Federal FY 2026

West Virginia
Bureau of Senior Services

Ensuring Well and Vital Seniors

County Provider Plan

(Provider Agency Name)

Marion County Senior Citizens, Inc.

County Provider Plan
Table of Contents

Part I: VERIFICATION OF INTENT

Marion Plan
(County)

The FY 2026 Provider Plan is hereby submitted for the:

Marion County, West Virginia
(Planning & Service Area)

This document is for approval of Bureau funded services and activities from October 1, 2025, through September 30, 2026

Marion County Senior Citizens, Inc.
(Name of Provider Agency)

assures that this document adheres to all of the provisions of the Older Americans Act, as implemented by the Administration on Community Living and the Bureau, during the period identified. The Provider Agency named above will assume full authority to develop and administer the Provider Plan in accordance with all requirements of the Act and related State policies, procedures and regulations. In accepting this authority, the Provider Agency assumes the major responsibilities to develop and administer a comprehensive and coordinated system of services and activities for providing a positive impact on the lives of elderly people within the service area.

By submitting this Provider Plan to the:

Northwestern Area Agency on Aging

for approval, the Provider Agency Board, it's Director, managers, and counselors agree to comply with the FY 2026 Provider Plan Assurances.

_____ _____

(Date) (Provider Agency Director's Signature)

The governing body of the Provider Agency has reviewed this Plan and supports all information contained herein.

_____ _____

(Date) (Sponsoring Board's Signature)

PART II: FY 2026 ASSURANCE OF COMPLIANCE

This section asserts and affirms the Provider's acceptance of the Bureau of Senior Services and federal and state conditions and assurances which govern use of Older Americans Act funds as well as other programs of the West Virginia Bureau of Senior Services as the designated focal point for the delivery of Older Americans Act services through the Bureau.

The Marion County Senior Citizens, Inc.
(Provider Agency)

confirms that the following assurances of compliance will be followed:

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

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

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—
(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);
(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the Provider Agency will report annually to the Area Agency on Aging in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and
(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)(i)(I) provide assurances that the Provider Agency will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);
(ii) provide assurances that the Provider Agency will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the Provider Agency, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —
(I) identify the number of low-income minority older individuals in the planning and service area; (II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the Provider Agency met the objectives described in clause (i).
(B) provide assurances that the Provider Agency will use outreach efforts that will—
(i) identify individuals eligible for assistance under this Act, with special emphasis on—
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and
(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and
(C) contain an assurance that the Provider Agency will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.
(5) provide assurances that the Provider Agency will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;
(6) provide that the Provider Agency will—
(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;
(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;
(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—
(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;
and that meet the requirements under section 676B of the Community Services Block Grant Act; and
(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;
(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the Provider Agency on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;
(E) establish effective and efficient procedures for coordination of—
(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and
(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;
(F) in coordination with the Area Agency on Aging and with the Area Agency on Aging responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the Provider Agency with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;
(G) if there is a significant population of older individuals who are Indians in the planning and service area of the Provider Agency, the Provider Agency shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;
(H) in coordination with the Area Agency on Aging and with the Area Agency on Aging responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and
(I) to the extent feasible, coordinate with the Area Agency on Aging to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;
(7) provide that the Provider Agency shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—
(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;
(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—
(i) respond to the needs and preferences of older individuals and family caregivers;
(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;
(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and
(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the Provider Agency itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and
(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;
(8) provide that case management services provided under this title through the Provider Agency will—
(A) not duplicate case management services provided through other Federal and State programs;
(B) be coordinated with services described in subparagraph (A); and
(C) be provided by a public agency or a nonprofit private agency that—
(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the Provider Agency;
(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);
(9) (A) provide assurances that the Provider Agency, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2025 in carrying out such a program under this title;
(B) funds made available to the Provider Agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;
(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;
(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the Provider Agency will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the Provider Agency will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the Provider Agency will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;
(12) provide that the Provider Agency will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.
(13) provide assurances that the Provider Agency will—
(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;
(B) disclose to the Assistant Secretary and the Area Agency on Aging—
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship;
(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;
(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and
(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;
(14) provide assurances that preference in receiving services under this title will not be given by the Provider Agency to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;
(15) provide assurances that funds received under this title will be used—
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;
(17) include information detailing how the Provider Agency will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;
(18) provide assurances that the Provider Agency will collect data to determine—
(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2025; and
(B) the effectiveness of the programs, policies, and services provided by such Provider Agency in assisting such individuals; and
(19) provide assurances that the Provider Agency will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2025.
(b)(1) An Provider Agency may include in the area plan an assessment of how prepared the Provider Agency and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(2) Such assessment may include—
(A) the projected change in the number of older individuals in the planning and service area;
(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and
(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.
(3) An Provider Agency, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;
(B) land use;
(C) housing;
(D) transportation;
(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness;
(K) protection from elder abuse, neglect, and exploitation;
(L) assistive technology devices and services; and
(M) any other service as determined by such agency.
(c) Each State, in approving Provider Agency plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the Provider Agency demonstrates to the Area Agency on Aging that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request. 07/09/2020 9
(d)(1) Subject to regulations prescribed by the Assistant Secretary, an Provider Agency designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the Area Agency on Aging, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.
(e) An Provider Agency may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.
(f)(1) If the head of a Area Agency on Aging finds that an Provider Agency has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the Provider Agency available under this title.
(2) (A) The head of a Area Agency on Aging shall not make a final determination withholding funds under paragraph (1) without first affording the Provider Agency due process in accordance with procedures established by the Area Agency on Aging.
(B) At a minimum, such procedures shall include procedures for—
(i) providing notice of an action to withhold funds;
(ii) providing documentation of the need for such action; and
(iii) at the request of the Provider Agency, conducting a public hearing concerning the action.
(3) (A) If a Area Agency on Aging withholds the funds, the Area Agency on Aging may use the funds withheld to directly administer programs under this title in the planning and service area served by the Provider Agency for a period not to exceed 180 days, except as provided in subparagraph (B).
(B) If the Area Agency on Aging determines that the Provider Agency has not taken corrective action, or if the Area Agency on Aging does not approve the corrective action, during the 180-day period described in subparagraph (A), the Area Agency on Aging may extend the period for not more than 90 days.
(g) Nothing in this Act shall restrict an Provider Agency from providing services not provided or authorized by this Act, including through—
(1) contracts with health care payers;
(2) consumer private pay programs; or
(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

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_____ _____

Board President Signature *Date*

_____ _____

Executive Director Signature *Date*

Provider: Marion County Senior Citizens, Inc.

Section A: Titles III B, D & E Program Narrative

1. Specify how your agency will organize Title III services to enable older adults to live independently at home and stay connected in their communities.

Title III B of the Older Americans Act refers to supportive services that help older adults remain independent and safely live in their homes and communities. These services may include transportation, information and assistance, case management, personal care, chore services, and other programs that promote independence and improve quality of life for seniors.

Title III-C of the Older Americans Act (OAA) is a significant source of federal funding for nutrition services for seniors.

	Strategies	Projected Outcomes
3B	1. **Comprehensive Needs Assessment & Person-Centered Planning** o Conduct detailed assessments to identify individual needs related to transportation, in-home assistance, social engagement, and health access. o Develop individualized service plans focused on promoting independence and connection.	100% of enrolled clients receive individualized service plans tailored to their needs.
	2. **Expand Transportation Services** o Increase availability of accessible transportation for medical appointments, grocery shopping, social activities, and senior center participation. o Collaborate with local transit programs to broaden reach.	20% increase in rides provided with a 90% client satisfaction with transportation services.
	3. **Enhance In-Home Support Services** o Provide client support services, personal care, and respite care to assist older adults in daily living activities. o Offer specialized support for caregivers, including education and respite options.	25% growth in client support and respite service hours delivered; decreased reports of caregiver burnout.
	4. **Strengthen Information and Assistance Programs** o Maintain up-to-date resource directories and provide one-on-one help navigating public benefits, health care, and community services. o Use outreach campaigns to connect isolated or underserved seniors to services.	Increase Information & Assistance contacts by 15%; 85% of clients report improved access to the services needed.

	5. **Develop Social and Recreational Opportunities** o Facilitate group activities, wellness programs, and peer support groups at senior centers and in community settings. o Encourage intergenerational programming to foster community ties. 6. **Coordinate with Healthcare and Community Partners** o Partner with healthcare providers, behavioral health services, and housing agencies to ensure holistic support. o Integrate Title III-B services with other OAA programs to maximize efficiency and impact.	30% increase in participation rates; reduction in reported social isolation by 20%. Established referral pathways with at least 5 local providers; improved client outcomes through integrated care.
3C	1. **Enhance Home-Delivered Meal Program (HDM)** o Maintain and expand routes to ensure timely delivery of nutritious meals to homebound seniors. o Train drivers to conduct informal wellness checks and report concerns to staff for follow-up. 2. **Strengthen Congregate Meal Services** o Offer nutritious meals in welcoming, socially engaging environments at senior centers. o Add wellness education, group activities, and guest speakers to enrich the congregate meal experience. . 3. **Reduce Social Isolation** o Use meal delivery and congregate sites as opportunities to connect seniors to other programs and social opportunities.	15% increase in the number of home-delivered meals; 90% of clients report meals help them remain at home. Increase in participation – up to set budget allotment with 80% of attendees reporting increased social engagement. 30% of congregate participants engage in additional center activities; measurable improvement in loneliness scores.

	○ Encourage peer interaction and community involvement through activities before or after meals. ○ Offer frozen or shelf-stable meals as part of contingency planning and caregiver support. 4. **Conduct Outreach and Education** ○ Promote nutrition programs through community partners, health providers, and local media. ○ Identify and enroll underserved older adults, particularly in rural areas or those facing barriers to access.	10% increase in new enrollments among underserved groups; strengthened partnerships with 5+ referral sources.
3D	1. We do not receive IIID funding	*Currently, we do not receive Title IIID funding; however, we remain committed to providing programs that support the health and wellness of our seniors through engaging activities, educational opportunities, and wellness initiatives.*

2. Specify how your agency strengthens our State Long-Term Care Ombudsman program.

Strategies	Projected Outcomes
1. **Educational Outreach to Seniors and Caregivers** ○ Host regularly scheduled workshops and information sessions at each senior center on topics including: ▪ Understanding residents' rights in long-term care ▪ The role of the Ombudsman in advocating for residents ▪ Signs of quality care and how to select a facility ▪ Advance directives and planning for future care needs ○ Distribute brochures and printed materials at all centers and through home-delivered meal programs to reach homebound seniors.	**Increased Awareness:** Seniors and caregivers in Marion County will gain a better understanding of their rights and the role of the Ombudsman, reducing confusion and anxiety around long-term care transitions.

2. **One-on-One Support and Resource Navigation** o Offer scheduled appointments for seniors and their caregivers to meet with case managers or our SHIP Coordinator for assistance on: ▪ Understanding facility options in Marion County and surrounding areas ▪ Medicaid eligibility and long-term care insurance ▪ Preparing for transitions from home to care facilities ▪ Knowing when and how to contact the Long-Term Care Ombudsman 3. **Collaboration with Regional Ombudsman** o Establish a presence by the regional Ombudsman at all three senior centers to: ▪ Build awareness and trust with local seniors ▪ Provide direct consultation or intake for concerns ▪ Offer updates on resident rights and regulatory changes 4. **Caregiver Support and Referral** o Provide targeted resources to family caregivers who are navigating or anticipating care facility placement for a loved one. o Integrate Ombudsman program information into existing caregiver education and support groups. 5. **Senior Center-Based "Pre-Planning for Care" Series covering:** ● What to know before choosing a care facility Financial and legal preparation for long-term care ● Knowing your rights as a resident or loved one ● Invite guest speakers including local social workers, ombudsmen, and long-term care administrators.	**Improved Transitions to Care Facilities:** More seniors will enter facilities with informed expectations and a stronger support network, reducing instances of isolation, neglect, or dissatisfaction. **Early Identification of Concerns:** Through proactive education and outreach, MCSC will help seniors and families recognize issues earlier and contact the Ombudsman promptly, improving outcomes for residents. **Greater Access to Trusted Resources:** Homebound and rural seniors will benefit from printed materials and referrals provided by case managers and nutrition staff, bridging the gap in access to advocacy services. **Strengthened Partnerships:** Regular collaboration between MCSC, Inc. and the Ombudsman Program will foster a coordinated network of care and accountability for seniors across the aging continuum.

3. Specify how your agency will provide quality non-formula-based services and integrate with Older Americans Act (OAA) core programs.

Strategies	Projected Outcomes

1. **Develop and Sustain Community Partnerships** o Collaborate with local organizations, hospitals, behavioral health providers, and universities, to offer services such as wellness checks, memory screenings, or transportation for social outings. o Leverage relationships with volunteers and students for intergenerational programs and service expansion.	Establish 3 new partnerships annually; increase referrals to OAA services by 20%.
2. **Secure Alternative Funding Sources** o Apply for private foundation grants, local government funds, etc. to offer supplemental services not covered under OAA formulas (e.g., minor home repair, emergency utilities). o Use in-kind community resources to enhance service delivery at no cost to the program.	Secure at least 2 new non-OAA funding streams per year to support older adults with unmet needs.
3. **Integrate Non-Formula Services with OAA Programs** o Link community-supported services (e.g., emergency meal kits, mobile mental health outreach) directly to core programs like home-delivered meals or caregiver support. o Train front-line staff (transportation drivers, meal delivery, case managers, etc.) to recognize and refer older adults to both OAA and non-OAA services.	75% of participants in non-formula services will be linked to at least one core OAA program.
4. **Implement Innovative Wellness and Engagement Programs** o Offer wellness classes (e.g., yoga, Tai Chi, art therapy, memory cafés). o Pilot pet care support program funded through local grants to extend Title III-B service goals.	Introduce 2 new wellness or social engagement activities yearly; 80% of participants report improved well-being.
5. **Regular Program Evaluation and Feedback** o Collect and analyze participant feedback and outcomes to refine non-formula services. o Use results to adjust and align services with the needs identified in OAA program assessments.	Annual satisfaction surveys show 90% of participants are satisfied with their relevance and quality of services.

4. Specify how your agency will increase Alzheimer's and Dementia awareness, education and services.

Strategies	Projected Outcomes
1. Partner with Experts and Community Organizations • Collaborate with the Alzheimer's Association, WV Bureau of Senior Services, and local healthcare providers to host: Workshops Memory screenings Community forums • Provide educational materials at all senior centers and outreach events.	Reach 250+ individuals annually through education and screenings; increase local awareness
2. Train Staff • Require annual dementia-friendly training for all staff. • Include tips on communication, behavior management, and person-centered care.	100% of staff trained in dementia-friendly practices each year.
3. Support Caregivers • Host caregiver support groups • Include dementia resources in newsletters and on social media.	Increase support group participation by 25%; reduce reported caregiver stress
4. Integrate Cognitive Health into Wellness Programming • Offer brain-health workshops, including diet, exercise, and cognitive games. • Partner with local libraries or schools for intergenerational programs that stimulate memory and social connection.	Organize four brain health programs with 50+ regular participants in conjunction with Lifelong Learners.
5. Outreach to Underserved Populations • Target isolated rural individuals and those without a diagnosis through outreach workers and home visits. • Use WellSky data to identify at-risk individuals and connect them to support services	Identify and engage 50 new seniors annually who may be experiencing cognitive decline; provide referral or direct support services.

5. Specify how your agency will target those with GEN and GSN in OAA and other grant programs.

Strategies	Projected Outcomes
1. Data-Driven Outreach • Use data from WellSky, client assessments, and community needs surveys to identify individuals with low income, disability, or limited access to transportation. • Coordinate with DHHR, food pantries, and housing authorities to reach low-income individuals.	Identify 50+ new GEN/GSN clients annually and connect at least 50% to at least one service.
2. Rural and Underserved Area Targeting • Increase services and outreach efforts in rural areas like Worthington, Farmington, Metz, and Baxter. • Set up mobile sites in public spaces or conduct home visits when transportation barriers exist.	Expand services into 3 underserved rural areas per year, reaching 50+ previously unserved seniors.

3. Partner with Community-Based Organizations
• Collaborate with agencies serving:
  ○ Low-income seniors (e.g., housing units, food pantries)
  ○ Individuals with disabilities
  ○ Grandparents raising grandchildren
• Share flyers, newsletters, and information on available services.
	Distribute program information through 10+ partner organizations; generate 100+ referrals.

4. Inclusive Program Design • Provide culturally sensitive materials and programs for marginalized or minority seniors. • Offer free or low-cost activities, meals, and wellness services with no fees or suggested donations for GEN individuals.	Ensure that 70% of service recipients meet GEN and/or GSN criteria.
5. Proactive Case Management • Case managers will prioritize clients who meet GEN and GSN criteria for: Emergency meals, Home-based services Transportation, Caregiver support and respite	Increase referrals to nutrition, transportation, and in-home services by 20% for GEN/GSN clients.

6. Specify how your agency will ensure program participants receive person-centered services and address Social Determinants of Health (SDoH).

Strategies	Projected Outcomes
1. Conduct Individualized Assessments • Use comprehensive intake and reassessment tools to identify client goals, challenges, preferences, and SDoH barriers (e.g., housing, transportation, food access, social isolation). • Update service plans regularly based on client feedback and changing needs.	100% of participants will have a person-centered plan of care; 90% will report their needs are being met.
2. Train Staff in Person-Centered and Trauma-Informed Care • Provide annual training for all staff and volunteers on: Active listening Shared decision-making Cultural humility Recognizing and addressing trauma and systemic inequities	100% of staff trained annually; post-training evaluations will show 90% improved knowledge.
3. Integrate Services to Address Key SDoH • Coordinate across departments and partners to provide: Nutrition support for food insecurity Transportation for access to healthcare and community Social activities to reduce isolation Referrals to housing, mental health, and legal aid	75% of participants with food insecurity, isolation, or transportation needs will receive direct support or referrals.
4. Client Choice and Voice in Program Design • Invite participants to serve on advisory boards and program committees. • Use surveys and one-on-one interviews to gather feedback and improve services.	Launch at least 2 advisory opportunities per year with senior input; satisfaction scores will improve by 15%.

5. Collaborate with Health & Human Service Providers • Establish referral systems with local clinics, hospitals, behavioral health providers, and public health agencies to streamline access to wraparound services.	Increase cross-referrals by 30% through partnerships with at least 5 healthcare and social service providers.

7. Specify how your agency will explore additional Title IIIB services and increase service provision of current services.

Strategies	Projected Outcomes
1. Conduct a Community Needs Assessment	
• Gather input from seniors, caregivers, staff, and community partners through surveys, focus groups, and public forums.	Identify at least 3 new service opportunities by next fiscal year.
• Identify unmet needs (e.g., technology support, legal assistance, mental health outreach).	
2. Pilot New Services Based on Community Feedback	
• Explore offering new Title III B services such as:	Launch at least 2 new supportive services by end of year; 75% participant satisfaction rate.
Technology training & digital access support Minor home modifications for fall prevention Mobile outreach to underserved areas	Increase transportation and in-home service units by 20% within 12 months.
• Launch short-term pilot programs with clear metrics for success.	
3. Strengthen and Expand Current Services	
• Recruit and train part-time staff to increase capacity in:	
Transportation (especially for medical and social trips) Information and assistance referrals In-home supportive services and wellness checks	Add 5 new collaborative partners and increase cross-referrals by 30%
4. Leverage Partnerships and Cross-Agency Referrals	
• Coordinate with local health providers, housing authorities, legal aid, and senior	

housing to cross-refer and co-host service events. • Apply for collaborative grants and shared service models. **5. Utilize Data to Prioritize Growth** • Track service utilization rates, unmet demand, and client satisfaction. • Use data trends to request increased funding or shift resources to high-need areas.	Develop an annual service expansion plan informed by client needs and usage data.

8. Specify how your agency will explore additional Title IIIC services and increase service provision of current services.

Strategies	Projected Outcomes
1. Assess Nutrition Needs and Preferences • Conduct surveys and listening sessions at congregate meal sites and with home-delivered meal recipients. • Identify interest in culturally appropriate meals.	Identify 3 new meal or service options by the next fiscal year
2. Additional Meal Options During Inclement Weather o Emergency shelf-stable kits for high-risk clients	Seek funding sources to purchase self-stable meals for home-delivered meals and congregate meal clients
3. Strengthen Outreach to Isolated and Underserved Seniors • Work with case managers and transportation staff to identify seniors not currently receiving nutrition services. • Use social media, newsletters, health fairs, and senior center events to promote enrollment.	Increase total number of meal recipients by 15%; specifically target 30 new isolated clients.
4. Improve Meal Quality and Nutrition Education • Work with dietitians/other meal providers to enhance meal appeal, nutritional value, and presentation. • Offer quarterly nutrition education and cooking demonstrations in partnership with WVU Extension or local health educators.	Improve client nutrition knowledge through at least 4 educational sessions per year; maintain compliance with state nutrition standards. Increase delivery efficiency and client contact consistency.

5. Leverage Technology • Continue using tech solutions (like text alerts or phone calls) for meal confirmations or changes.	

9. Specify how your agency will explore additional Title IIID services and increase service provision of current services.

Strategies	Projected Outcomes
We do not currently use Title IIID funding, but we are implementing new wellness activities such as chair yoga, gentle movement & breathing exercises, line dancing and Tai Chi for Fall Prevention & Arthritis	1 - 2 monthly wellness activities at all three centers. Maintain the fitness equipment at the three centers

10. Specify how your agency will provide information and seek other resources to increase older adult independence, health and safety.

Strategies	Projected Outcomes
1. Provide Accessible Information & Referral Services	
• Maintain an up-to-date resource directory of local, regional, and state services (e.g., legal aid, housing, home repair, transportation, mental health).	Increase the number of I&R contacts by 20% through better outreach and materials.
• Train front-desk and staff to guide clients to appropriate programs.	
• Use printed newsletters, social media, and bulletin boards to promote helpful programs and contact info.	
2. Host Education and Wellness Programs	
• Offer evidence-based workshops and seminars (e.g., Chronic Disease Self-Management, Fall Prevention, Medication Management).	Offer at least 12 safety or health-related workshops annually; aim for 75% satisfaction rate among participants.
• Invite local health professionals, fire departments, WV Attorney General representative and law enforcement to speak	

on topics related to home safety, scams, and emergency preparedness. **3. Form Resource Partnerships** • Collaborate with public libraries, faith groups, fire departments, and WVU Extension to extend educational reach and share resources. • Apply for supplemental funding (local grants, foundation support) to provide home safety checks. **4. Expand In-Home & Caregiver Supports** • Promote services such as light housekeeping, personal care, or respite for family caregivers. • Offer family caregiver education and connections to the Alzheimer's Association and other specialty supports. **5. Promote Technology for Health and Safety** • Introduce older adults to tools like medical alert systems, pill organizers with timers, and telehealth platforms.	Establish at least 3 new collaborations to support older adult wellness and safety. Expand caregiver service referrals by 10%; hold 2 caregiver workshops Host basic tech-literacy classes to help seniors navigate phones, tablets, and wellness Train 30 seniors annually in basic technology use for safety and health access

11. Specify how your agency will organize Title IIIE services to enable older adults to live at home and stay connected in their communities.

Strategies	Projected Outcomes
1. Provide Respite and Support Services to Family Caregivers • Offer in-home respite care for family caregivers supporting older adults with chronic conditions or cognitive decline. • Increase awareness of respite services through direct outreach, printed materials, and caregiver events. **2. Offer Caregiver Training & Education** • Provide hands-on and virtual training focused on dementia care, stress management, legal planning, and end-of-life care.	Host at least 4 caregiver trainings annually with 80% participant satisfaction.

• Partner with Alzheimer's Association and WVU Health to offer educational sessions and support groups.	
3. Develop Peer Support & Social Engagement Opportunities	Establish monthly support group meetings in at least two service areas.
• Host quarterly caregiver support groups and community gatherings to reduce caregiver isolation and stress.	
• Create opportunities for care recipients to engage in group activities while their caregivers receive needed breaks.	100% of Title IIIE clients will be offered connection to at least one other OAA service.
4. Coordinate with Other Aging Network Services	
• Ensure caregivers are connected to nutrition, transportation, homemaker, and case management services to support care recipients' continued independence.	Implement at least one recognized evidence-based caregiver support program by year-end.
• Utilize case managers to conduct assessments and make targeted referrals.	

12. Describe plans to promote the RAISE Family Caregiver Advisory Council, the National Strategy to Support Family Caregivers and the National Technical Assistance Center on Grandfamilies and Kinship Family recommendations, as feasible, to better address caregiver needs.

Strategies	Projected Outcomes
1. Promote Awareness of National Caregiver Initiatives	
• Share and distribute educational materials on the **RAISE Family Caregiver Advisory Council**, the **National Strategy to Support Family Caregivers**, and resources from the **National Technical Assistance Center on Grandfamilies and Kinship Families**.	Reach at least 150 caregivers annually with educational materials promoting national caregiver strategies.
• Incorporate summaries and updates into caregiver newsletters, support group sessions, and social media platforms.	
2. Support Grandfamilies through Local Collaboration	Maintain monthly Healthy Grandfamilies meetings at the Fairmont Senior Center with at least 10 families regularly participating.

• **Partner with the Marion County Board of Education** to host monthly **Healthy Grandfamilies meetings** at the **Fairmont Senior Center**, creating a welcoming and accessible space for grandparents raising grandchildren. • Provide transportation assistance and on-site support for attendees when needed. **3. Offer Training & Resource Navigation** • Host informational workshops to help caregivers and kinship families navigate legal, financial, and educational systems. • Provide individual consultations to connect caregivers to services aligned with national strategies and best practices. **4. Integrate National Priorities into Local Programming** • Ensure that planning for Title IIIE services and outreach reflects the core pillars of the **National Strategy to Support Family Caregivers**, such as increasing respite access, financial protections, and culturally competent services. • Utilize tools and data from the National Technical Assistance Center to inform kinship family support programming.	Host 3 caregiver/kinship family resource sessions annually with 80% of participants reporting increased knowledge Incorporate elements from the National Strategy into annual caregiver program planning and report measurable alignment.

13. Specify how your agency will strengthen Emergency Service Contingency Operation Plans (ESCOP).

Strategies	Projected Outcomes
1. Engagement in Local Emergency Planning • The Executive Director of MCSC, Inc. now serves on the **Marion County Local Emergency Planning Committee (LEPC)**, ensuring the agency has a voice in county-wide disaster preparedness and emergency response efforts. • This involvement allows for real-time coordination, resource sharing, and integration of senior-focused concerns into broader emergency response protocols.	Stronger coordination between MCSC, Inc. and local emergency response agencies; more senior-specific needs integrated into local plans

2. Implementation of a One-Call Notification System • MCSC, Inc. has adopted an **online One-Call System** to notify both **home-delivered meal clients** and **congregate meal participants**, as well as their **emergency contacts**, of: Emergencies affecting service delivery Inclement weather closings Schedule changes or delays • This system enhances our ability to communicate critical information quickly and efficiently, ensuring no senior is left unaware during service disruptions.	At least 95% of active clients and emergency contacts receive timely alerts during emergencies or schedule changes.
3. Review and Update of ESCOP Protocols • ESCOPs will be reviewed annually and revised to reflect updated contact systems, shelter locations, staff training procedures, and alignment with Marion County LEPC emergency response strategies. Staff will participate in emergency drills and receive training on the One-Call System and ESCOP procedures to improve responsiveness and confidence during an actual event	Annual ESCOP updates completed; 100% of key staff trained on emergency procedures and use of the One-Call System.

14. Specify how your agency will implement initiatives to protect older adults at risk.

Strategies	Projected Outcomes
1. Risk Identification & Outreach • Utilize data from **case management assessments**, home-delivered meal intake, and wellness checks to identify at-risk individuals (e.g., living alone, low income, limited mobility, no family support). • Establish a **red flag system** to prioritize follow-up for seniors exhibiting signs of neglect, confusion, or declining health. **2. Partner with Community Organizations**	100% of new clients screened for risk factors; at-risk seniors flagged for priority follow-up.

• Strengthen partnerships with local law enforcement, Adult Protective Services, housing authorities, and healthcare providers to report and intervene in cases of abuse, neglect, or exploitation. • Coordinate care plans and service referrals for individuals flagged by these partners. **3. Expand Wellness & Safety Checks** • Increase **regular wellness calls** to isolated seniors. • Train transportation and meal delivery staff to report any health or safety concerns observed in the home. • Implement **seasonal safety campaigns** (e.g., winter heating checks, summer hydration, emergency preparedness). **4. Strengthen Mental Health Referrals** • Partner with behavioral health providers to refer individuals showing signs of depression, anxiety, or cognitive decline. • Encourage social engagement via center-based programming, volunteer opportunities, and peer outreach.	Increase in reported and addressed elder abuse/neglect cases by 20% through better coordination. At least 90% of isolated seniors receive a monthly check-in call or home visit. Increased participation in behavioral health services; reduced reports of senior depression/isolation.

15. Specify how your agency will implement initiatives to promote independence and decrease social isolation.

Strategies	Projected Outcomes
1. Expand Social Engagement Opportunities • Increase the variety and frequency of **center-based programs**, including fitness classes, educational workshops, art and music activities, and intergenerational events.	25% increase in participation at senior centers over the next year.

• Implement themed events such as holiday socials, community dances, and volunteer-led clubs to build routine social connections.	At least 90% of riders report reduced feelings of isolation and improved independence.
2. Promote Accessible Transportation • Offer reliable **door-to-door transportation** for shopping, medical appointments, and social activities. • Develop monthly outings (such as grocery trips, farmers markets, and lunch events) to reduce isolation in homebound individuals.	
3. Increase Access to Technology • Provide **basic tech education workshops** to teach seniors how to use smartphones, video calls, and social media to stay connected with family and friends. • Partner with the Marion County Public Library and local high school students for 1-on-1 digital coaching.	100 seniors trained annually, with 60% reporting increased contact with family/friends.
4. Enhance Volunteer and Peer Support Programs • Recruit and train older adult volunteers to support peers through phone reassurance, wellness checks, and companion visits. • Launch a **"Senior Buddy" program**, pairing isolated seniors with friendly volunteers for weekly check-ins or shared activities.	Launch of Senior Buddy program; 50 participants enrolled by year one.
5. Support Aging-in-Place with Person-Centered Services • Strengthen case management, homemaker, and in-home support services to help older adults maintain their independence safely at home. Conduct regular reassessments and home safety evaluations to identify emerging needs early	85% of in-home clients remain safely at home for at least 12 months without hospitalization.

Explanation of Programs and key terms:

Title III B of the Older Americans Act refers to supportive services that help older adults remain independent and safely live in their homes and communities. These services may include transportation, information and assistance, case management, personal care, chore services, and other programs that promote independence and improve quality of life for seniors.

Title III-C of the Older Americans Act (OAA) is a significant source of federal funding for nutrition services for seniors. The NSP includes two primary types of meal services:
Congregate Meals: Meals served in group settings, often at senior centers or similar locations, promoting social interaction.
Home-Delivered Meals: Meals delivered to homebound older individuals who cannot easily access congregate meal sites.
Beyond Meals: In addition to meals, Title III-C also supports other nutrition services like nutrition education, screening, and counseling.

Title III-D funding, established under the Older Americans Act (OAA) in 1987, is dedicated to promoting the health and well-being of older adults (60+) through evidence-based health promotion and disease prevention programs.

The State Long-Term Care Ombudsman program is a government-funded program that advocates for the health, safety, welfare, and rights of individuals residing in long-term care facilities. These facilities include nursing homes, assisted living facilities, and other residential care communities. The program investigates and resolves complaints, promotes quality of care, and works to improve conditions in these facilities.

GEN (Greatest Economic Need): Refers to the need of older individuals stemming from an income level at or below the poverty line.

GSN (Greatest Social Need): Refers to the need caused by non-economic factors that restrict an older individual's ability to perform daily tasks or live independently.

Within the context of the Older Americans Act (OAA), "non-formula-based services" refers to services or programs funded through competitive grants or cooperative agreements, rather than through formula-based funding allocations.

Section B: Titles III B, C, D, & E Public Comment Period

Attach additional pages if necessary

Attach public comment agenda, attendance sheet and minutes from the agency's public comment period.

Response:

FY 2026 Service Provider Budget

Title III - B, C1, C2, D & E

Provider Plan - Part V Budget Pages - Section A:

General Information Page

REVISED 08-04-2025

Name of Service Provider: MARION COUNTY SENIOR CITIZENS, INC.

Name, Address, Phone Number & Email of Grantee	Address Where Service Provision will be Conducted
MARION COUNTY SENIOR CITIZENS, INC 105 MAPLEWOOD DRIVE FAIRMONT WV 26554 304-366-8779 executivedirector@marionseniors.org	105 MAPLEWOOD DRIVE, FAIRMONT 1 SENIOR DRIVE, MANNINGTON 404 MAIN STREET, FAIRVIEW
Program Period: Beginning: 10/1/2025 Ending: 9/30/2026	**Name of Director or Coordinator** LEISHA ELLIOTT, EXECUTIVE DIRECTOR
Type of Budget [X] New [ ] Revision - Date _____ [ ] Continuation [ ] Supplement	**Geographic Area Covered by Service Provider** MARION COUNTY WV

COMPUTATION OF FUNDS REQUESTED

	III B	III C1	III C2	III D	III E
A. Title III Federal Funds	#REF!	#REF!	#REF!	#REF!	#REF!
B. Local Match	#REF!	#REF!	#REF!	#REF!	#REF!
C. Program Income	#REF!	#REF!	#REF!	#REF!	#REF!
D. State Funds	#REF!	#REF!	#REF!	#REF!	#REF!
E. LIFE	#REF!	#REF!	#REF!	#REF!	#REF!
F. Total Funding	**#REF!**	**#REF!**	**#REF!**	**#REF!**	**#REF!**
Other Resources					

Terms and Conditions: It is understood and agreed by the undersigned that:

1) Funds granted as a result of this request are to be expended for the purpose set forth herein and in accordance with all applicable laws, reulations, policies, and procedures of this State , the Area Agency on Aging and the Administration on Community Living of the U. S. Department of Health and Human Services.

2) Any proposed changes in the proposal as approved will be submitted in writing by the applicant and upon notification of approval by the AAA adnd State Agency, shall be deemed incorporated into and become a part of this agreement.

3) Funds awarded by this agency may be terminated at any time for violations of any terms and requirments of this agreement.

Individual Authorized to Commit Organization to this Agreement (Grantee)

Name: Leisha Elliott Signature:

Title: Executive Director Date: 08/14/2025

MARION COUNTY SENIOR CITIZENS, INC.
Program Service Projections FY26
Title III B/C: Supportive and Nutrition Services

Cluster 1

Service Activity	60+ Served	Total Units
Adult Day Care ($10.00 per hour)		
Home-Delivered Meals ($7.50 per meal)	150	34,004
Homemaker ($15 per hour)		
Chore ($15 per hour)		
Personal Care ($18 per hour)		
Home-Delivered Pick-Up Meals ($7.00 per meal)		
Home-Delivered Non-Emergency Frozen/Shelf Stable/Pre-prepared Meals ($5.50 per meal)	150	7,626

Cluster 2

Service Activity	60+ Served	Total Units
Assisted Transportation (1-way trip)		
Congregate Meals ($7.00 per meal)	250	9,657
Home Delivered Meal Grab-N-Go Meals ($7.00 per meal)		
Congregate Non-Emergency Frozen/Shelf Stable/Pre-Prepared ($5.50 per meal)		

Cluster 3

Service Activity	60+ Served	Total Units
Information & Assistance (1 contact)	G-6	500
Outreach (1 contact)	G-6	3
Transportation (1-way trip)	100	2,500
Nutrition Education (1 session)	G-6	0

Other: Titles III-B & C: Supportive & Nutrition Services

Service Activity	60+ Served	Total Units
Group Meals ($7.00 per meal)	G-6	70
Public Information/Education	G-6	
Group Client Support*	G-6	5,000
Individual Client Support**	20	32

*Instruction & Training, Material Aid

**Counseling, Discount, Letter Writing/Reading, Prescription Aid, Telephoning, Visiting, Medication Management

Title III-D: Evidence Based Programs

Service Activity	60+ Served	Total Units
Chronic Disease Self-Management		
Dining with Diabetes		
A Matter of Balance		
Healthy Steps in Motion		
Tai Ji Quan: Moving for Better Balance		
Tai Chi for Arthritis		
Tai Chi for Diabetes		
Tai Chi for Osteoporosis		
Walk with Ease		
Stepping On		
Bingocize		
Drums Alive		
Other Approved:		
Other Approved:		

Title III-E Family Caregiver Services

Service Activity	60+ Served	Total Units
Caregiver of Older Adults - Information & Access Assistance	G-6	
Caregiver of Older Adults - Public Information/Education (Activity/Event)	G-6	
Caregiver of Older Adults - Support Groups (Sessions)	G-6	
Caregiver of Older Adults - Training (Not Agency Staff)		
Caregiver of Older Adult - In-Home Respite ($18.00 per hour)	5	1,964
Caregiver of Older Adult - Congregate Respite ($10.00 per hour)		
Older Relative Caregivers - Information & Access Assistance	G-6	
Older Relative Caregivers- Public Information/Education (Activity/Event)	G-6	
Older Relative Caregivers- Support Groups (Sessions)	G-6	