supported in their deliberations to make informed long-term support choices in the context of the individual's preferences, strengths, values, and individual needs. It involves respecting the rights of individuals to control and make decisions about their own lives. PC-OC is a process, not an event, that may include multiple contacts over a short-term period, or ongoing over a longer period of time, depending on the individual's choice and the care plan.

CVACL Agency staff who deliver Person-Centered Options Counseling must have training in the statewide Person-Centered Options Counseling curriculum. Counselors collaborate with individuals, their families, caregivers, and significant others to explore long-term support options and develop an personal care plan that reflects the individual's goals and desired outcomes.

At present, CVACL employs two Person-Centered Options Counselors. Once Person-Centered Options Counseling services are terminated, an Options Counseling Individual Survey is sent to each CVACL individual within 10 working days, to gain insight concerning their satisfaction with the Person-Centered Options Counseling supports that they received.This feedback is used to assess service effectiveness and identify areas for improvement.

CVACL's Person-Centered Options Counseling services are designed to empower individuals to make informed decisions about their long-term care options. By adhering to statewide training standards and actively seeking client feedback, CVACL ensures that services are responsive to the unique needs and preferences of each individual.

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**	511	**People Served**	40

Proposed Expenditure Amount	**Funding Source**	**Match Funding**
	General Fund- OAA General	X
30,323	General Fund- CCEVP	X
	Voluntary Contributions	
30,323	**Total Proposed Expenditures**	

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	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 with greatest economic need, with particular attention to individuals at or below poverty; individuals with greatest social need, with particular attention to those experiencing language barriers, physical and mental disabilities, and those experiencing isolation due to cultural, social, rural or geographical factors (including racial or ethnic status and chronic conditions), and any other status that threatens the capacity for individuals to live independently.

Persons at greatest risk of readmission to a hospital within 30 days of discharge.

Service Description:

TAKE CHARGE is a partnership with Centra Health and other providers to address Care Transitions of high-risk patients from hospital or facility to home, with a goal of reducing readmissions, improving patient response to health care issues, and increasing the knowledge and education of patients in regard to chronic and acute medical conditions. The program seeks to impact patient response to health issues through education and behavioral changes. The program has involved multidisciplinary collaboration with Centra staff and leadership to ensure the integrity and quality development of the components of service.

The program operates according to the Coleman Care Transitions Intervention Model and is currently managed by a Director of Social Service Programs with a MA in Counseling Psychology. Direct service staff are a RN, Lead CTI Coach, and a CTI Coach.

The priority of the program is to serve frail and high-risk individuals identified and referred by Centra and other providers. The program addresses the many needs documented among individuals transitioning from hospital to home or other transition in health care. The Take Charge Care Transitions Intervention Program accepts referrals for individuals transitioning within health care settings with a focus on empowering individuals to take charge of their health by understanding and managing their health conditions to their best ability. The program supports individuals in maintaining independence and quality of life. A secondary goal is to avoid admissions and readmissions to hospitals and other health care facilities. The program anticipates serving the uninsured and the underinsured individuals who are at high risk of readmission or admission to health care facilities and lack the resources to respond.

The program will involve:
- specific health related education;
- support with accessing and following through with medical care;
- support with accessing resources needed for medical equipment and emergency medications;
- medication management strategies based on individual health care needs,
- assessment of social determinants impacting health care and support in addressing them;
- assessment for connection with community-based services; and
- referral for follow up and support services with CVACL care management programs.

The program utilizes a three-pronged approach to providing service to individuals referred. Service delivery is based in the individual's home or residential facility. All referrals from the hospital will receive initial assessment at the hospital, if at all possible, followed by home visits and implementation of an individual plan for service delivery consisting of a 30-day CTI coaching and follow-up model.

PART 6: OTHER AAA SERVICES

Service: Managed Care Services					
Unit Type		**Total Units**		**People Served**	

Proposed Expenditure Amount	**Funding Source**
0	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
State of Virginia	CVACL	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Partnership with VAAACares, a statewide Community Care Hub, to help address an individual's health-related social needs (HRSN), such as housing, food insecurity, isolation, and transportation, to improve health outcomes and reduce costs.

Eligible Populations:

Managed Care Organization (MCO) clients referred by Bay Aging, d/b/a Virginia Area Agencies on Aging Caring for the Commonwealth ("VAAACares").

Service Description:

Most government health care programs now require health plans and providers to identify and address members' health-related social needs (HRSNs) as part of a holistic approach to health. Health plans also understand that unmet HRSNs play a large role in health disparities and preventable health care costs. Area Agencies on Aging (AAAs) provide a vast array of social services including outreach, care management, nutrition support and supportive housing services. Managed Care Organizations partnering with AAAs is an efficient and effective means of providing essential social care benefits to health plan members, many of whom face significant structural and social barriers, including racism, poverty and isolation.

Collaboration between Bay Aging d/b/a Virginia Area Agencies on Aging Caring for the Commonwealth (VAAACares) and Central Virginia Alliance for Community Living, Inc., has entered into a Long Term Support Services Agreement with Managed Care Organizations (MCOs) to provide long term services and supports (LTSS) and related services to MCOs to provide, encourage and support innovative strategies and interventions for more effective LTSS and related services to eligible clients.

Service: Navigating Dementia					
Unit Type	meeting	**Total Units**	50	**People Served**	25

Proposed Expenditure Amount	**Funding Source**
$12,250	Genworth
$5,500	other private donations
$17,750	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Navigating Dementia: Empowerment and Connection is a six-meeting chronic disease self-management workshop and peer support group for persons living with dementia.

Eligible Populations:

Adults with mild cognitive impairment and early stages of Alzheimer's or other form of dementia who want to be proactive managing life with the disease. Care partners are welcome.

Service Description:

Meeting online weekly, and led by a Certified Dementia Practitioner, the program works through the Dementia Self-Management Guidebook, a publication of the Dementia Engagement, Education, and Research (DEER) Program in the School of Public Health at the University of Nevada, Reno. Additional resources are brought in to expand the material, guiding planning and decision-making to help make disease progression easier to handle for those affected by it.

After the initial workshop, facilitated peer group meetings are available so participants can continue to stay in touch with and learn from each other.

Service: Bedford Ride					
Unit Type		**Total Units**	2,900	**People Served**	200

Proposed Expenditure Amount	**Funding Source**
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Bedford County	CVACL	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:

Non-emergency transportation services to individuals living within the County and Town of Bedford with greatest economic or social need, residing in rural or geographically isolated areas.

Eligible Populations:

Bedford Ride serves assessed individuals over age 18, focusing on seniors living in their own homes with no means of transportation available to them.

Service Description:

CVACL plans to provide non-emergency transportation (Bedford Ride Transportation) to both ambulatory and non-ambulatory (but not stretcher bound) individuals, door through door, for individuals living in their own homes who lack the ability or means to transport themselves to appointments and services (e.g., doctors, therapists, pharmacies, grocery store) that promote continued independent living. Spouses or necessary escorts may accompany eligible participants and may be required if individuals need extra assistance. Individuals cannot be carried or lifted by drivers, and individuals in wheelchairs cannot be taken up or down steps.

Individuals are assessed using the Virginia UAI. Transportation arrangements may be requested after individuals have been assessed and approved for transportation services. Ride requests should be made as far in advance as possible, but in no case with less than two working days lead time. We do not provide emergency transportation. Rides are provided on a first come first served basis and requests are accepted as volunteer driver and vehicle availability, schedules, destinations, and budgets allow. Generally, rides are provided only to destinations we serve (PSA 11), with some service to Franklin and Roanoke County medical facilities.

Service: New Freedom Transportation					
Unit Type		**Total Units**		**People Served**	

Proposed Expenditure Amount	**Funding Source**
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	AAA
		Select Option
		Select Option
		Select Option
		Select Option
		Select Option

Service Definition:
Non-emergency transportation services to adults with disabilities, including assistance with boarding, exiting, and traveling to and from destinations.

Eligible Populations:
New Freedom transportation service is for individuals with disabilities over the age of 18 who need help due to mobility or other physical limitations and lack other means of transportation.

Service Description:
CVACL plans to provide non-emergency transportation (New Freedom Transportation) to both ambulatory and non-ambulatory (but not stretcher bound) individuals with disabilities, door through door, for individuals living in their own homes who lack the ability or means to transport themselves to medical appointments and food services (e.g., doctors, therapists, pharmacies, grocery stores) that promote continued independent living. Spouses or necessary escorts may accompany eligible participants. Escorts may be required to accompany individuals if individuals need extra assistance. Individuals cannot be carried or lifted by drivers and individuals in wheelchairs cannot be taken up or down steps. Individuals are assed using the Virginia UAI.

Transportation arrangements may be requested after individuals have been assessed and approved for transportation services. Ride requests should be made as far in advance as possible, but in no case with less than two working days lead time. We do not provide emergency transportation. Rides are provided on a first come, first served basis and requests are accepted as driver and vehicle availability, schedules, destinations and budgets allow. Generally, rides are provided only to destinations within the planning district we serve (PSA 11).

Service: Essential Home Accessibility Repair Program (EHARP)					
Unit Type	Housing	**Total Units**	5	**People Served**	8

Proposed Expenditure Amount	**Funding Source**
$13,697.04	Department of Housing & Community Development (DHCD)
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Counties of Amherst, Appomattox, and	CVACL	AAA
Bedford.	Subcontractors - multiple & may include:	For Profit
	J&J Weatherization, Inc	For Profit
	BTB Construction, Inc	For Profit
	Sullivan Plumbing	For Profit
	Perimeter Roofing	For Profit

Service Definition:

The EHARP provides funds to remove essential health and safety hazards, address physical accessibility barriers for low-income households, and undertake physical home repairs

Eligible Populations:

All populations age 18 and older in the counties Amherst, Appomattox, and Bedford whose household income does not exceed 80% of the area median income, adjusted for family size, which is determined by HUD. Homeowners and tenants (with homeowner approval) may apply.

Service Description:

Eligible repairs can include plumbing, structural, electrical and roofing, as well as the installation of wheelchair ramps and other accessibility modifications. The maximum assistance is $5,000. The applicant is responsible for procuring estimates from contractors of their choice. Permits are necessary when deemed necessary by the Jurisdiction Having Authority (JHA). Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance and must be eligible to perform work as determined by SAM.GOV. In addition, all contractors being awarded work must be preapproved by CVACL.

Service: Low Income Home Energy Assistance Program (LIHEAP)					
Unit Type	Housing	**Total Units**	44	**People Served**	70

Proposed Expenditure Amount	**Funding Source**
$393,569.20	Department of Housing & Community Development (DHCD)
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Counties of Amherst, Appomattox, and	CVACL	AAA
Bedford.	J&J Weatherization, Inc	For Profit
	Other Sub-Contractors Possible	For Profit
		Select Option
		Select Option
		Select Option

Service Definition:

LIHEAP funds energy efficiency and health & safety measures to be retrofitted to existing homes that have not received weatherization services within the past 15 years.

Eligible Populations:

Homeowners and tenants age 18 and older in the counties Amherst, Appomattox, and Bedford whose household income does not exceed 60% of the state median income or 200% HUD federal income guidelines and the house has not received weatherization services within the past 15 years.

Service Description:

LIHEAP funds part of the Weatherization Assistance Program (WAP) which reduces household energy use through the installation of cost-effective energy savings measures, which also improve resident health and safety. The goal is to reduce overall heating and cooling costs for low income families and individuals, thus relieving some energy burden while allowing the resident to remain living in place. Common measures including sealing air leaks, adding insulation, and repairing heating and cooling systems. WAP does not offer assistance with paying utility bills. Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance, hold all required training and certifications, and must be eligible to perform work as determined by SAM.GOV. Any contractor being awarded work must be selected through a RFP bidding process.

Service: Senior Cool Care (SCC)					
Unit Type	Housing	**Total Units**	30	**People Served**	45

Proposed Expenditure Amount	**Funding Source**
$4,000.00	Dominion Energy
$4,364.00	Private Funding
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
PSA 11	CVACL	AAA
	Buzz Electric	For Profit
	Other Contractors as Needed	For Profit
		Select Option
		Select Option
		Select Option

Service Definition:

The SCC program provides additional cooling to seniors that income and age qualify. Additional cooling will be provided on a limited quantity basis in the form of fans and window air conditioners.

Eligible Populations:

All seniors age 60 and older in the counties Amherst, Appomattox, Bedford, and Campbell, as well as the city of Lynchburg, whose individual or with spouse income does not exceed 150% of the federal poverty level as defined by HUD. Homeowners and tenants (with homeowner approval) may apply.

Service Description:

Eligible applicants may receive one of the following while supplies last:
Electric Fan
Window Air Conditioner
Portable Air Condtioner
Installation of Window Air Conditioner (private funding source only)

The qualified senior must have a need for additional cooling. Qualified applicants will be eligible to receive an air conditioning unit provided they have not received an air conditioning unit in the previous year. The unit awarded must be picked up at the CVACL office in Lynchburg and the recipient is responsible for installation, unless they are awarded installation services in addition to a window unit.

Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance and must be eligible to perform work as determined by SAM.GOV. In addition, all contractors being awarded work must be preapproved by CVACL.

Service: Utility Weatherization (APCo Wx & ODEC)					
Unit Type	Housing	**Total Units**	25	**People Served**	40

Proposed Expenditure Amount	**Funding Source**
$150,000.00	Appalachian Power Company Weatherization
$6,000.00	Old Dominion Electric Co-op Weatherization
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Counties of Amherst, Appomattox, and	CVACL	AAA
Bedford.	J&J Weatherization, Inc	For Profit
	Other Sub-Contractors Possible	For Profit
		Select Option
		Select Option
		Select Option

Service Definition:

APCo Wx and ODEC are utility programs in Virginia that offer a supplemental funding source for weatherization measures and are approved programs by the State Corporation Commission (SCC)

Eligible Populations:

Homeowners and tenants age 18 and older in the counties Amherst, Appomattox, and Bedford who meet the same qualifying rules of the Weatherization Assistance Program. Both programs can WAP supplements or be stand-alone services for qualified applicants.

Service Description:

Utility Weatherization funds are non-federal funds provided by specific individual utility providers in Virginia and are designed to supplement the Weatherization Assistance Program (WAP) which reduces household energy use through the installation of cost-effective energy savings measures, which also improve resident health and safety. The goal is to reduce overall heating and cooling costs for low income families and individuals, thus relieving some energy burden while allowing the resident to remain living in place. Appalachian Power Company Weatherization (APCo Wx) and Old Dominion Electric Co-op Weatherization (ODEC) funding can be used with LIHEAP, DOE, and IIJA funds as a second or third source of weatherization funding for qualified homes. It can also be used in cases where the home is not eligible for traditional Weatherization Assistance Program fund due to length of time when last served. Common measures including sealing air leaks, adding insulation, and repairing heating and cooling systems. Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance, hold all required training and certifications, and must be eligible to perform work as determined by SAM.GOV. Any contractor being awarded work must be selected through a RFP bidding process.

Service: Weatherization Deferral Repair / Weatherization Readiness Fund (WDR/WRF)					
Unit Type	Housing	**Total Units**	14	**People Served**	18

Proposed Expenditure Amount	**Funding Source**
$144,000.00	Weatherization Deferral Repair - DHCD
$15,133.00	Weatherization Readiness Fund - DOE
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Counties of Amherst, Appomattox, and	CVACL	AAA
Bedford.	J&J Weatherization, Inc	For Profit
	Perimeter Roofing	For Profit
	CENVAR Roofing	For Profit
	Sullivan Plumbing	For Profit
	Other Sub-Contractors Possible	For Profit

Service Definition:

The purpose of WDR and WRF funding is to fund needed repairs that have caused homes to be deferred from the Weatherization Assistance Program (WAP).

Eligible Populations:

Homeowners and tenants age 18 and older in the counties Amherst, Appomattox, and Bedford who must qualify for the Weatherization Assistance Program (WAP). The home has to have been deemed a deferral based on the WAP deferral guidelines and is not a remodeling type project.

Service Description:

WDR and WRF funds may be braided or used separately to repair/replace structural, electrical, plumbing, and/or limited mechanical equipment that has deemed the home a deferral from WAP services. Once the needed repairs are made using the WDR funds and the home is "weatherization-ready," clients can then receive energy efficiency and health and safety measures available through WAP (such as insulation, air sealing, energy efficient light bulbs, and carbon monoxide detectors). Clients are required to sign an agreement with the weatherization subgrantee, agreeing to both the WDR repairs and the weatherization services. Households may not receive the initial repairs without agreeing to also receive the weatherization services. The weatherization work must be completed within 6 months of the completion of any WDR/WRF work. Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance, hold all required training and certifications, and must be eligible to perform work as determined by SAM.GOV. Any contractor being awarded work must be selected through a RFP bidding process.

Service: Weatherization Assistance Program (WAP)					
Unit Type	Housing	**Total Units**	45	**People Served**	75

Proposed Expenditure Amount	**Funding Source**
$112,265.00	Department of Energy (DOE) - Federal - Standard WAP
$199,866.00	Department of Energy (IIJA/BIL) - Federal - 5 year initiative
$17.75	**Total Proposed Expenditures**

Locality Served	**Service Provider**	**Entity Type**
Counties of Amherst, Appomattox, and	CVACL	AAA
Bedford.	J&J Weatherization, Inc	For Profit
	Other Sub-Contractors Possible	For Profit
		Select Option
		Select Option
		Select Option

Service Definition:

Weatherization Assistance Program (WAP) is funded by DOE to install energy efficiency and health & safety measures to reduce energy burden and costs for low income individuals and families.

Eligible Populations:

Homeowners and tenants age 18 and older in the counties Amherst, Appomattox, and Bedford whose household income does not exceed 60% of the state median income or 200% HUD federal income guidelines and the house has not received weatherization services within the past 15 years.

Service Description:

Department of Energy (DOE) funding consists of traditional WAP funds and Infrastructure Investment & Jobs Act (IIJA), formerly BIL - Bipartisan Infrastructure Act (a 5 year energy efficiency initiative), and is part of the Weatherization Assistance Program (WAP) which reduces household energy use through the installation of cost-effective energy savings measures, and improves resident health and safety. The goal is to reduce overall heating and cooling costs for low income families and individuals, thus relieving some energy burden while allowing the resident to remain living in place. DOE and IIJA funds cannot be used on the same job or within 15 years of a home being previously weatherized, regardless of the occupants. Common measures including sealing air leaks, adding insulation, and repairing heating and cooling systems. WAP does not offer assistance with paying utility bills. Contractors must be licensed in Virginia with a contractors license, carry required general liability insurance, workers compensation insurance, hold all required training and certifications, and must be eligible to perform work as determined by SAM.GOV. Any contractor being awarded work must be selected through a RFP bidding process.

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

Agency: Central Virginia Alliance for Community Living, Inc. **PSA #** 11

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	24,046	15,000	60,000		11,363			
FY'26 Obligation	432,454	229,430	384,085	15,932	148,537	3,408	21,718	24,016
FY'26 Transfers								
Total Resources	456,500	244,430	444,085	15,932	159,900	3,408	21,718	24,016
Total Proposed Spending FY'26	456,500	244,430	444,085	15,932	159,900	3,408	21,718	24,016
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)	161,554	98,422	35,644	125,665	30,448	43,367	12,754
FY'26 Transfers (Oct 1, 2025 - Jun 30, 2026)							
FY'27 Obligation (Jul 1, 2026 - Sep 30, 2026)	23,335	32,807	11,881	41,888	10,149	14,456	4,251
FY'27 Transfers (Jul 1, 2026 - Sep 30, 2026)							
Total Resources	184,889	131,229	47,525	167,554	40,597	57,823	17,005
Total Proposed Spending FY'26*	185,889	131,229	47,525	167,553	40,597	57,823	17,005
Balance prior to Reallocation of Undesignated Funds	(1,000)	0	0	1	0		0
Reallocation Requested of Undesignated Funds **	1,000						
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	5,952
Total Resources	5,952
Total Proposed Spending FY'26	5,952
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.

05/06/25

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

Agency: Central Virginia Alliance for Community Living, Inc. **PSA:** 11

Requirement		Agency Status
Minimum Adequate Proportion		
Access (minimum 15%)	305,000	66.8%
In-Home (minimum 5%)	24,000	5.3%
Legal (minimum 1%)	5,000	1.1%
Title III-B Preparation and Administration		
Spending (10% or less)	115,552	10.0%
Federal Share (75% or less)	115,552	57.6%
Non-Federal Share (25% or more)	85,192	42.4%
Title III and Title III-E Preparation and Administration using OAA General Fund (5% or less)		
FY 2019 Title III-B Expenditures in the LTC Ombudsman Program Comparison	Current YR Diff 5,538	YR 2019 4,462
Title III-B Services		
Federal Share (85% or less)	402,500	53.8%
Non-Federal Share plus State Share (15% or more)	323401	42.8%
State Share (5% or more)	280,401	39.7%
Title III-C1 Services		
Federal Share (85% or less)	216,528	82.3%
Non-Federal Share plus State Share (15% or more)	46,452	17.7%
State Share (5% or more)	42,452	16.1%
Title III-C2 Services		
Federal Share (85% or less)	400,435	60.5%
Non-Federal Share plus State Share (15% or more)	261,940	39.5%
State Share (5% or more)	238,940	36.1%
	10/1/25-6/30/26	**7/1/26 - 9/30/26**
State Transfers (40% or less)		
Community Based Transfers		
Transportation Transfers		
Home Delivered Meal Transfers		
Total Transfers Equal Zero		
		10/1/25-9/30/26
Federal Transfers		
Title III-B (30% or less)		
Title III-C(1) (25% or less to C(2), 10% or less to B)		
Title III-C(2) (25% or less to C(1), 10% or less to B)		
Total Transfers Equal Zero		

Requirement	Agency Status
Title III-E	
Prep & Admin Spending (10% or less)	9.9%
Prep & Admin Federal Share (75% or less)	57.0%
Services Federal Share (75% or less)	72.7%
Title III-E Categories	
Respite Services	
Supplemental Services	31,800
Funds Spent on Grandparents	
% Spent on Grandparents (10% or less)	
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.	
Enter **Title III-C1** general fund expenditures used to match non OAA funds.	
Enter **Title III-C2** general fund expenditures used to match non OAA funds.	
CCEVP Tab (If yellow go to tab)	
Care Coordination Level 2	
Care Coordination Level 1	
Care Transitions	
Senior Outreach to Services (S.O.S.)	
Options Counseling Services	
Undesignated Funds	
Match Required (Title III-B, C1, C2)	184,583
Match Met	561,793
Undesignated Funds	377,210
Total Undesignated Funds Budgeted to OAA General *	1,000 **
Total Undesignated Funds Budgeted to CCEVP *	

- The allocation of "Undesignated Funds" must be done during the initial budget period at the beginning of the area plan year.

5/6/2025

- 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.

Title III
(Except III-E)

	A	B	C	D	E	F	G	H
1	**PSA:**	**11**						
2			This row is left available for your internal comments. For example, some agencies use it to indicate internal acco					
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		5,000			19,000	14,000
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						
15		Fees					4,000	
16	**Other Federal**							
17		DMAS - Ombudsman						
18		Other Local Federal Funding						
19		NSIP						
20	**General Funds**							
21		OAA General						
22		Community Based		12,000			119,229	
23		Transportation						
24		Home Delivered Meals						
25		Supplemental Nutrition						
26		CCEVP						5,000
27		Ombudsman						
28	**Undesignated Funds to OAA General***							
29	**Undesignated Funds to CCEVP***							
30	**Total Cash**			17,000			142,229	19,000
31	**In-Kind Amount**							
32	**Service Data:**							
33	Planned Number of Units			2,314			2,652	185
34								
35	Unit Defined as:		Hours	Contacts	Individual Hours	Individual Hours	Individual Hours	Individual Hours
36	Unit Cost			$7.35			$53.63	$102.70
37	Planned Persons Served			160			14	13
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 avail**							
41								
42	05/06/25							

Title III
(Except III-E)

	A	B	I	J	K	L	M	N	O
1	**PSA:**	**11**							
2			unt 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				122,000	10,000	70,000	89,000
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				5,000		5,000	33,000
15		Fees							6,000
16	**Other Federal**								
17		DMAS - Ombudsman							
18		Other Local Federal Funding							
19		NSIP							
20	**General Funds**								
21		OAA General				22,709		30,491	48,447
22		Community Based							
23		Transportation						47,525	
24		Home Delivered Meals							
25		Supplemental Nutrition							
26		CCEVP	7,500	30,323			15,000		
27		Ombudsman							
28	**Undesignated Funds to OAA General***					1,000			
29	**Undesignated Funds to CCEVP***								
30	**Total Cash**		7,500	30,323		150,709	25,000	153,016	176,447
31	**In-Kind Amount**								
32	**Service Data:**								
33	Planned Number of Units		208	511		2,000	145	5,502	2,048
34									
35	Unit Defined as:		Individual Hours	Contacts	Referrals	Contacts	Hours	1-Way Trips	1-Way Trips
36	Unit Cost		$36.06	$59.34		$75.35	$172.41	$27.81	$86.16
37	Planned Persons Served		10	40		1,150	20	50	110
38									
39									
40	***All undesignated funds budgeted for a sable funding source for that service, then the funds will be added to "CCEVP".**								
41									
42	05/06/25								

Title III
(Except III-E)

	A	B	P	Q	R	S	T	U	V	W
1	**PSA:**	**11**								
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							2,500	900
7		Title III-C(1)	214,028			500	2,000			
8		Title III-C(2)		390,435		2,500	7,500			
9		Title III-D						13,532	1,200	1,200
10		Title VII - Ombudsman								
11		Title VII - Elder Abuse								
12	**Other Funds**									
13		Voluntary Contributions	500	3,000						
14		Other Non-Federal	4,000	23,000						
15		Fees								
16	**Other Federal**									
17		DMAS - Ombudsman								
18		Other Local Federal Funding								
19		NSIP		21,718						
20	**General Funds**									
21		OAA General	42,452	30,790						
22		Community Based								
23		Transportation								
24		Home Delivered Meals		167,553						
25		Supplemental Nutrition		40,597						
26		CCEVP								
27		Ombudsman								
28	**Undesignated Funds to OAA General***									
29	**Undesignated Funds to CCEVP***									
30	**Total Cash**		260,980	677,093		3,000	9,500	13,532	3,700	2,100
31	**In-Kind Amount**									
32	**Service Data:**									
33	Planned Number of Units		2,913	88,000		60	500	179	30	30
34										
35	Unit Defined as:		Eligible Meals	Meals	Non NSIP Meals	Hours	Sessions	Sessions	Sessions	Sessions
36	Unit Cost		$89.59	$7.69		$50.00	$19.00	$75.60	$123.33	$70.00
37	Planned Persons Served		70	450		40	900	9	10	10
38										
39										
40	***All undesignated funds budgeted for a s**									
41										
42	05/06/25									

Title III
(Except III-E)

	A	B	X	Y	Z	AA	AB
1	**PSA:**	**11**					
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					500
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					1,000
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					
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**						1,500
31	**In-Kind Amount**						
32	**Service Data:**						
33	Planned Number of Units						50
34							
35	Unit Defined as:		Individual Hours	Devices	Payments	Payments	Contacts
36	Unit Cost						$30.00
37	Planned Persons Served						30
38							
39							
40	***All undesignated funds budgeted for a s**						
41							
42	05/06/25						

Title III
(Except III-E)

	A	B	AC	AD	AE	AF	AG	AH
1	**PSA:**	**11**						
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				52,500		10,000
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				500		
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						
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**					53,000		10,000
31	**In-Kind Amount**							
32	**Service Data:**							
33	Planned Number of Units					1,199		2,645
34								
35	Unit Defined as:		Individual Hours	Individual Hours	Individual Hours	# of Activities	Homes Repaired	Individual Hours
36	Unit Cost					$44.20		$3.78
37	Planned Persons Served							70
38								
39								
40	***All undesignated funds budgeted for a s**							
41								
42	05/06/25							

Title III
(Except III-E)

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP
1	**PSA:**	**11**								
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	2,100	5,000		10,000		44,000	456,500	
7		Title III-C(1)						27,902	244,430	
8		Title III-C(2)						43,650	444,085	
9		Title III-D							15,932	
10		Title VII - Ombudsman				24,016			24,016	
11		Title VII - Elder Abuse			3,408				3,408	
12	**Other Funds**									
13		Voluntary Contributions							5,000	
14		Other Non-Federal				4,903		85,192	160,095	
15		Fees							10,000	
16	**Other Federal**									
17		DMAS - Ombudsman				5,952			5,952	
18		Other Local Federal Funding								
19		NSIP							21,718	
20	**General Funds**									
21		OAA General							174,889	
22		Community Based							131,229	
23		Transportation							47,525	
24		Home Delivered Meals							167,553	
25		Supplemental Nutrition							40,597	
26		CCEVP							57,823	
27		Ombudsman				17,005			17,005	
28	**Undesignated Funds to OAA General***								1,000	
29	**Undesignated Funds to CCEVP***									
30	**Total Cash**		2,100	5,000	3,408	61,876		200,744	2,028,757	
31	**In-Kind Amount**									
32	**Service Data:**									
33	Planned Number of Units		517	50	35					
34										
35	Unit Defined as:		Individual Hours	Individual Hours	Contacts		# of Incentives			
36	Unit Cost		$4.06	$100.00	$97.37					
37	Planned Persons Served		18	20	8					
38										
39										
40	***All undesignated funds budgeted for a s**									
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			500		69,500	42,200
7	**Other Funds**							
8		Voluntary Contributions						
9		Other Non-Federal					5,000	2,000
10		Fees						
11	**Other Federal**							
12		Other Local Federal Funding						
13		NSIP						
14	**General Funds**							
15		OAA General					10,000	
16		Community Based						
17		Transportation						
18		Home Delivered Meals						
19		Supplemental Nutrition						
20	**Undesignated Funds to OAA General ***							
21	**Total Cash**				500		84,500	44,200
22	**In-Kind Amount**							
23	**Service Data:**							
24	Planned Units of Service						500	2,038
25	Unit Defined as:		Hours	Sessions	Hours	Individual Hours	Contacts	# of Activities
26	Unit Cost						$169.00	$21.69
27	Planned Persons Served with a Caregiver						230	Est. Audience Size
28	Planned Caregivers Served				10		70	25
29	Planned Number of Caregivers Benefited				10		70	
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 s**							
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						
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:		# of Vouchers	Individual Hours	Individual Hours	Individual Hours	Individual Hours	Define Here
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 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							

	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						31,800
7	**Other Funds**							
8		Voluntary Contributions						
9		Other Non-Federal						25,000
10		Fees						1,000
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**							57,800
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							21
28	Planned Caregivers Served							6
29	Planned Number of Caregivers Benefited							6
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				15,900	159,900
7	**Other Funds**						
8		Voluntary Contributions					
9		Other Non-Federal				12,000	44,000
10		Fees					1,000
11	**Other Federal**						
12		Other Local Federal Funding					
13		NSIP					
14	**General Funds**						
15		OAA General					10,000
16		Community Based					
17		Transportation					
18		Home Delivered Meals					
19		Supplemental Nutrition					
20	**Undesignated Funds to OAA General ***						
21	**Total Cash**					27,900	214,900
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						