

WHYS AND WHEREFORES:

An Introductory Manual  
for  
Members of  
Boards of Trustees  
and  
Advisory Councils



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## Welcome

Thank you, aging-service board and advisory council members, for your service to older Americans and all those who care for them – and for your interest in coming to these pages. You are working in the field of aging at a most exciting, critical time – a time when the older population is rapidly expanding; a time when Americans are increasingly asking for home- and community-based alternatives to traditional nursing home care; and a time when government is trying harder to provide those alternatives.

In short, you are working on behalf of our country's older citizens in a new era. Recent amendments to the Older Americans Act will allow state and area agencies more flexibility in creating innovative programs and services. The amendments also offer more latitude (and encouragement) in coordinating and collaborating with other health and social service agencies to help older Americans live as independently as possible for as long as possible in the domain of overwhelming choice – their own homes. The opportunities have never loomed larger. Nor have the responsibilities and rewards.

We hope to assist you in your role as a board director (aka trustee) or advisory council member for state and/or area agencies on aging by including in this manual:

- a synopsis of your major duties and responsibilities;
- general guidelines and suggestions for advocacy and lobbying on behalf of older Americans;
- a short history and overview of America's aging network and the services it provides;
- a brief introduction to trends and new aging-service programs, such as Choices for Independence, designed to help older Americans live as long and independently as possible in their own homes and communities;
- a chart delineating the aging network's organizational structure;
- a chart itemizing the OAA budget and funding priorities; and
- a glossary of terms and acronyms useful for reading and conversing about aging services.

Again, on behalf of the National Association of Area Agencies on Aging (n4a) – and all the area agencies on aging and Title VI programs the association represents – we extend our abiding appreciation to each and every board and council member giving so unselfishly of himself and herself to help make all of America not just a better place to grow up, but a better place to grow old.

# **Aging Service Boards and Councils**

## *Whys and Wherefores*

Older Americans Act services, as outlined in the act's 1973 amendments, are administrated by 56 state and territorial units on aging, the 655 area agencies on aging these units oversee, and (via 1975 and 1978 amendments) 243 tribal organizations that manage aging services for Native Americans in this country. ([read more...](#))

Last year, the states, territories and their respective area agencies and tribal organizations distributed nearly **\$1.85 billion**<sup>1</sup> in OAA transportation, nutrition, home-care and other direct services – and more than \$1 billion more in Medicaid, federal block grant, levy and other senior-service funds - that helped more than 8 million older Americans live as independently and fully as possible. More than twice that number benefited from information and referral assistance pertaining to government programs aiding the elderly.

Most of the 655 area agencies, being non-profit entities, are governed by a board of directors/trustees. An exception is made, however, for tribal organizations and for the 32 percent of area agencies that also serve as direct branches of county **or city government**.<sup>2</sup> But, as required by the **Older Americans Act**, all area agencies (except the 243 tribal organizations) must have an **advisory council**.<sup>3</sup>

Both boards and councils help area agencies establish goals, build community support, advocate for innovations and improvements, and ensure that each unit's and agency's objectives are being strived for in an efficient, cost-effective and conscientious manner. And while the basic roles of these boards and councils in offering diverse

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<sup>1</sup> AoA: Older Americans Act Legislation and Budget: [www.aoa.gov/about/legbudg/current\\_budg/legbudg\\_current\\_budg.asp](http://www.aoa.gov/about/legbudg/current_budg/legbudg_current_budg.asp)

<sup>2</sup> Mid-Florida Area Agency on Aging: [www.mfaaa.org/AreaAgency.aspx?state=New%20York](http://www.mfaaa.org/AreaAgency.aspx?state=New%20York)

<sup>3</sup> U.S. Code Home: Title 42, The Public Health and Welfare: Chapter 35: Programs for Older Americans Subchapter III: Grants for State and Community Programs on Aging: Part A/ General Provisions: Older Americans Act: Grants for State and Community Programs on Aging: General Provisions: Sec. 3026: Area Plans [www.access.gpo.gov/uscode/title42/chapter35\\_subchapteriii\\_parta.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapteriii_parta.html)

perspectives and expertise, establishing goals, prioritizing services and overseeing budgets are generally understood, uncertainty and confusion surrounding specific areas of responsibility and action – and a lack of clear policies and procedures – can interfere with optimal functioning.

Hence, it is a good idea for new board and council members – and, now and then, the entire board and council itself – to review (and sometimes revise) the stated mission of the board or council, and the individual and group roles in achieving that mission. Those roles should be clearly spelled out in policies that delineate the responsibilities of board and council members and provide discernible boundaries separating the duties of those actually managing an organization and those overseeing and/or advising that organization. Boards and councils supply the broad strokes, and can be very helpful in strategizing, modernizing and expanding services and drumming up (and keeping an eye on) funds, but they are rarely involved in the day-to-day operations of an agency.

While it is understood that not every board or advisory council can, or should, operate under the same exact bylaws, protocols and rules of procedure, some common guidelines will apply and prove beneficial to all boards and advisory councils overseeing aging services in this country. A primary guideline for board and council members, especially those newly appointed or elected, is to feel strongly encouraged to ask questions regarding roles and responsibilities whenever there is the slightest uncertainty.

### **Distinction between Boards of Directors/Trustees and Advisory Councils**

A basic distinction between boards and advisory councils is found in the terminology. An advisory council, by definition, gives advice. That advice can be acted upon, ignored or put on hold for future decisions. The point is that the advice is just that. Respective organizations consider, but are not bound to act upon, advisory council recommendations, as much as they may appreciate them. A board of directors/trustees' decisions, however, are binding and serve to govern the organization. That is why boards of directors/trustees may be held collectively liable for the functioning of their organizations while advisory councils, generally, are not.

## Why Have a Board of Directors/Trustees?

For area agencies on aging, the foremost reason is that a board of directors/trustees is required by the Internal Revenue Service as a condition of filing for non-profit status. But, the law and tax breaks aside, it is a good business practice in other ways as well. ([read more...](#))

Boards are usually composed of individuals with a great deal of personal and business experience that is helpful in heading – in the case of many area agencies on aging – multi-million dollar operations. Board members are often professionals, such as bank executives, accountants, politicians, educators and social service administrators. They might also be prominent, influential members of the community whose notoriety and connections serve as crucial assets in fundraising and facilitating progress for their agencies. Ideally, these individuals are representative of the diverse ethnic and age groups that they serve.

As governing bodies, boards provide valuable oversight to ensure that the agencies they oversee are heading in the right direction and operating efficiently. In essence, the buck stops with the board. Boards decide on and fine-tune the missions and objectives of their respective organizations, as well as recruit, hire (and fire) chief executive officers. They retain overall fiscal responsibility for their respective organizations. Agency budgets, policies and strategic plans are usually crafted with board input and *always* require board approval. Other functions of boards of directors/trustees for non-profit agencies include:

- promotion and enhancement of the agency, its mission, and services within the community;
- promotion of ethical standards;
- assistance with organizational design and planning;
- monitoring of programs, services and overall performance relative to mission and goals;
- ensuring adequate resources and assistance with fundraising;
- recruitment and orientation/training of new board members; and
- assumption of overall responsibility and accountability for the agency.

## Why Have an Advisory Council?

One simple reason: two heads are better than one. Or, in this case, 10, 20 or 30 and more heads. The number of council (and board) members will vary from board to board and council to council within states and across the country. ([read more...](#))

The number is not as important as the representation. Advisory councils, like boards of directors/trustees, are optimally composed of representative members of a community bringing a wide range of perspectives, experience and expertise to an agency. In the field of aging – wherein the percentage and overall number of persons age 65 and older in this country is expected to grow from roughly 38 million (12.8 percent of the total U.S. population) to some 50 million (20 percent of the total U.S. population) by the year 2030 – keeping up with research, data and innovations across the country and around the world is increasingly vital to providing the best and most efficient services. And staying abreast of the rapidly evolving needs of one's own community, and making sure its representative agency understands those needs, is just as crucial.

Another more formal and pressing reason is that advisory councils, like boards of non-profit entities, are required adjuncts for area agencies on aging. This mandate comes from the Older Americans Act (U.S. Code Sec. 3026 {D} of the OAA), which stipulates that area agencies on aging must: *“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, representatives of older individuals, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters related to the development of the area plan, the administration of the plan and operations conducted under the plan.”*

Also like boards, advisory councils are vital links between the agencies and communities they serve. Though they have neither formal hiring nor formal fiscal responsibilities, nor any absolute say-so over agency organization, planning and policy, advisory councils provide crucial input to agencies regarding the particular needs and priorities of the communities and populations they represent.

### Advisory Councils:

- provide proportional representation of older persons, minorities and other groups with particular concerns, serving as the eyes and ears of their communities;
- keep up with regional and national demographic trends, demonstration projects and other innovations in aging-service delivery that may be beneficial to both the agency they advise and the aging population they represent;
- assist with the development and administration of area agency strategic and operational plans; and
- provide input on the initiation of new programs and services and/or the phasing out non-productive practices.

### **Intersection of Duties and Potential for Conflict**

It is important for boards of directors/trustees and advisory councils serving the same agencies to be aware of possible areas of intersection of duties and activities. There should be no secrets. Within reason, the left hand should always know what the right hand is doing to avoid duplication of effort, stepping on toes and other types of potential conflict. In general, advisory councils will focus on educating themselves, their communities and their agencies on the many issues and emerging trends, innovations and best practices in aging and social service delivery. Meanwhile, boards will place emphasis on the big picture, helping area agencies decide when to act on advisory council recommendations and providing leadership and resource stewardship that cultivates the most efficient, effective and responsible operation of the agency. **(read more...)**

Advisory councils and boards should keep in mind that they serve to advise and give direction to their agencies; form links and partnerships within the community; help plan goals and fine-tune mission statements; and approve long-range plans and budgets. As a rule, neither boards nor councils should get overly involved in the day-to-day business of the agencies they serve, or try to micromanage an agency's services and programs.

## Composition of Boards and Councils

Again, there is no hard and fast number of members required for boards and councils. Most range from 8 to 24 members, not including ex-officio representatives (i.e., members who hold positions on a board by virtue of other offices they hold, such as a state representative or political cabinet member, but do not regularly attend meetings or hold official voting privileges). All boards – and, especially, advisory councils, as specified in the previously cited **Older Americans Act language**<sup>4</sup> – should have membership that strives to represent constituents in terms of age, race and social strata. All should live in the geographic area that they represent. (Special mandates for advisory council composition can be found a few pages forward in this manual under the heading *Duties and Responsibilities of Advisory Councils.*) (**read more...**)

The best boards and councils will be comprised of those from various backgrounds in both the public and private sectors: e.g., parents, grandparents, business, labor, health, social services, education, psychology, community planning, law enforcement and politics (bipartisan). Board members, and sometimes advisory council members, may be selected with their community connections and fundraising potential in mind. Ex officio members, often holding political office, can be very influential and resourceful in helping their boards and councils plan and achieve objectives. Often, they (and other board members) will represent agencies with areas of intersection and common interest with aging services, such as health, disabilities and family services.

Board and council memberships are often political appointments, but once a board or council is formed, these bodies will frequently adopt authority for nominating and/or selecting their own members. They will generally vote for their own chairs, treasurers, secretaries, etc. And, just as there is no set number for aging-service boards and advisory councils, there is no set time period for service. Board and council members usually serve terms of from one to three years, but the terms can be longer or shorter, depending on agency-specific bylaws. Also, members can usually be re-appointed to consecutive and multiple terms.

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<sup>4</sup> U.S. Online Code: Older Americans Act: Grants for State and Community Programs on Aging: General Provisions: [frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse\\_usc&docid=Cite:+42USC3026](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC3026)

## **Officers**

Boards and councils will have officers, almost always: a chair or president; a vice-president; a treasurer; and a secretary. The chair or president is responsible for conducting meetings in a fair and efficient manner; the treasurer is, of course, in charge of tracking monetary matters, such as fundraising, associated with the board or council; and the secretary takes minutes of the meetings and oversees records and paperwork related to the board or council. In most cases, officers – preferably persons with experience related to their positions – will be elected by a simple majority of the boards or councils. In some instances, volunteers for the offices may be requested.

## **Committees**

Depending on the size of the board of directors/trustees or the advisory council and the agency each oversees, it may be wise and expedient for the board or council to form committees to explore and discuss certain issues. This may be especially useful when the subject matter involves expertise in a specific area held by one or more of the board or council members, such as finance, public relations, real estate or human resources. ([read more...](#))

These committees may be standing committees (formed as part of the board's permanent structure) or ad hoc (that is, formed on a temporary basis to address a pressing issue). Standing committees may address such issues as the budget; fundraising; public relations/marketing; strategic planning; community outreach; and board recruitment and development. Ad hoc committees might deal with the hiring or firing of a new Chief Executive Officer; the feasibility of finding a new building or implementing a new service; or any number of concerns that might be brought to the board by the community and/or agency that it serves.

## **Duties and Responsibilities of the Board**

Board members are expected to conduct themselves in accordance with time-honored legal principles emphasizing good faith and the ever-governing term “reasonable” in relation to judgment and actions. As boards of directors/trustees may be

held liable for their decisions and behavior, it is extremely important that they, as individuals – and as a group - become acquainted with the laws related to their positions. [\(read more...\)](#)

These legalities pertain not only to personal behavior, but to mandates for a range of requirements, such as:

- filing articles of incorporation – and sometimes bylaws – usually with the respective secretary of state;
- filing [Tax Form 990](#)<sup>5</sup> with the IRS for federal tax-exempt status; and filing with the state for state tax-exempt status;
- filing employees’ social security and income tax withholding with the IRS;
- filing of annual reports;
- applying with the state for accreditation and/or licensure;
- being aware of the [Fair Labor Standards Act](#)<sup>6</sup> and other employment regulations; and
- following statutes regulating solicitation, fundraising and political lobbying by non-profit organizations.

The vast majority of the above requirements will likely be taken care of by agency staff and consultants. Still, the board is ultimately responsible, and the importance of boards consulting legal counsel concerning the intricate state, federal and local requirements governing non-profit corporations cannot be overstated.

### **Duties of Care, Loyalty and Obedience**

Though the language may seem archaic, [BoardSource](#)<sup>7</sup> – formerly the National Center for Non-Profit Boards (NCNPB) – states that the traditional standards board members are obligated to meet in conducting themselves fall under the headings of “duty of care, duty of loyalty, and the duty of obedience.” [\(read more...\)](#)

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<sup>5</sup> IRS Form 990: [www.irs.gov/pub/irs-pdf/f990.pdf](http://www.irs.gov/pub/irs-pdf/f990.pdf)

<sup>6</sup> U.S. Dept. of Labor: Fair Labor Standards Act: Compliance With: [www.dol.gov/esa/whd/flsa/](http://www.dol.gov/esa/whd/flsa/)

<sup>7</sup> [BoardSource](#): Building Effective Non-Profit Boards: [www.boardsource.org/](http://www.boardsource.org/)

The “duty of care” essentially concerns the competent behavior of the board. According to the *BoardSource*, some 20 states have statutory language to the effect that “duty of care,” can be defined as “the care that an ordinarily prudent person would exercise in a like position and under similar circumstances.”

The “duty of loyalty” requires board members to be faithful to the best interests of the organization they oversee when making decisions or taking action in relation to that organization. Mainly, this duty pertains to **NOT** using information or contacts acquired as a board member for personal gain, or the gain of business associates, family members or friends. Similarly, board members should be aware of the principle of “private inurement,” which holds that income from non-profit organizations cannot be used for the benefit of those connected to the organization.

This does not mean that board members cannot be compensated for their work, but it does prohibit compensation considered excessive. In any case, board members should be extremely sensitive to even the appearance of conflicts of interest, and it is best to have strict policies and bylaws governing such issues firmly – and prominently – in place.

The “duty of obedience” calls for board members to act in accordance with the mission and goals of their organization. While board members are certainly entitled to exercise their own, individual judgment in pursuit of their organization’s goals, words and actions should not be inconsistent with their organization’s overall mission.

### **Duties and Responsibilities of Advisory Councils**

According to the federal law that spells out the details of the previously cited OAA mandate, area agency on aging **advisory council duties and responsibilities**<sup>8</sup> (and regulations for composition) are as follows:

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<sup>8</sup> Code of Federal Regulations, Title 45, V.4: Grants to State and Community Programs on Aging: Area Agency Advisory Councils:  
[http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr\\_2004/octqtr/45cfr1321.57.htm](http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/45cfr1321.57.htm)

- a. The council shall advise the agency relative to:
  1. Developing and administering the area plan;
  2. Conducting public hearings;
  3. Representing the interest of older persons; and
  4. Reviewing and commenting on all community policies, programs and actions that affect older persons with the intent of assuring maximum coordination and responsiveness to older persons.
  
- b. Composition of council. The council shall include individuals and representatives of community organizations who will help to enhance the leadership role of the area agency in developing community-based systems of services. The advisory council shall be made up of:
  1. More than 50 percent older persons, including minority individuals who are participants or who are eligible to participate in programs under this part;
  2. Representatives of older persons;
  3. Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);
  4. Representatives of supportive services providers organizations;
  5. Persons with leadership experience in the private and voluntary sectors;
  6. Local elected officials; and
  7. The general public.
  
- c. Review by advisory council. The area agency shall submit the area plan and amendments for review and comment to the advisory council before it is transmitted to the State agency for approval.

## Bylaws

A point of similarity concerning boards and advisory councils exists in the area of bylaws. Both boards and councils need bylaws to provide formal structure to their operations. ([read more...](#))

These bylaws state the purpose and objectives of a board or council, and specify how the organizations may, for instance:

- (s)elect members and officers;
- establish terms of service;
- organize committees;
- be compensated and reimbursed;
- schedule and conduct meetings;
- address and avoid potential conflicts of interest;
- raise funds (usually boards only);
- hire CEOs (boards only); and
- handle personnel matters (boards only).

Board and council members should familiarize themselves with their organization's bylaws and, perhaps, revise them from time to time in accordance with changing circumstances and objectives. It is highly recommended that legal counsel be obtained before creating or updating bylaws to ensure that any alteration is in line with local, state and federal law. Bylaws of aging-service boards and councils will often be more specific than the Older Americans Act regarding the composition of advisory councils. The Council on Aging of Southwestern Ohio, for example, mandates in its bylaws that 51 percent of the 12 to 15 council members be "over the age of 60."

That same organization's bylaws for its board of directors/trustees, though, are much less specific, stating only that "board membership shall be broadly representative of the senior population in each of the five counties of the service area." Since boards tend to put more emphasis on the professional backgrounds of their members, demographic requirements may be more prevalent on advisory councils.

Regarding bylaws and protocol for conducting meetings, many boards and councils use *Roberts Rules of Order*,<sup>9</sup> a reliable guide to getting down to business in meeting rooms across America for over a century. This thorough manual covers everything from opening a meeting, to initiating, amending and passing a motion, to establishing a quorum to disciplining those found out of order.

## **Advocacy**

Advocacy is simply the support of an idea, cause, or – in this case, more aptly – a particular population. Successful advocacy requires a comprehensive understanding of the issues involved, and is almost always a byproduct of clear, concise communication and building positive relationships. Its key components include passion, persistence and patience; creativity, cooperation and collaboration; and energy, flexibility and resourcefulness in pursuit of an organization’s objectives.

Area agencies on aging are not only encouraged to advocate for the older people in their districts, they are *mandated* to do so. Older Americans Act regulations specify that agencies “shall serve as the public advocate for the development or enhancement of comprehensive and coordinated community-based systems of services in each community throughout the planning and service area” (45CFR:Sec.1321.61). Among other advocacy-related requirements, the regulations stipulate that area agencies shall:

- *“Represent the interests of older persons to local level and executive branch officials, public and private agencies and organizations.”*
- *“Monitor, evaluate, and, where appropriate, comment on all policies, programs, hearings, levies, and community actions which affect older persons.”*
- *“Undertake a leadership role in assisting communities throughout the planning and service area to target resources from all appropriate*

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<sup>9</sup> Robert’s Rules of Order: <http://www.robertsrules.org>

*sources to meet the needs of older persons with greatest economic or social need, with particular attention to low income minority individuals.”*

Accordingly, each area agency should strive to educate locally elected officials (city, county, state and federal), as well as private service organizations, on the issues and concerns of older persons and the field of aging. Area agencies should also aim to ensure that older persons and those who care for them are aware of the programs, services and resources available to them in their respective areas. Far too many older Americans do not avail themselves of in-home and community-based services because, 42 years after passage of the Older Americans Act, they remain unaware of them.

Although it is often associated with political lobbying, advocacy can be many other things as well, including: letters to the editor and media campaigns; minority outreach and coalition building among stakeholders; public testimony; presentations at community forums and health fairs; and a number of other grassroots’ efforts. Whatever form advocacy takes, however, certain fundamentals will usually apply. The following guidelines should prove helpful in efforts to increase the visibility of your agency and improve the lives of older Americans.

## **Advocacy Tools**

### ***A) Have an Effective Message***

Develop a message that is easy to understand, appeals to core values and is broad enough to appeal to all major stakeholders. Provide reasons why it is important to act. Back up your message with facts and human-interest stories that hit home.

### ***B) Enlist Major Stakeholders***

Make sure you’ve brought everyone on board who cares about the issue(s) you are trying to address. Seek out the ideas and opinions of leaders in your field (e.g., the National Association of State Units on Aging, the National Citizens’ Coalition for Nursing Home Reform, or AARP), or related areas, who have also tried to gain support for their cause. Form an informal or formal coalition as a way to engage other groups, to

drum up support and to unify messages and activities. Depending on the issue, consider inviting these types of groups/individuals to the table:

- Women's groups/caucuses
- Older Americans' groups/caucuses (e.g, AARP)
- Caregivers
- Minority groups
- Disability community
- Social workers
- Other advocates, such as housing, transportation and anti-poverty activists
- Business Community
- Agencies of local or state government
- Volunteer or service organizations
- Faith community/ Religious leaders
- Community Leaders (who in your community really gets things done?)
- Children and Youth Issues Leaders (intergenerational efforts are very powerful)

### ***C) Increase Your Visibility***

There are many ways to gain visibility and attention for your agency and its services. Local newspapers and broadcast media are often happy to oblige a worthy cause brought home to readers and viewers by a related human-interest story. Create a press list of newspapers, TV and radio stations, and other media outlets throughout your area agency on aging. Send regular updates on your activities to the press and local opinion leaders. Feature prominent local leaders on talk shows, radio programs and in press articles. Commission studies and host events announcing the results of your findings. Enlist “champions” to encourage others to support your cause.

Current and former actors, sports stars and other notable people make excellent spokespersons for causes related to aging. Actress Shelley Fabares and former First-Lady Nancy Reagan have done much for national and local Alzheimer's associations, for example. Actor Michael J. Fox has increased nationwide awareness and support for Parkinson's disease, and former Cincinnati Reds pitcher and broadcaster Joe Nuxhall recently played a vital role in raising millions of dollars for in-home services for the elderly in the Cincinnati area. Arrange site visits, awards or other events with legislators and other prominent decision-makers or opinion leaders.

Host a statewide “call-in” or other activity day to gain attention from legislators or other public officials. Compile compelling personal stories and invite the people involved to relay these stories in person at a planned event (site visit, press event, ceremony, etc.). Develop fact sheets and background papers and distribute them broadly. Participate in health fairs and be continuously on the look-out for opportunities to address at forums and seminars at local libraries, community halls and churches.

The *Alliance for Justice* has a Website devoted to **Nonprofit Advocacy**, providing information on technical assistance, publications, workshops, seminars, and legal referrals on a range of matters regarding nonprofit advocacy and participation in the public policy process. ([www.afj.org/nonprofit/](http://www.afj.org/nonprofit/); or call: **866-NPLOBBY**, 866-675-6229)

### **Lobbying and Political Activities**

There can be a very slim line between advocacy, lobbying, and engaging in political activities – thick splits of a fine hair. Both boards and advisory councils (as extensions of their organizations) should be very careful about these divides. *BoardSource* warns that the rules governing lobbying activities by charitable, tax-exempt organizations (such as area agencies on aging) are “complex, frequently misunderstood and have severe consequences.” ([read more...](#))

To demonstrate that complexity, *BoardSource* cautions that while the law “strictly prohibits political activities” by charitable, tax-exempt nonprofit organizations, this does not make it illegal for individual board members to be involved in politics, or support certain candidates for office, so long as those individuals are not representing or attempting to speak for the board.

And though partisan “political activities” (defined by *BoardSource* as “activities intervening directly or indirectly in any political campaign on behalf of or in opposition to any candidate for public office”) are off-limits to nonprofit organizations, these organizations can conduct lobbying activities under certain circumstances. Lobbying (defined by *BoardSource* as attempting to “influence legislation”) by nonprofit organizations is permitted under the condition that the lobbying activities do not constitute “a substantial part of the organization’s total activities.”

*BoardSource* notes that the IRS puts a dollar amount on the term “substantial” to guide organizations in adhering to the tax-exempt statutes. For example, nonprofit organizations may allot up to 20 percent of their first \$500 in expenditures for lobbying activities; 15 percent for the next \$500,000; 10 percent of the next \$500,000; 5 percent of the next \$500,000, on up to \$1 million total in lobbying expenditures.

The IRS further stipulates that only 25 percent of all non-profit expenditures can be devoted to grassroots lobbying (i.e., efforts to gain political support of the general public). Though it is highly unlikely that an area agency on aging would reach that 25 percent cap, it is critical that agencies carefully track their lobbying activities and funds – and all the more reason for boards of directors/trustees to consult legal counsel in areas of uncertainty related to lobbying. There will usually be many.

## **Contacting Elected Officials**

### ***Identifying Your Area’s Members of Congress***

Making contact with the elected officials in position to help your agency is always a good idea. You may wish to include them on your agency’s mailing list, invite them to aging-related functions, or find other ways to let them know the value and/or need of certain aging services in the district they represent. If the AAA or Title VI program serves people from multiple congressional or state legislative districts, it’s important that you be in touch with all of those senators and representatives, regardless of where your agency’s central office is located.

Most area agencies on aging will have a roster of their respective political representatives. For those that don’t, the information is readily available. Congress, of course, serves all 50 states, as well as the District of Columbia, the five U.S. territories as well as the tribal organizations, and the information for phoning, faxing or e-mailing your state Congressional representatives is easily located on the Internet.

**(Please Note:** Those without Internet access or experience can obtain the above and following information through their local and/or state boards of election, addresses and phone numbers of which should be available in local phone books and libraries.)

To identify and contact your **Senators:** [www.senate.gov](http://www.senate.gov)

To identify your **Representatives:** [www.house.gov](http://www.house.gov)

If you know the names of your Congressional senators and representatives, you will find information about where and how to contact them by going to the Senate and House of Representatives Internet addresses (listed directly preceding this paragraph) and clicking on “representatives” and/or “senators,” whatever the case may be. The roster for each will appear alphabetically. If you are not sure who your representatives are (there will often be more than one, as well as two senators), you may need your “ZIP plus four” zip code to correctly identify them. Zip codes may be looked up on the U.S. Postal Service’s web site: [www.usps.gov](http://www.usps.gov) if you have the exact street address.

### ***How to Reach Members of Congress***

**PHONE:** Every member of Congress maintains a web page that should contain the phone numbers of his/her Washington, D. C., office as well as any local offices. (To find your member’s web page, go to [www.house.gov](http://www.house.gov) or [www.senate.gov](http://www.senate.gov)) This will also be listed in the phone book. If you want to call Washington and don’t have time to look up a number, use the Capitol Switchboard at **202-224-3121**; operators will connect you to the office you want.

**FAX:** Faxing a letter can be a great way to be in touch with your elected officials. Fax numbers should be available on your member’s web site or listed in local phone books.

**EMAIL:** Another good way to send an advocacy message, email also has some limitations you should be aware of. Most congressional offices offer a web-based form for communication to specific legislators, but do not accept general emails. This allows them to filter out correspondence from individuals not residing in the legislator’s district or state. To send a message to your member, go to [www.house.gov](http://www.house.gov) or [www.senate.gov](http://www.senate.gov) and use the lists of members to connect to his/her web site. It should be clear how they want you to use their communication system.

**U.S. MAIL:** We do not recommend corresponding via regular U.S. mail. The process by which it must be irradiated and scanned creates long delivery delays and greatly reduces the quality and strength of the document (i.e., letterhead may be faded and stationery crumbly by the time it reaches Capitol Hill). If you prefer to type or hand-write your correspondence, deliver it to your legislator via fax.

### ***Identifying Your Area's State and Local Representatives and Political leaders***

Those in the aging network will find that the late Speaker of the House Tip O'Neill knew what he was talking about when he said, "All politics is local." Though Congressional representatives potentially wield broader influence, many important government policy decisions are made and applied locally. This seems particularly true in the field of aging, where there can be significant differences in funding and services among area agencies and tribal organizations – both within certain states and across the country. If your agency doesn't have contact information for local political representatives readily available, the Internet – and its rapid and reliable search engines – has made identifying political representatives very easy.

In most cases, a *Google* search with a state's name followed by the word "legislature" should bring up a Home Page with the desired rosters of state representatives and senators, including links to legislative district maps. As with Congressional districts, you may need your "ZIP plus four" zip code to correctly identify the representatives and senators for your agency. Governors, county commissioners and city/village council contacts should also be traceable via *Google* searches containing the localities searched along with the terms "governor," "county commissioners" and/or "city council." Though traditional U.S. mail may work better locally, the same information given for contacting Congressional representatives applies generally to contacting local government officials. Whether writing a traditional letter, fax, or email, use the following forms of address to your Congressional representatives. For state and local government leaders, the same form – with appropriate substitutions in titles and names, of course – should do just fine. In general, keep the letter as congenial, clear and concise as possible.

**(Again:** For those without access to, or familiarity with, the Internet, an inquiry to the local library or board of elections should suffice for locating the above information.)

**Correct Forms of Address:**

U.S. SENATOR  
The Honorable (Full Name)  
United States Senate  
Washington, DC 20510

U.S. REPRESENTATIVE  
The Honorable (Full Name)  
U.S. House of Representatives  
Washington, DC 20515

Dear Senator (Last Name):

Dear Representative (Last Name):

**Building Relationships**

***How to Request a Visit***

There's seldom a better way to build meaningful rapport than in-person contact. But preliminary steps are usually required as a matter of protocol. Most requests for a representative's, senator's or other local leader's time (whether a visit to his/her office or a site visit to your agency) should be put in writing and faxed to the representative's office. (**Note:** This *is necessary* for meetings with members of Congress; and be sure to put such requests to the attention of the "Scheduler.")

Follow up 2-3 days after your invite/request has been sent by calling to inquire about the status of your invitation. If you can't get on the government official's calendar the first time around, ask to meet with a relevant staff member. This may be particularly helpful when dealing with Congress, where the best way to a representative is often through his/her staff members!

**Face-to-Face Visits**

Meeting face-to-face with your political representatives, and/or their staff, is one of the most effective advocacy tools at your disposal. Here are a few quick tips to help you make your visits successful.

***Be Prompt***

Try to be on time for all your meetings, even though government officials may keep you waiting. Schedules change quickly, especially on Capitol Hill, but you want to be reliable and courteous.

### ***Be Patient***

Be prepared to encounter changes at the very last minute. A visit scheduled with a government official, particularly members of Congress, may suddenly turn into a meeting with staff. Be gracious and go with the flow. **Note:** You never know where a Hill meeting with your Congressional representative might be held — from a Senator’s grand office to a hallway; or even the building’s cafeteria.

### ***Be Polite***

Treat everyone you encounter as a potential ally. Staff members may be young and not know a lot about your issues, but they are often gatekeepers to political leaders and could end up being your best point of contact. See your meeting as an opportunity to build relationships with ***all*** those in your representative’s office.

### ***Be Prepared***

First of all, know your audience. The more you know about your representative’s philosophy, interests and awareness of your agency, the better you can converse about your concerns in ways s/he can understand. Have your talking points ready and know what you want to cover in the meeting. But, also remember that you will need to be flexible — if you end up with less time than you planned for, present the short version. If you are visiting as a group, be sure to plan in advance who will say what in the meeting. Bring along materials that can be helpful to staff, like short fact sheets, stats on your PSA, etc. Whenever possible, make your case with hard numbers. They often speak much louder — and more convincingly — than words.

### ***Be Persuasive***

Be clear about what you are asking for (e.g., increased appropriations, livable communities’ initiatives, etc.) and why it is needed. People are constantly coming to lawmakers asking for more money, so you need to make the best possible case.

### ***Be Passionate***

Use anecdotes to bring your programs and services to life. As you know, many government leaders have personal experiences of their own with older family members, friends and neighbors, and they will readily connect with real life examples of how your agency helps older adults remain in their homes and communities. Political representatives and their staff are usually passionate about their work, too, so use language that allows them to get excited about your mission and how they can help you.

### ***Be Realistic***

Government officials, and even their staff, have tremendous work loads and are sometimes at the mercy of more pressing issues. (This is especially true in Congress, where floor action or committee schedules may pull representatives away from original schedules.) Do not be discouraged by such events. Simply reschedule and try again. If you are given generous time, use it wisely. But be aware that most visits will be rather short and sometimes subject to interruption. But, keep in mind that even a ten-minute visit can still be very effective!

### ***Be a Resource***

Ask the government official and/or staff member what you can do for them. If they ask questions you can't answer, promise you'll get back to them later. Offer to send any additional materials or data they may need or be interested in. Invite them to visit your agency to learn more about aging programs and services in the area, and let them know you welcome their calls if they have any questions about aging policy. Your goal is to become their local aging expert so that you can help them advocate for what your community needs!

### ***Follow Up***

Be sure to follow up after the visit. Send a thank you note/email, then suggest a next step that will further your relationship with the representative's office. And stay in touch. You now have, at the very least, the name of a staff member who is tasked with following aging issues. Ideally, you will have such contacts at the local, state and federal

level. And, the federal contact will give you a jump on things when the National Association of Area Agencies on Aging (n4a) send out an *Advocacy Alert* asking your agency to call or email Congress on certain issues. You will have a personal contact who may be more inclined to listen to your particular concerns on the matter.

### **Identifying Critical Legislators**

Members of Congress, as well as state senators and representatives and city/village council members, serve on committees that govern a particular policy area, agency of government or function. You should take the time to find out which committees your representatives are on — this will help you better understand what they are most interested in and how you can make a connection.

This manual identifies members of key aging-related committees and subcommittees on the national level (comparable information should be available via the state legislature, *Internet*, library or other means at the local level). What follows is a current list of Congressional appropriators (those who determine the specific spending levels for discretionary programs like Older Americans Act, Social Services Block Grants or others) for the subcommittee which most aging programs are funded from. If your representative or senator is on this subcommittee, it is that much more important that you enlist their support for the work you do and the federal programs that support it.

### **Key Appropriators of the 110<sup>th</sup> Congress\***

(\*January 2007-January 2009)

#### ***HOUSE Committee on Appropriations***

*Subcommittee on Labor, Health and Human Services, Education, and Related Agencies*

#### **MAJORITY**

**Chair: David Obey (WI)**

Nita M.	Lowey	(NY)
Rosa L.	DeLauro	(CT)
Jesse L.	Jackson,Jr.	(IL)
Patrick J.	Kennedy	(RI)

Lucille Roybal-Allard		(CA)
Barbara Lee		(CA)
Tom Udall		(NM)
Michael Honda		(CA)
Betty McCollum		(MN)
Tim Ryan		(OH)

**MINORITY**

**Ranking Member: James T. Walsh (NY)**

Ralph Regula		(OH)
John E. Peterson		(PA)
Dave Weldon		(FL)
Michael K. Simpson		(ID)
Dennis R. Rehberg		(MT)
Jerry Lewis*		(CA)

(\*Ex Officio, Chair of the full Appropriations Committee)

**SENATE Committee on Appropriations**

*Subcommittee on Labor, Health and Human Services, Education, and Related Agencies*

**MAJORITY**

**Chair: Tom Harkin (IA)**

Daniel Inouye (HI)  
 Herb Kohl (WI)  
 Patty Murray (WA)  
 Mary Landrieu (LA)  
 Dick Durbin (IL)  
 Jack Reed (RI)  
 Frank Lautenberg (NJ)

**MINORITY**

**Ranking Member: Arlen Specter (PA)**

Thad Cochran (MS)  
 Judd Gregg (NH)  
 Larry Craig (ID)  
 Kay Bailey Hutchison (TX)  
 Ted Stevens (AK)  
 Richard Shelby (AL)

## **More Information:**

For more information on legal responsibilities and/or questions related to advocacy and lobbying by nonprofit boards of directors/trustees, please contact:

**BoardSource:** Suite 900/ 1828 L Street, NW/ Washington, DC 20036. Telephone: 202-452-6262; Fax: 202-452-6299. Website: [www.boardsource.org/](http://www.boardsource.org/); and/or

**Alliance for Justice: Washington, D.C., Office** – 11 Dupont Circle, NW/ 2<sup>nd</sup> Floor/ Washington, DC 20036. Telephone: 202-822-6070; Fax: 202-802-6068. Website: [www.afj.org/nonprofit](http://www.afj.org/nonprofit)

**Alliance for Justice: West Coast Office** – 519 17<sup>th</sup> Street/ Suite 560/ Oakland, California 94612-1257. Telephone: 510-444-6070; Fax: 510-444-6078. Website: [www.afj.org/nonprofit](http://www.afj.org/nonprofit).

For easy recollection, *Alliance for Justice* may also be reached by phone at: 866-NPLOBBY (866-675-6229).

For more detailed information on the political process that may be useful to your agency, please see the following:

### ***How a Bill Becomes a Law***

For a refresher on the federal legislative process, go the U.S. House of Representatives's web page: [www.house.gov/house/Tying\\_it\\_all.shtml](http://www.house.gov/house/Tying_it_all.shtml)

### ***Glossary***

Unsure what a legislative term means? Turn to the U.S. Senate Glossary: [www.senate.gov/pagelayout/reference/b\\_three\\_sections\\_with\\_teasers/glossary.htm](http://www.senate.gov/pagelayout/reference/b_three_sections_with_teasers/glossary.htm)

# Agging Services in America: an Overview<sup>10</sup>

## Growth of Our Aging Population

Though documentation is rare, many people over the past several thousand years have likely lived as long as Jean Calment, the Frenchwoman who died at age 122 in 1997. But while the upper limit of our lifespan has remained relatively stable through the course of recorded history, the number (and percentage) of people reaching the later stages of that span has increased dramatically during the last century. ([read more...](#))

In 1900, the average life expectancy for Americans was 47 years. By 1935, thanks to advances in health and medical technology, that figure had jumped to nearly 62 years of age. [Average life expectancy](#)<sup>11</sup> increased to 71 years in 1970, and has continued to rise steadily in the past 35 years. The average American born in 2004 can expect to live [77.9 years](#)<sup>12</sup> (75.2 for males and 80.4 for females). And the percentage of older persons (those age 65 and over) in our country's general population has risen even more remarkably – from 4 percent in 1900 to 12.7 percent today (and, as the baby-boom generation ages, a projected 20 percent by the year 2030).

## Origins of Social Security

The growing number of older persons in our society is accompanied by many obvious benefits (e.g., extended retirement and leisure years, more time with grandchildren and great-grandchildren). But, the phenomenon has also been attended by economic and societal challenges. The concept of retirement, pensions and public assistance for the elderly is a relatively new one, advanced in the United States most prominently by the [Social Security Act of 1935](#),<sup>13</sup> the first major legislation on behalf of the elderly in this country. ([read more...](#))

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<sup>10</sup> AoA Online History: Timeline: ([www.aoa.gov/about/over/over\\_history.asp](http://www.aoa.gov/about/over/over_history.asp))

<sup>11</sup> U.S. Bureau of the Census: Homepage: ([www.census.gov](http://www.census.gov))  
& ([www.census.gov/population/socdemo/statbriefs/agebrief.html](http://www.census.gov/population/socdemo/statbriefs/agebrief.html))

<sup>12</sup> 2007 CIA Factbook: ([www.cia.gov/cia/publications/factbook/rankorder/2102rank.html](http://www.cia.gov/cia/publications/factbook/rankorder/2102rank.html))

<sup>13</sup> Social Security History: ([www.ssa.gov/history/history.html](http://www.ssa.gov/history/history.html))

There were several precursors to our Social Security program in Europe and elsewhere. Pensions for older people were promoted by **Thomas Paine**,<sup>14</sup> the heralded political pamphleteer of the American Revolution, more than 200 years ago. In his 1795 treatise on *Agrarian Justice*, Paine advocated for a 10 percent inheritance tax on all bequeathed property (more if there were no direct heirs) that would be used to provide every person age 50 and older with a retirement income of 10 pounds, annually.

This proposal went nowhere. But, nearly a century later, in 1889, Germany's Chancellor (and battleship namesake) Otto von Bismarck implemented a system making his country the **first in the world**<sup>15</sup> to adopt a national old-age insurance program, offering government-sponsored annual retirement income at age 70 (cut to age 65 in 1916). The policy was based on Bismarck's principle that: "Those who are disabled from work by age and invalidity have a well-grounded claim to care from the state." England followed with its Old Age Pension Act of 1908, which also initiated yearly retirement incomes for those age 70 and older.

America's Social Security program took its lead from these and other European predecessors (**34 countries had some type of social security system by 1935**),<sup>16</sup> but it also built upon smaller pension programs already set up in this country. Along with limited military pensions for disabled Civil War veterans (including their wives and dependents), most notable among these was the Pennsylvania Railroad Pension, begun in 1890, and widely considered the first modern pension system in the United States. The largest private employer in the nation at the time, the Pennsylvania Railroad created a benefit plan "equal to one percent of the average wage in the last ten years of employment times the number of years worked," with a mandatory retirement age of 70. This pension system, like those that followed it, was launched not only for altruistic reasons, but also to cultivate worker loyalty, lessen the likelihood of strikes and to decrease turnover of experienced employees.

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<sup>14</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/paine4.html](http://www.ssa.gov/history/paine4.html))

<sup>15</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/ottob.html](http://www.ssa.gov/history/ottob.html))

<sup>16</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/pre1935.html](http://www.ssa.gov/history/pre1935.html))

Still, well into the 20<sup>th</sup> century – despite some noble efforts by former President Theodore Roosevelt and the Bull Moose Party in 1912 (“The hazards of sickness, accident, invalidism, involuntary unemployment, and old age should be provided for through insurance.”) – the vast majority of Americans had no retirement or **old-age pension system**.<sup>17</sup> The issue remained mostly on the back burner until the crash of the American stock market on Black Friday, Oct. 29, 1929. The subsequent economic downturn brought the need for a nationwide social safety net for the unemployed, elderly and disabled to the forefront of political discussion. After several years of debate – and after some 30 states had enacted varying forms of piecemeal, largely inadequate pension legislation covering only a small portion of older persons – Social Security was **passed by Congress in 1935** (372-33 in the House; and 77-6 in the Senate, 12 “not voting”).<sup>18</sup>

But not until a few more radical ideas were entertained in the interim. One of the more memorable such plans was U.S. Senator **Huey Long’s (D-Louisiana) “Every Man a King” proposition**,<sup>19</sup> guaranteeing each American family a minimum annual income of \$5,000 and promising an old-age pension for every person past age 60 (and also limiting annual incomes to \$1 million and personal fortunes to \$50 million). Another (more warmly received) proposal, the Townsend Plan (sponsored by **Dr. Francis Townsend**),<sup>20</sup> asked for a 2 percent national sales tax to fund a \$200 monthly pension for all American workers age 60 and older, provided each beneficiary would spend the \$200 in the United States within 30 days of its receipt.

**President Franklin D. Roosevelt**<sup>21</sup> (Teddy’s 5th cousin) fought for Social Security early in his term, observing that the program represented not a change in American social philosophy, but “rather a return to values lost in the course of our economic development and expansion.” He signed the Social Security Act into law on August 14, 1935, stating: “We can never insure one hundred percent of the population

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<sup>17</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/trspeech.html](http://www.ssa.gov/history/trspeech.html))

<sup>18</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/tally.html](http://www.ssa.gov/history/tally.html))

<sup>19</sup> Social Security Online, Historical Background and Development of Social Security ([www.ssa.gov/history/hlong1.html](http://www.ssa.gov/history/hlong1.html))

<sup>20</sup> Social Security Online, Historical Background and Development of Social Security (<http://www.ssa.gov/history/towns5.html>)

<sup>21</sup> Social Security Online, Historical Background and Development of Social Security (<http://www.ssa.gov/history/briefhistory3.html>)

against one hundred percent of the hazards and vicissitudes of life, but we have tried to frame a law which will give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-ridden old age."

That measure of protection has been thorough enough to mark Social Security as the most successful social program in United States history, helping decrease the poverty rate among older Americans from close to 50 percent in the mid-1930s, and roughly **35 percent in 1959**,<sup>22</sup> to just 9.8 percent in the year 2004, lower than the current U.S. poverty rate for all ages, **12.7 percent**.<sup>23</sup>

Social Security is best known for establishing (under Title II) a wage-deduction pension plan for workers, but this law (technically known as the *Old Age Survivors and Disability Insurance Act*) also provides (under Title I) small subsidies to those outside of the workforce, specifically destitute older persons (who received *Old Age Assistance*), the blind, and, through 1950 amendments, to those with a broader range of disabilities. In 1974, these initiatives (falling under Title I of the SS Act) were folded into the *Supplemental Security Income* program, with subsidies (and matching grants from the 50 states) that annually increased with inflation.

### **Benefits of Social Security**

Social Security, known as a progressive system because lower-wage workers receive a higher return on their contributions for retirement, began deducting 1 percent (now 6.2 %, 7.45 % including Medicare coverage) of workers' wages in 1937 and paid out its first monthly benefit check to **Ida Mae Fuller**<sup>24</sup> on Jan. 31, 1940. This retired legal secretary from Ludlow, Vermont, is a fine example of how well the system can serve its beneficiaries. Fuller, who paid a grand total of \$24.75 in Social Security wage deductions from 1937 to 1939, retired at age 65 and lived to be 100. She received \$22.54 every month, adjusted for yearly cost-of-living increases after the Social Security amendments of 1950, until her death in 1975. Altogether, she took in nearly a thousand times return of \$22,888.92 on her \$24.75 in withheld wages.

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<sup>22</sup> U.S. Census Bureau: Historical Poverty Tables  
([www.census.gov/hhes/www/poverty/histpov/histpov16html](http://www.census.gov/hhes/www/poverty/histpov/histpov16html))

<sup>23</sup> U.S. Census: Poverty – 2004 Highlights  
<http://www.census.gov/hhes/www/poverty/poverty04/pov04hi.html>

<sup>24</sup> Social Security Online, Historical Background and Development of Social Security  
[www.ssa.gov/history/briefhistory3.html](http://www.ssa.gov/history/briefhistory3.html)

Since its inception, Social Security has paid out approximately \$500 billion in benefits to millions of beneficiaries. Currently, close to 155 million Americans pay \$700 billion into the Social Security Trust Fund each year.

### **Supplemental Security Income, Adjustments for Inflation, Result in Marked Decrease in Poverty Among the Elderly**

While *Old Age Assistance*, the Title I Social Security program administered by the states, provided some relief to older and disabled Americans, the monthly stipends did not go as far as originally hoped in diminishing poor living conditions among the elderly and disabled in the first 35 years of the program. The Social Security Amendments of 1972 placed *Old Age Assistance*, *Assistance for the Blind*, and *Assistance for the Permanently Disabled* under the newly created umbrella of **Supplemental Security Income (SSI)**.<sup>25</sup> [\(read more...\)](#)

These amendments increased *Old Age Assistance* monthly payments at the time, but, more importantly, allowed for the permanent alignment of SSI and other Social Security benefits to the consumer price index – i.e., inflation. That crucial step had the effect of helping to cut the poverty rate of older Americans ever after, slicing it in half from over 20 percent in the early 1970s to less than 10 percent today.

### **Brief History of American Nursing Homes**

Prior to Social Security, frail and destitute older persons without family members to look after them often ended up in America's almshouses and poor farms, generally decrepit remnants of England's punitive quarters for the impoverished and impaired for the preceding 400 years. The old were often mixed in with the mentally incompetent, chronically inebriated, blind and physically disabled of all ages in these almshouses, a situation increasingly embarrassing and unpalatable for America's policymakers and public alike in the early decades of the 20<sup>th</sup> century. The expanding longevity at the time was accompanied by society's continuing shift from an agrarian to industrial economy, often separating family members and eroding the family unit's traditional abilities and inclinations to care for older members. [\(read more...\)](#)

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<sup>25</sup> "How Supplemental Security Income Works." ([casnov1.cas.muohio.edu/scripps/publications/SSI.html](http://casnov1.cas.muohio.edu/scripps/publications/SSI.html))

It is a fading fact that a prominent side-purpose of Social Security, when first enacted, was to empty the elderly out of these almshouses and poor farms, almost all of which were operated by state, county and municipal governments. This measure would be accomplished via monthly Social Security stipends that impaired older persons could use to purchase lodging and care in more hospitable board and care homes and other upgraded accommodations. It was, in fact, an explicit stipulation of the original Social Security act that individuals **could not use Social Security funds in publicly supported almshouses**<sup>26</sup> or other government residential institutions. (This ban on Social Security checks used in public facilities was lifted in the 1950 Social Security amendments due to government's waning confidence in private nursing homes and the need for more facilities.)

Thus did America close the doors on its almshouses and, in turn, induce the rapid rise of private, for-profit (and non-profit) nursing facilities in this country. U.S. nursing homes began as mostly small board-and-care accommodations, but eventually grew to include much larger institutions, modeled on hospitals during the health-care building boom of the 1950s and 1960s.

Today, close to 90 percent of the country's **16,100 nursing homes**<sup>27</sup> are privately owned; about half are part of large chains; and roughly 62 percent are for-profit. America now has approximately 1.7 million nursing home beds occupied by roughly 1.5 million persons for an occupancy rate near 86 percent (down from over 90 percent 15 years ago). The average nursing home has about 107 residents. After nearly a half-century marked by spotty, uneven regulations from state to state, in 1987 the federal government enacted the Nursing Home Reform Act – also known as OBRA '87 (Omnibus Budget Reconciliation Act, 1987) – calling for stricter nationwide standards and more stringent enforcement. The act has gone a long way in improving conditions in nursing homes, but the quality of life in many remains a widespread concern.

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<sup>26</sup> Payne, Michael R. "How Did We End Up Here?" A Critical Inquiry Regarding the Evolution of the American Nursing Home and Ohio's Medicaid Funding Formula:  
[http://www.ohiolink.edu/etd/view.cgi?acc\\_num=miami1154010278](http://www.ohiolink.edu/etd/view.cgi?acc_num=miami1154010278)

<sup>27</sup> Nursing Home Facilities- 2006 ([www.cdc.gov/nchs/data/nhhd/nursinghomefacilities2006.pdf](http://www.cdc.gov/nchs/data/nhhd/nursinghomefacilities2006.pdf))

## Forerunners to Medicaid/Medicare and the Older Americans Act

As mentioned, Social Security was, in part, originally meant to help older Americans purchase health care in settings outside the almshouses and poor farms. The 1950 Social Security amendments allowed for Social Security dollars (including *Old Age Assistance*) to be paid directly to health care providers, and it is likely no coincidence that **Old Age Assistance**<sup>28</sup> to health care providers increased from \$36 million to \$280 million in the 10 short years that followed. (**read more...**) Escalating medical costs gave impetus to initial thrusts of legislation in the late 1950s and early 1960s designed to provide hospitalization and nursing home coverage as well as other forms of health-care insurance for older Americans.

In 1960, the Kerr-Mills Act – aka *Medical Assistance for the Aged (MAA)* – a precursor to Medicaid, was passed, setting up the disbursement of federal matching funds to states offering financial help to older persons whose medical expenses exceeded their incomes. These funds were allocated for those who did not qualify for *Old Age Assistance*, or those who did qualify but did not receive enough from OAA to cover their medical expenses. MAA gave tremendous leeway to the 50 states in determining eligibility, benefits and medical services covered, however, resulting in limited, glaringly disparate and often ineffective implementation across the country. (Still, by 1965, the time of Medicaid’s initiation, U.S. nursing home residents had increased by 33 percent, from 400,000 to 600,000 in five short years, with close to half of the residents covered by MAA, Medicaid’s direct predecessor.)

In 1961, prompted by calls for extended medical benefits and “a broad spectrum of institutional and in-home services” for older Americans from the first White House Conference on Aging (and a presidential task force), President John F. Kennedy put the wheels in spin on medical insurance legislation that would become Medicare.

Taking up the flag and seeking to eliminate poverty among those of all ages and ethnic backgrounds for his Great Society programs of the mid-1960s, Kennedy’s

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<sup>28</sup> Payne, Michael R. “How Did We End Up Here?” A Critical Inquiry Regarding the Evolution of the American Nursing Home and Ohio’s Medicaid Funding Formula:  
[http://www.ohiolink.edu/etd/view.cgi?acc\\_num=miami1154010278](http://www.ohiolink.edu/etd/view.cgi?acc_num=miami1154010278)

successor, President Lyndon Baines Johnson, picked up where Kennedy left off and signed Medicaid, Medicare and the Older Americans Act into law in 1965. These three programs quickly poured millions of dollars into a range of programs for older persons, creating the foundation for what is now known as America's aging network.

**The Older Americans Act**<sup>29</sup> sprang, in part, from the same social concerns for older, impoverished persons that spawned Medicare and Medicaid in the same year. All three were initiated, to some extent, in response to a call for a broad range of in-home, community-based and institutional health-care services and coverage from the first White House Conference on Aging; all three were pushed forward by the 1961 *Presidential Task Force on the Health and Social Security of the American People*; and all three were launched at a time when nearly **30 percent of older Americans lived below the poverty line**,<sup>30</sup> compared to about 20 percent for Americans of all ages in the mid-1960s. Notably, the Older Americans Act, Medicare and Medicaid all became law in the same month: first the Older Americans Act on July 14, 1965; then **Medicaid and Medicare**,<sup>31</sup> both signed into law as amendments to the Social Security Act on July 30, 1965 (Medicare as Title XVIII, and Medicaid as Title XIX).<sup>32</sup> President Johnson signed the Medicare bill into law in a special ceremony at the Truman Library in Independence, Missouri, in honor of former President Harry Truman's attempts to initiate government-sponsored health care almost two decades earlier. Not many recall that former President Truman was presented at the ceremony with our country's **first Medicare beneficiary card**.<sup>33</sup>

### **The Older American's Act**<sup>34</sup>

The Older Americans Act created the **Administration on Aging (AoA)**<sup>35</sup> within the U.S. Dept. of Health, Education and Welfare (now Dept. of Health and Human Services). It was the first federal agency to focus solely on the special concerns of older Americans, promoting their well-being through a range of programs such as nutrition,

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<sup>29</sup> AoA: Older Americans Act: [www.aoa.gov/about/legbudg/oa/legbudg\\_oaa\\_faq.asp](http://www.aoa.gov/about/legbudg/oa/legbudg_oaa_faq.asp)

<sup>30</sup> <sup>30</sup> (U.S. Bureau of the Census <http://www.census.gov/hhes/www/poverty/poverty04/pov04hi.html>)

<sup>31</sup> Social Security Online: ([www.ssa.gov/history/corning.html](http://www.ssa.gov/history/corning.html))

<sup>32</sup> U.S. Dept. of Health and Human Services, Center for Medicare and Medicaid Systems: [www.cms.hhs.gov/History](http://www.cms.hhs.gov/History))

<sup>33</sup> Social Security Online: [www.ssa.gov/history/lbjasm.html](http://www.ssa.gov/history/lbjasm.html)

<sup>34</sup> AoA: Older Americans Act: [www.aoa.gov/about/legbudg/oa/legbudg\\_oaa\\_unofficial\\_comp.asp](http://www.aoa.gov/about/legbudg/oa/legbudg_oaa_unofficial_comp.asp)

<sup>35</sup> AoA: [www.aoa.gov/about/over/over.asp](http://www.aoa.gov/about/over/over.asp)

housing, health care, home-services, employment, counseling and other types of information and referral. **(read more...)** The AoA, first headed by social worker and academician William Bechill (and now led by its 10<sup>th</sup> executive officer, Assistant Secretary for Aging Josefina Carbonell), also emphasized research in the field of aging and encouraged demonstration and pilot programs to explore the most efficient and effective means of providing services to the older population in America. The administration mandated the creation of state and territorial units on aging for oversight (including the District of Columbia, Guam, the Mariana Islands, Puerto Rico, Samoa and the Virgin Islands) and, in key amendments passed in 1973, provided for establishment of area agencies on aging for more localized administration and delivery of OAA programs and services. That framework, which expanded in 1980 to include distribution of funds to Native Americans via **243 Tribal Organizations**<sup>36</sup> (for the most part operating separately from area agencies), stands reliably in place today as the infrastructure of home and community services for older persons in this country.

## **OAA Objectives**

The core goals of the Older Americans Act have remained basically intact for 42 years, though more elaborative and specific language has been worked in during the act's various reauthorizations, generally every three to five years. As in 1965, the act's aims are explicit in its opening pages: **(read more...)**

*“The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our nation are entitled to ... the full and free enjoyment of the following objectives:*

- 1. An adequate income in retirement in accordance with the American standard of living.*

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<sup>36</sup> AoA Fact Sheets: American Indians, Alaska Natives, and Native Hawaiians:  
[www.aoa.gov/press/fact/alpha/fact\\_ain.asp](http://www.aoa.gov/press/fact/alpha/fact_ain.asp)  
Older Americans Act: Grants for Native Americans:  
[www.access.gpo.gov/uscode/title42/chapter35\\_subchapterx\\_.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterx_.html)

2. *The best possible physical and mental health which science can make available and without regard to economic status.*
3. *Obtaining and maintaining suitable housing, independently selected, designed and located with reference to special needs and available at costs which older people can afford.*
4. *Full restorative services for those who require institutional care and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals needing long-term care services.*
5. *Opportunity for employment with no discriminatory personnel practices because of age.*
6. *Retirement in health, honor, dignity – after years of contribution to the economy.*
7. *Participating in and contributing to meaningful activity within the widest range of civic, cultural, educational and training and recreational opportunities.*
8. *Efficient community services, including access to low-cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed, with emphasis on maintaining a continuum of care for vulnerable older individuals.*
9. *Immediate benefit from proven research knowledge which can sustain and improve health and happiness.*
10. *Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection against abuse, neglect and exploitation.”*

Of the aforementioned additions to the act, the most significant innovations over the years are found in language added to:

- objective 4, calling for comprehensive services to keep older persons in their own homes and communities – along with the creation of services and programs in support of family members and others providing voluntary care for loved ones and friends;
- objective 8, calling for low-cost transportation services;
- objective 10, calling for the protection of older Americans against abuse, neglect and exploitation.

## **Federal Funding**

When established in 1965, eligibility for – and distribution of – most OAA dollars was **based on age, 65 and older**<sup>37</sup> (changed to 60 and older in 1973), rather than on need. That is, a healthy person with substantial savings and a good retirement income would be no less eligible for most services than an older person with multiple impairments living below the poverty level. Money was distributed from the federal government to the states and, in turn, to the area agencies on aging in relation to the number of their citizens age 65 (later 60) and older. (**read more...**)

**The essence of that funding formula is still used today.**<sup>38</sup> But, modest OAA funds stretched thin by the steadily rising 60-and-older population – and the increasing federal mandate for prioritizing services to “the elderly with the greatest economic and social need,” as stipulated in language added in later amendments to the OAA – have resulted in increased funneling of state allocations to older persons who stand to benefit from them the most. That is, older persons with severe disabilities living at, or below, the poverty level.

But, it should be made clear that the formula of federal funding to the states is based mainly on 60-plus population, and it is up to the states to oversee the distribution of those funds to those in the most need of them, both economically and in terms of

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<sup>37</sup> 1965 Older Americans Act, P L 89-73, sec. 302 (a) 2: [www.aoa.gov/about/legbudg/oa/oa\\_1965.pdf](http://www.aoa.gov/about/legbudg/oa/oa_1965.pdf)

<sup>38</sup> AoA: Legislation and Budget: [www.aoa.gov/about/legbudg/oa/legbudg\\_oa\\_unofficial\\_comp.asp](http://www.aoa.gov/about/legbudg/oa/legbudg_oa_unofficial_comp.asp)

disability and living situation. The states do so based on a funding formula that takes into account regional poverty levels and population distribution. Older persons in rural areas, for example, typically require more resources to serve than those in urban or suburban areas, simply because of the distances traveled to reach them.

The **OAA funding formula to the states**<sup>39</sup> ensures that no state, regardless of population, receives less than one-half percent of total OAA dollars. For territories, that minimum may vary from one-fourth to one-sixteenth of one percent. Funds are then distributed to states and territories, for the most part, on the basis of 60-plus population. (Exceptions are made in funding for Caregiver Support and Elder Rights.) In some states, such as Florida, the 60-plus population comprise nearly one-fourth of the overall population. In others, such as Alaska, the 60-plus population may constitute only **10 percent of the state's overall population**.<sup>40</sup> Through “hold harmless” and “growth guarantees” (which will gradually be phased out by 2011), the funding formula also ensures that monetary allocations to the states will not dip below previous levels and that all states will receive a share of any increases in AoA appropriations.

As stated in the previous paragraph, exceptions to the 60-plus funding formula are made for **Caregiver Support** (Title III-E)<sup>41</sup> and **Elder Rights (Title VII)**<sup>42</sup> programs. Funding for Caregiver Support, because it so often involves services for those of a more advanced age, is based on a state's 70-plus population. Funding for Elder Rights is based on the 60-plus population, but does not have the “guaranteed growth” adjustment for inflation and has a less generous “hold harmless” component.

From its inception, the OAA has set broad and lofty aspirations against a backdrop of restrained budgeting. OAA allotments have always been far less than government allocations for Medicare and Medicaid, and have continuously diminished in proportion to those programs over the years. For example, OAA's initial budget in 1966

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<sup>39</sup>U.S. Code Online: Chapter 35 - Programs for Older Americans/SUBCHAPTER III—Grants for States and Community Programs on Aging: [frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse\\_usc&docid=Cite:+42USC3024](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC3024)

<sup>40</sup> AoA Statistics: Population by State (Excel) 2005-2030:

[www.aoa.gov/prof/Statistics/future\\_growth/future\\_growth.asp](http://www.aoa.gov/prof/Statistics/future_growth/future_growth.asp)

<sup>41</sup> The Older Americans Act – National Family Caregiver Support Program: Compassion in Action, 2004: [www.aoa.gov/prof/aoaprogram/caregiver/careprof/proguidance/resources/FINAL%20NFCSP%20Report%20July22,%202004.pdf](http://www.aoa.gov/prof/aoaprogram/caregiver/careprof/proguidance/resources/FINAL%20NFCSP%20Report%20July22,%202004.pdf)

<sup>42</sup> National Center on Elder Abuse: [www.elderabusecenter.org/default.cfm?p=lawslegislation.cfm](http://www.elderabusecenter.org/default.cfm?p=lawslegislation.cfm)

was \$7.5 million, less than 5 percent of Medicaid/Medicare spending at the time. And while OAA funding has increased over the years to today's **annual \$1.85 billion**,<sup>43</sup> that figure is now less than one-half percent of the more than \$511 billion the U.S government currently spends on Medicare and Medicaid every year.

**The U.S. Government Accounting Office and AoA  
show the following outlays for the year 2006:**

- Medicare - \$325 billion
- Medicaid (federal portion only) - \$186 billion
- Older Americans Act - \$1.34 billion

Consequently, OAA funds are increasingly being targeted by states and tribal organizations to those most in need of them economically and in terms of disability. More and more OAA dollars (and Medicaid-waiver allocations used to fund alternatives for nursing home care in the states) during the past decade have been earmarked for in-home and community services – as well as in support of family members and other voluntary caregivers – helping to keep older persons living as independently, enjoyably and fulfillingly in the place they overwhelmingly most want to be, their own homes.

**Other Funding Sources and Expanded Roles for Area Agencies on Aging**

While the OAA dollars have been shrinking in proportion to other types of funding for older Americans, many state offices and area agencies on aging have been expanding their functions to also administrate – on top of OAA revenues – sizeable allocations from Medicaid-waiver programs, federal social services block grants, senior-service levies, and other sources. Forty-eight states (and the District of Columbia) now have some type of **Medicaid-waiver program**<sup>44</sup> (allowing for the diversion of nursing home funds to in-home and community-based care). These Medicaid waivers pour

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<sup>43</sup> AoA; Budget and Legislation: ([www.aoa.gov/about/legbudg/current\\_budg/legbudg\\_current\\_budg.asp](http://www.aoa.gov/about/legbudg/current_budg/legbudg_current_budg.asp))

<sup>44</sup> Centers for Medicare and Medicaid Services – HCBS Waivers – Section 1915 (C): ([www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05\\_HCBSWaivers-Section1915\(c\).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp))

billions of dollars into aging service programs, and some **two-thirds of the states administrate these programs through area agencies on aging.**<sup>45</sup> (read more...)

Also outside of traditional OAA funds, a portion of \$630 million in FY 2007 U.S. Dept. of Health and Human Services' **Community Services Block Grant**<sup>46</sup> money, allocated for a variety of social services for low-income Americans of all ages, is designated for senior services. The money is available to the states, District of Columbia, territories and tribal organizations in accordance with populations living in poverty.

A larger federal block grant, the **Social Services Block Grant**<sup>47</sup> (aka Title XX of the Social Security Act, 1975), provides roughly \$1.7 billion each year to states and territories based on population. The money is used, in large part, to promote economic self-sufficiency, reduce neglect and abuse of children and the elderly, and to prevent the unnecessary institutionalization of those able to live in more independent settings. Approximately 20 percent of the annual \$1.7 billion is directed toward helping older and disabled persons.

Some states also supplement OAA funds with varying state and local allocations for specific programs, such as Alzheimer's- and/or ombudsman-related services. And most states and area agencies on aging (69 percent, according to AoA) take in significant amounts (altogether over \$250 million a year) in **client cost-sharing and voluntary contributions**<sup>48</sup> for a variety of OAA services (even though mandatory cost-sharing for many services is prohibited). Additionally, five states – Kansas, Louisiana, Michigan, Ohio, and North Dakota – bring in a combined \$140 million a year in local **senior-service property-tax levies.**<sup>49</sup> It is well worth noting that Ohio, which has brought in more senior-service levy funds than the rest of the states combined, has a better than 90 percent success rate with senior-service levies at its county ballot boxes.

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<sup>45</sup> U.S. Dept. of HHS: Statement of Josefina Carbonell to the U.S. Senate Special Committee on AoA Priorities: [www.hhs.gov/asl/testify/2007/02/t20070215c.html](http://www.hhs.gov/asl/testify/2007/02/t20070215c.html)

<sup>46</sup> U.S. Dept. of Health and Human Services: Admin. For Children & Families: Community Services Block Grant: [www.acf.hhs.gov/programs/ocs/csbg/](http://www.acf.hhs.gov/programs/ocs/csbg/)

<sup>47</sup> U.S. Dept. of Health and Human Services: Admin. For Children & Families: Social Services Block Grant: [www.acf.hhs.gov/programs/ocs/ssbg/](http://www.acf.hhs.gov/programs/ocs/ssbg/)

<sup>48</sup> Older Americans Act: (Sec. 315) Consumer Contributions: [www.aoa.gov/about/legbudg/oa/Cost%20Sharing%20statute.doc](http://www.aoa.gov/about/legbudg/oa/Cost%20Sharing%20statute.doc).

<sup>49</sup> Locally Funded Services for Seniors: A Description of Levy Programs in Ohio: [www.scripps.muohio.edu/research/publications/documents/LocallyFundedServicesforSeniors06.pdf](http://www.scripps.muohio.edu/research/publications/documents/LocallyFundedServicesforSeniors06.pdf)

And most area agencies also benefit from local dollars. County, city and other local government funds comprise 11 percent of the average area agency's overall budget. Another five percent of area agency budgets come courtesy of charitable contributions from **private groups and foundations**.<sup>50</sup>

Although there are still several states and area agencies that operate only with OAA funds, those federal, non-Medicaid and non-Medicare funds represent a decreasingly small fraction of the total aging-service allocations overseen by the majority of states and their area agencies on aging, mainly because of the steadily growing popularity and preference for home services funded through Medicaid-waiver programs.

### **OAA Titles (Components of the Older Americans Act)**

The Older Americans Act can best be understood in relation to its various subheadings – or titles, as they are known in government parlance. The act has seven titles. The most recent of them, Title VI (grants to Native American tribal organizations as separate entities from standard area agencies on aging) and Title VII (elder rights; and benefits outreach) were funded in 1980 and 1992, respectively. (**read more...**)

1. Title I stipulates the mission of the OAA through its aforementioned 10 objectives.
2. Title II pertains to AoA policies and procedures for the administration of the OAA (funding, planning, developing, coordinating and evaluating services) at the federal, state and area agency level. It authorizes the presidential appointment of the OAA head, known as the Assistant Secretary for Aging (currently Josefina Carbonell).
3. Title III is the heart and soul of the OAA, providing **major in-home and community-based services**<sup>51</sup> through the establishment and operation of

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<sup>50</sup> AoA 2006 Survey of Area Agencies on Aging: <http://www.aoa.gov/about/results/aaasurvey08082006.pdf>

<sup>51</sup> AoA Services for Seniors: [http://www.aoa.gov/eldfam/Service\\_Options/Service\\_Options.asp](http://www.aoa.gov/eldfam/Service_Options/Service_Options.asp)

**senior centers**<sup>52</sup> and programs advancing nutrition (both congregate dining and home-delivered meals); transportation; in-home health and other supportive services, such as visiting nurse, homemaker and chore); preventive health services; and family caregiver support.

4. Title IV involves research on older persons and in the field of aging, including grants for demonstration projects and initiatives related to intergenerational programs, developmental disabilities, housing and alternate funding sources.
5. Title V originally dealt with training, but now covers **senior employment**.<sup>53</sup> Unlike most OAA programs, senior employment is administered by the U.S. Dept. of Labor through the Senior Community Service Employment Program, and the eligibility starts at age 55 and older for those whose incomes are below 125 percent of the poverty level (\$10,210 for an individual in 2007). The program targets older persons with poor employment prospects.
6. Title VI, the portion of the OAA providing direct grants to the **243 Native American tribal units**<sup>54</sup> (Native American versions of area agencies on aging), was added to the OAA via 1975 and 1978 amendments to the act, though funds were not appropriated until 1980. This title originated in response to concerns that Native Americans were underserved by traditional area agencies on aging. In 1987, further amendments broadened Title VI to serve Native Alaskans and Native Hawaiians. Roughly \$32 million in OAA funds went to Native Americans, Alaskans and Hawaiians in 2007.

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<sup>52</sup> Older Americans Act: Multipurpose Senior Centers:  
[www.access.gpo.gov/uscode/title42/chapter35\\_subchapterv\\_.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterv_.html)

<sup>53</sup> AoA: Senior Community Service Employment Program:  
[www.access.gpo.gov/uscode/title42/chapter35\\_subchapterv\\_.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterv_.html)  
and U.S. Dept. of Labor - Senior Community Service Employment Program :  
[www.access.gpo.gov/uscode/title42/chapter35\\_subchapterv\\_.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterv_.html)

<sup>54</sup> AoA: Older Americans Act: Grants to Native Americans:  
[www.access.gpo.gov/uscode/title42/chapter35\\_subchapterx\\_.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterx_.html)

7. Title VII formalized and consolidated components of four initiatives related to **elder rights**<sup>55</sup> and placed them under a new title in efforts to improve communication and more emphatically promote and protect the rights of older Americans. The four components are:

- ombudsman programs overseeing the rights and care of nursing home residents and others receiving long-term care services in their own homes and communities;
- programs to prevent abuse, neglect and financial exploitation of older persons;
- elder rights outreach, promoting the education of older persons and those caring for them on rights guaranteed in nursing home residents bill of rights and other federal and state regulations protecting older persons; and
- benefits outreach and counseling regarding Medicare, Medicaid, pensions and other public benefits and assistance programs that may help older persons.

### **Older Americans Act Allocations to the States**

Funding for these various titles is, as mentioned earlier, allotted to states mainly on the basis of age 60-and-older populations. The states, in turn, make adjustments in **funding their respective area agencies**<sup>56</sup> in accordance with regional variations in poverty levels and population distribution. Rural populations, for example, are often widely dispersed and require more resources to serve than the more condensed populations of urban and suburban areas. **(read more...)** Targeting resources to those in

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<sup>55</sup> AoA: Older Americans Act: Allotments for Vulnerable Elder Rights Program Activities: [www.access.gpo.gov/uscode/title42/chapter35\\_subchapterx.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapterx.html)

<sup>56</sup> Grants for State and Community Programs on Aging (Sec. 3026: Area Plans): [www.access.gpo.gov/uscode/title42/chapter35\\_subchapteriii\\_parta.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapteriii_parta.html)

the greatest social and economic need, with a special emphasis on service to minorities, as mandated by the OAA, is the responsibility of the states and area agencies on aging. States and their area agencies, by OAA law, are required to submit formal **two- three- or four-year plans**<sup>57</sup> to demonstrate how they will go about targeting those in the greatest social and economic need, and how they intend to distribute their funds in accordance with the dictates of the OAA and AoA objectives. The 655 area agencies must submit their plans to their respective states and the states (and territories and tribal units) must, in turn, submit their plans to the U.S. Administration on Aging.

Of the roughly \$1.37 billion in AoA funding **shared among the 50 states in 2005**,<sup>58</sup> the District of Columbia, territories and 243 Native American tribal units, about 52 percent went to nutrition programs, and another 25 percent was allocated for other home- and community-based services, such as transportation and personal care, according to the AoA 2005 Annual Report. Eleven percent went to caregiver support programs initiated in the act's 2000 amendments; five percent was earmarked for grants to demonstration projects and other innovative programs and services (and network support); three percent was set aside for preventive services; two percent was reserved for Native American programs; and another two percent was reserved for administration. (**Note:** On top of the \$1.37 billion in OAA funding from the U.S. Administration, and outside of the percentages specified for the above services, some \$483 million more was allocated for Title V Senior Employment from the U.S. Dept. of Labor. This boosted total 2005 OAA funds to about \$1.85 billion, approximately what they are in 2007.

States, territories, tribal organizations and area agencies are given great leeway as to how they go about spending their OAA allotments, and most are very adept at leveraging state, local and, sometimes, private funds. For every Older Americans Act dollar, the average area agency on aging leverages about \$2 to \$3 more from other sources. In other words, all told, the \$1.85 billion in OAA funds results in close to \$5 billion in programs and services for older Americans.

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<sup>57</sup> AoA; Strategic Plan: [www.aoa.gov/about/strategic/strategic.asp](http://www.aoa.gov/about/strategic/strategic.asp); and Grants for State and Community Programs on Aging (Sec. 3026: Area Plans): [www.access.gpo.gov/uscode/title42/chapter35\\_subchapteriii\\_parta.html](http://www.access.gpo.gov/uscode/title42/chapter35_subchapteriii_parta.html)

<sup>58</sup> AoA: Annual Report 2005: ministration. ([www.aoa.gov/about/annual\\_report/2005\\_Final\\_Annual\\_Report.pdf](http://www.aoa.gov/about/annual_report/2005_Final_Annual_Report.pdf))

## Discretionary Spending

OAA funding budgeted for **demonstration projects and innovative services**<sup>59</sup> is designated as “discretionary spending” for program innovations (often related to **AoA priorities**)<sup>60</sup> That is, the money is, to a considerable extent, up for grabs to the states, territories and area agencies on aging willing to put the time, energy and creative thought into going after these **discretionary grants**.<sup>61</sup> (**read more...**)

From the start, the OAA has put an emphasis on innovation and the wealth of shared information arising from demonstration projects across the states as the country explored how “to develop, test and promote more effective and more efficient services to older Americans and their families,” in accordance with OAA ideals and aspirations. This is an area where boards of directors/trustees and advisory councils can be very influential and instrumental in helping their area agencies on aging access more federal, state and local dollars while providing valuable and innovative services to the older population.

Currently, above and beyond funding based on 60-plus population, about 3 percent of OAA’s budget (currently over \$24 million) goes to discretionary spending grants to the states, territories, area agencies on aging and the tribal units. These grants fund an array of demonstration and best-practice innovations, ranging from transportation services for the rural elderly, to inner city congregate meal programs, to Cash & Counseling initiatives (giving older persons more control over who provides their services, and when, where and how the services are provided).

The past decade, with the OAA’s emphasis on in-home services and caregiver support, a greater portion of discretionary spending grants has gone to initiatives supporting in-home services and caregivers. One such initiative that board of directors/trustees and advisory council members should be aware of is the OAA’s proposed **Choices for Independence program**.<sup>62</sup> AAAs planning, developing and implementing innovative programs helping older persons live out their lives in their own

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<sup>59</sup> AoA 2005 Annual Report: [www.aoa.gov/about/annual\\_report/2005\\_Final\\_Annual\\_Report.pdf](http://www.aoa.gov/about/annual_report/2005_Final_Annual_Report.pdf)

<sup>60</sup> HHS – Testimony on AoA Priorities: ([www.hhs.gov/asl/testify/2007/02/t20070215c.html](http://www.hhs.gov/asl/testify/2007/02/t20070215c.html))

<sup>61</sup> AoA Grant Programs: Funding Opportunities: [www.aoa.gov/doingbus/fundopp/fundopp.asp](http://www.aoa.gov/doingbus/fundopp/fundopp.asp)

<sup>62</sup> Choices for Independence: a National Leadership Summit:  
[www.aoa.gov/summit/main\\_site/summithome.aspx](http://www.aoa.gov/summit/main_site/summithome.aspx)

homes and communities will have opportunities to receive federal dollars reserved for programs and services outlined in the *Choices for Independence* grant program.

### **Choices for Independence**

In 2006, the **16<sup>th</sup> reauthorization of the Older Americans Act**<sup>63</sup> (OAA 2006) included concepts supporting AoA's proposed *Choices for Independence* demonstration project. The project is rooted in AoA's mission to enhance the dignity and independence of older people through promoting consumer-directed, community-based long-term care options. (**read more...**) As planned, *Choices* would build on various existing programs, including the ***Cash & Counseling Demonstration Project***<sup>64</sup> (allowing consumers to select family members, friends and neighbors as government-paid caregivers) and the ***Aging and Disability Resource Centers***<sup>65</sup> (providing a single point of entry into the aging network, making services more accessible), and integrate other in-home service demonstration projects and best practices into a three-point strategy focused on:

1. *empowering individuals to make informed decisions about their long-term support options;*
2. *providing more choices for individuals at high-risk of nursing home placement; and*
3. *enabling older people to make behavioral changes that will reduce their risk of disease, disability, and injury.*

*Choices* would allow states and communities greater flexibility under the Older Americans Act to help older individuals to remain in their homes and delay what may be their premature entry into nursing homes. The program would provide flexible funding targeted at individuals, not service categories, as with the current titles under the Act. This flexible funding method should make it easier for states to respond to individualized needs and preferences and promote the use of consumer-directed approaches, including “cash and counseling” models giving consumers more control over the care they receive.

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<sup>63</sup> AoA: OAA Amendments of 2006: [www.aoa.gov/OAA2006/Main\\_Site/index.aspx](http://www.aoa.gov/OAA2006/Main_Site/index.aspx)

<sup>64</sup> Cash & Counseling: [www.cashandcounseling.org/about/partners, and](http://www.cashandcounseling.org/about/partners_and)

AoA Memorandum: Cash & Counseling Projects: [www.hhp.umd.edu/AGING/CCDemo/AOA.html](http://www.hhp.umd.edu/AGING/CCDemo/AOA.html)

<sup>65</sup> AoA: Aging and Disability Resource Centers: [www.aoa.gov/prof/aging\\_dis/aging\\_dis.asp](http://www.aoa.gov/prof/aging_dis/aging_dis.asp)

*Choices* also will stress preventive medicine and health promotion, empowering older Americans to make lifestyle changes that will reduce their risk of disease, disability, and injury. A growing body of scientific evidence supports the benefits of low-cost programs empowering older individuals, including those functionally impaired, to better maintain their health. These programs focus on interventions such as chronic disease self-management, falls prevention, exercise, and nutrition.

Additionally, *Choices* would strengthen the role of the Older Americans Act in translating research into practice. *Choices* would do so by promoting the use of evidence-based health promotion and disease prevention programs at the community-level through local aging services provider organizations, such as senior centers, nutrition programs, senior housing projects, and faith-based groups. The nationwide deployment of these programs will improve quality of life while reducing health-care costs.

### **Implementing Choices for Independence**

*Choices* will likely provide millions of dollars in **competitive matching grants**<sup>66</sup> to states, accompanied by rigorous program evaluation requiring states to track outcomes based on measures such as the promotion of older persons' health and well-being, and reductions in the unnecessary and costly use of hospital and nursing home care. Though *Choices* is not yet funded as a line item in the federal budget, money for components of the program, including Aging and Disability Resource Centers (one-stop- shopping headquarters for aging services) and preventive health measures (e.g., self-management programs for chronic diseases; advice on preventing falls) has been appropriated from allocations for general Program Innovations. And while specific funding for *Choices* in federal fiscal year 2008 (Oct. 1, 2007 through Sept. 30, 2008) has not yet been confirmed, President George W. Bush has requested \$28 million for the program for that fiscal year. The same amount was included in the Senate Appropriations' Committee's recommended funding level. The House of Representatives, however, included a lesser amount for *Choices*, \$16.5 million. Historically, final funding levels tend to fall somewhere between the House and Senate's recommended funding levels.

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<sup>66</sup> Remarks of AoA Assistant Secretary for Aging Josefina Carbonell at the Sixth Annual New Freedom Initiatives Conference: [www.aoa.gov/PRESS/speeches/2006/04\\_Apr/NFIJGCspeech41006web.pdf](http://www.aoa.gov/PRESS/speeches/2006/04_Apr/NFIJGCspeech41006web.pdf)

Aging Network Flow Chart

**U.S. Dept. of Health and Human Services (HHS)**

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**U. S. Administration on Aging (AOA)**

**56 State Units and Territories**

(Includes District of Columbia & 5 U.S. territories: Guam, North Mariana Islands, Puerto Rico, Samoa & Virgin Islands)

**243 Tribal Organizations**

**Providers**

**Population served**  
112,438  
(of approx. 284,650  
Native Americans,  
Alaskans & Hawaiians 60+)

**Natl. Assoc. of Area  
Agencies on Aging  
(n4a)**

**State Assoc. of AAAs**

**655 Area Agencies on Aging**

**29,000 Provider Agencies**

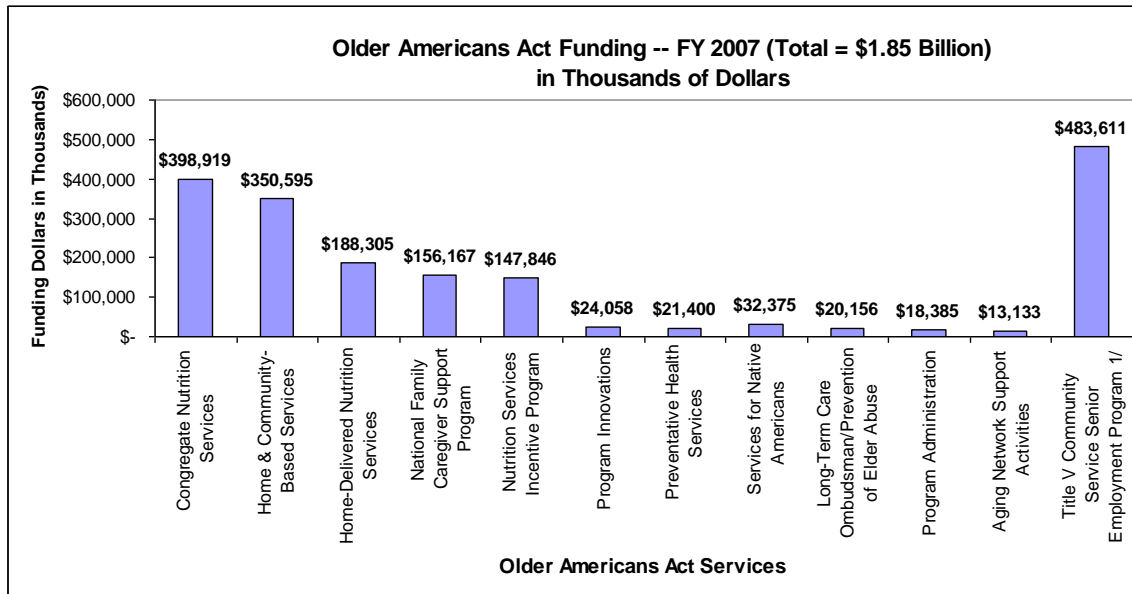
**National Assoc. of State Units on Aging  
(NASUA)**

**Population Served**  
approx. 16 million  
(of approx. 50 million Americans age 60+)

## Older Americans Act Funding Charts

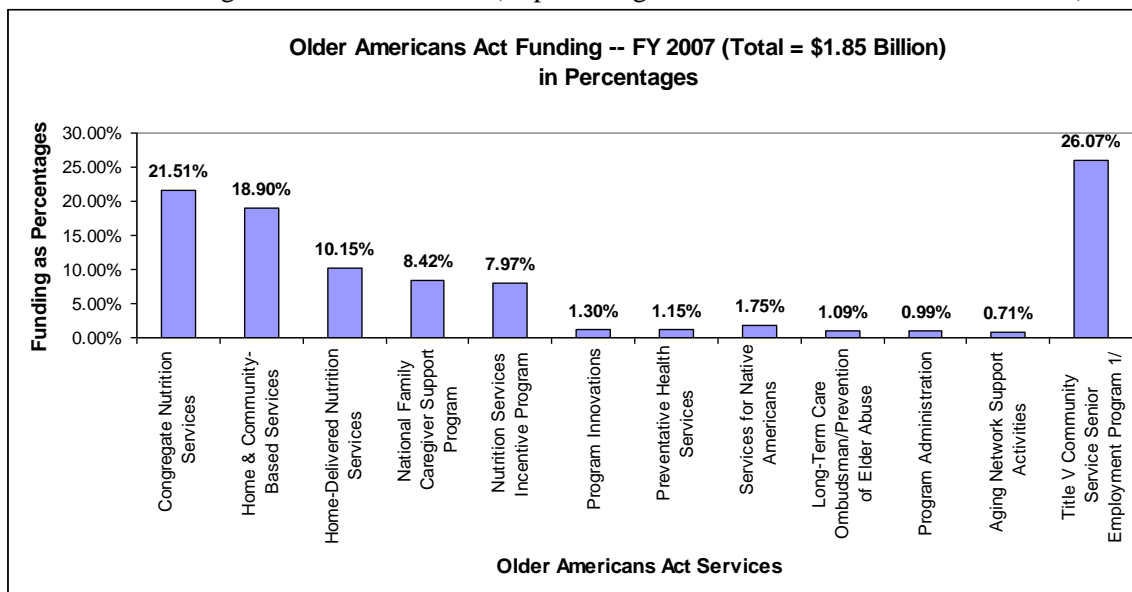
**Table 1**

OAA Funding for Fiscal Year 2007 (in thousands of dollars: e.g., \$398,919 = \$398.9 million)



**Table 2**

OAA Funding for Fiscal Year 2007 (as percentages of the total \$1.85 billion allocated)



\* Title V Senior Service Employment Funding is through the U.S. Dept. of Labor; all other funding in the above charts is through the U.S. Administration on Aging.

\*\* \$11,668,000 in Alzheimer's disease program funding is not listed in the charts above as the money is distributed to states via the U.S. Public Health Service Act, not through the OAA.

**Older Americans Act Funding**  
*Home- and Community-Based Services*

The OAA budget charts on the preceding page, listing congregate meals and home-delivered meals as categories separate from Home- and Community-Based Services (HCBS), may very well beg the question: “Aren’t home-delivered meals (by definition) and congregate meals (served in senior centers, community centers, church basements, etc.) home- and community-based services?”

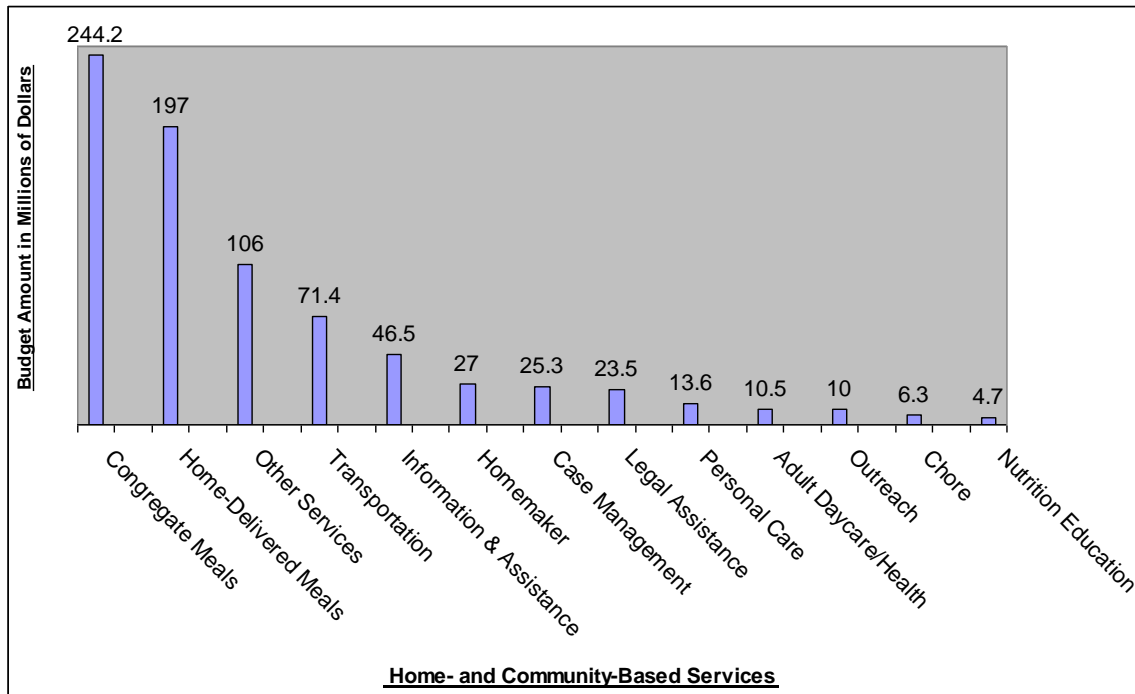
They most certainly are. But, as Congress has a tradition of ensuring that senior nutrition services are prioritized, *Congregate Meals* (aka Title III-C1) and *Home-Delivered Meals* (aka Title III-C2) have retained line-item budgeting status distinct from, rather than as components of, *Home- and Community-Based Services* (aka “supportive services,” Title III-B). It should be noted, though, that the OAA allows states to shift up to 30 percent of funding from home-delivered and/or congregate meals to general HCBS programs and vice-versa (about \$33 million is transferred to HCBS, annually). Further, states can transfer up to 40 percent of funding between congregate and home-delivered meal programs (about \$30 million is transferred to home-delivered meals, annually).

In short, nutrition services are separate from general HCBS for technical, budgetary purposes, but are one and the same as general HCBS for all practical purposes. To simplify understanding of the distribution of the various HCBS services funded and distributed via the Older Americans Act, **the budget chart on the following page** categorizes home-delivered and congregate meals as components (or subsets) of HCBS. As the chart shows, home-delivered and congregate meals (totaling \$440,966,529) comprised 56 percent of the \$787,662,815 OAA dollars allocated for all HCBS programs in 2005 (the latest year for which such figures are available.)

The following HCBS chart lists *Other Services*, which at \$106 million is the third highest category in the chart. This category is composed of more than 20 services, from advocacy to home modification to “wanderer locator” (motion detectors for people with Alzheimer’s disease). The services are placed together under one heading by AoA as a means of keeping the chart from becoming unwieldy and overly cumbersome. More detailed information regarding the HCBS budget chart may be accessed via the AoA Website: [www.aoa.gov/prof/agingnet/NAPIS/SPR/2005SPR/profiles/us.pdf](http://www.aoa.gov/prof/agingnet/NAPIS/SPR/2005SPR/profiles/us.pdf)

**Fiscal Year 2005 Funding for OAA HCBS Services  
(in Millions of Dollars)**

*Total = Approx. \$787 Million (slightly less due to rounding)*



**Please Note:**

The “***Other Services***” category in the chart above is a catch-all for a range of Home- and Community-Based Services, including: Advocacy, Alternative Living Arrangements (i.e., help in finding); Benefits Specialist; Companion & Friendly Visitor Services; Competency Evaluations; Counseling (Mental Health); Employment Assistance; Environment Accessibility; Exercise & Physical Education; Financial Management; Geriatric Assessment; Grocery Shopping; Guardianship (Legal); Home Modification; Letter Writing; Occupational Therapy; Support Groups (e.g., Arthritis and Parkinson’s disease); Translation (English/Spanish); Public Utility Assistance; Volunteer Recruitment & Development; and Wanderer Locator (electronic motion sensors). Also, “***Case Management***” refers to administrative and professional efforts coordinating a comprehensive range of senior services for individuals. For example, case managers often spend hours, days and weeks contacting, procuring, arranging funding for and following up on various services for clients. “***Outreach***” is used to get the word out on the availability of services (many of them free of cost) to older Americans. This outreach often takes the form of paid advertisements on TV, radio and in newspapers, as well as actual door-to-door, person-to-person communications. “***Transportation***” actually represents the combination of two categories, *Transportation* (actual services, \$67.6 million) and *Assisted Transportation* (covering individuals needing personal assistance with transportation, such as the visually impaired, \$3.8 million). Likewise, the “***Nutrition Education***” category is composed of *Nutrition Education* (usually group instruction overseen by a licensed dietitian, \$3.4 million) and *Nutrition Counseling* (usually individual counseling by a licensed dietitian, \$1.3 million).

## Common Acronyms

**AAA (Area Agency on Aging)** – A local or regional agency, funded under the federal **Older Americans Act** through the state unit on aging, that plans and coordinates various social and health service programs for persons 60 years of age or older. The national network of AAA offices consists of 655 approved area agencies on aging (not including Native American tribal agencies).

**AARP (formerly the American Association of Retired Persons)** – A nonprofit, nonpartisan lobbying organization advocating for improved quality of life for Americans age 50 and over. AARP, with more than 35 million members, provides a wide range of benefits and services, including investment opportunities, and discounts on insurance and travel.

**ADLs (Activities of Daily Living)** – Eight basic activities usually engaged in during the course of the day: bathing, eating, dressing, grooming, mobility (ambulation), transferring from bed to chair, and toileting (bladder & bowel control).

**AoA (U.S. Administration on Aging)** – Federal agency that funds, administrates and oversees **Older Americans Act** programs through the state units, area agencies on aging and the Native American Tribal Units. The AoA, created in 1965, is an agency of the U.S. Department of Health and Human Services. It is now headed by Assistant Secretary for Aging Josefina G. Carbonell.

**APS (Adult Protective Services)** – Service protecting the rights of frail older adults by investigating cases of abuse, neglect, and (financial) exploitation as mandated by law.

**CCRC (Continuing Care Retirement Community)** – A community offering multiple, continuing levels of care (**independent living, assisted living, skilled nursing care**) in different facilities within the same area or campus, giving residents the opportunity to remain in the same community if their needs change. These communities provide residential services (meals, housekeeping, laundry), social and recreational services, health care services, personal care, and nursing care. CCRCs require payment of a monthly fee and, possibly, a large lump-sum entrance fee.

**CMS (Centers for Medicare & Medicaid Services)** – This federal organization, known until 2001 as the Health Care Financing Administration, oversees the **Medicare** and **Medicaid** programs. The organization's primary goal is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. It also provides information to assist consumers in choosing a variety of types of service providers through its website at [www.medicare.gov](http://www.medicare.gov).

**HCBS (Home- and Community-Based Services)** – Services designed to keep older persons living as independently as possible in their own homes and communities.

**HHS (U.S. Dept. of Health and Human Services)** – The federal department that administrates and oversees the U.S. Administration on Aging and an array of other medical and social programs.

**HMO (Health Maintenance Organization)** – A health-care care organization that offers a range of health services to its members for a set rate, but, in attempts to control costs, requires its members to receive care only from health care professionals who are part of the organization’s selected network of providers. (See also **Medicare HMOs**)

**IADLs (Instrumental Activities of Daily Living)** – Specific living tasks, crucial to maintaining independence, that include using the telephone, taking medications, money management, housework, meal preparation, laundry, and grocery shopping.

**LTC (Long-Term Care)** – The broad spectrum of medical and support services provided – often for years or decades in duration – to persons who have lost the capacity to function on their own due to a chronic illness or condition. Long-term care can consist of care in the home and community by family members assisted with voluntary or employed help, adult day health care, or care in **assisted living** or **skilled nursing facilities**.

**MDS (Minimum Data Sets)** – System used in tracking demographic and impairment levels of nursing home residents to better understand nursing home utilization patterns. Aspects of MDS are used by some states in calculating reimbursement rates.

**NAAAA (aka n4a): National Association of Area Agencies on Aging)** – The membership organization for the 655 area agencies on aging and a voice in the nation’s capital for the 243 Title VI Native American aging programs in the U.S. Headquartered in Washington, D.C., this association advocates on behalf of all area aging agencies and Title VI programs to ensure that the necessary resources are available to older Americans and those who serve and care for them.

**NASUA (National Association of State Units on Aging)** – Founded in 1964, the National Association of State Units on Aging is a non-profit association representing the nation's 56 officially designated state and territorial agencies on aging. Its mission is to advance social, health, and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity and independence of, and expand opportunities and resources for, current and future generations of older persons, adults with disabilities and their families.

**NCCNHR (National Citizens' Coalition for Nursing Home Reform)** – A coalition of concerned citizens advocating and lobbying for improved conditions in nursing homes across the country. Formed in 1975, NCCNHR provides information and leadership on federal and state regulatory and legislative policy development and models and strategies to improve care and life for residents of nursing homes and other long term care facilities. Ongoing work addresses issues such as inadequate staffing and poor working conditions in nursing homes, as well as residents' rights issues.

**PSA (Planning and Service Area, same as Area Agency on Aging)** – Regions of the state, often consisting of various counties, wherein aging services are coordinated by **Area Agencies on Aging** in coordination with the State Unit on Aging.

**QMB (Qualified Medicare Beneficiary)** – Program for low-income older persons wherein individuals are enrolled in a **Medicaid** program that also pays for **Medicare** cost-share expenses (**deductibles, co-payments, and Part B** premiums).

**SLMB (Specified Low-Income Medicare Beneficiary)** – **Medicaid** program that pays for **Medicare Part B** monthly premiums for low-income elders and persons with **disabilities** who qualify for **Medicare Part A**.

**SLMB-Plus (Specified Low-Income Medicare Beneficiary Plus)** – SLMB-Plus eligibles have full **Medicaid** benefits. The SLMB-Plus was created when Congress changed eligibility criteria for SLMBs to eliminate the requirement that SLMBs could not otherwise qualify for **Medicaid**.

**SNF (Skilled Nursing Facility)** – A facility certified by **Medicare** to provide 24-hour residential nursing care and **rehabilitation services** in addition to other medical services.

**SSA (Social Security Administration)** – Created in 1935, the federal office that administers the social security program and its monthly payments to Americans. The office also administers Supplemental Security Income (SSI) payments. In 2006, nearly 49 million Americans received approximately \$539 billion in Social Security benefits. Currently, some 162 million U.S. workers, 96% of all American workers, contribute more than \$700 billion to the program each year.

**SSI (Supplemental Security Income)** – Supplemental Security Income is a federal supplemental income program – adjusted yearly for inflation and administered by the SSA – for those who do not receive enough (or any) social security to lift them above the poverty level. Many states boost federal SSI payment with (optional) additional funds. In most states, SSI recipients are also automatically eligible for **Medicaid**.

## Glossary

**Activities of Daily Living** – Eight basic activities usually engaged in during the course of the day: bathing, eating, dressing, grooming, mobility (ambulation), transferring from bed to chair, and toileting (bladder & bowel control).

**Administration on Aging (AoA)**, aka U.S. Administration on Aging) – Federal agency that funds, administrates and oversees **Older Americans Act** programs through the state units, area agencies on aging and the Native American Tribal Units. The AoA, created in 1965, is an agency of the U.S. Department of Health and Human Services and is headed by Assistant Secretary for Aging Josefina G. Carbonell.

**Adult Care Facility** – Residential care homes classified as either an adult family home (3-5 residents) or an adult group home (6-16 residents). Skilled nursing services, such as medication administration, cannot be provided in adult care facilities. Many of Ohio's adult care facilities serve residents with mental or behavioral problems.

**Adult Day Care** (also **Adult day services**) – Programs offering social and recreational activities, supervision, health services, and meals in a single setting to older adults with physical and/or cognitive disabilities. Typically open weekdays during standard business hours.

**Adult Family Home** – An adult care facility that provides accommodations and support services for three to five unrelated adults, and personal care services to at least three of those adults.

**Adult Foster Care/Home** – A live-in arrangement in which one or two adults live with, and are provided care and/or services by, an unrelated individual or family. In addition to room and board, the services include housekeeping, laundry, some personal care, and supervision with finances and medications when deemed necessary. These individuals must not be in need of 24-hour supervision. Adult foster homes are certified by area agencies on aging.

**Adult Group Home** – An **adult care facility** providing accommodations and support services for 6 to 16 unrelated adults, and providing personal care services to at least three individuals.

**Adult Protective Services (APS)** – Service that protects the rights of frail older adults by investigating cases of abuse, neglect, and (financial) exploitation as mandated by law.

**Advance Directive** – Legal document allowing people, (in case of incapacitation) to give others legally binding instructions about their preferences regarding health care decisions. Types of advance directives are **living will** and **durable power-of-attorney for health care**.

**Aging and Disability Resource Centers (ADRC)** – “One-stop shopping” through community centers that offer referrals and help people make informed decisions about

their service and supports options. These centers serve as the single point of entry to the **long-term care** service system and are intended to make accessing a wide array of senior services easier and less time consuming.

**American Association of Retired Persons** (now officially known simply as **AARP**) – A nonprofit, nonpartisan lobbying organization advocating for improved quality of life for Americans age 50 and over. AARP, with more than 35 million members, provides a wide range of benefits and services, including an array of publications, investment opportunities and discounts on insurance, travel and other items.

**Area Agency on Aging (AAA)** – A local or regional agency, funded under the federal **Older Americans Act** through the state unit on aging, that plans and coordinates various social and health service programs for persons 60 years of age or older. The national network of AAA offices consists of 655 approved area agencies on agencies (not including Native American aging programs).

**Assisted Living/Assisted living facility** – Residences providing a “home with services” emphasizing residents’ privacy and choice. Residents typically have private rooms (only shared by choice) with bathrooms and locks on the doors. **Personal care** services are available on a 24-hour a day basis.

**Capitation** – A system of health-care payment in which set rates are established according to persons served rather than services performed.

**Caregiver** – Can be either informal (unpaid) or formal (usually paid). An informal caregiver is a person who provides care and assistance with various activities to a family member, friend, or neighbor. Formal caregivers are volunteers or paid care providers who are usually associated with an agency or social service system. Roughly 75 percent of all caregiving for older persons is provided by informal caregivers, i.e., family, friends and neighbors.

**Care plan** – (Also called service plan or treatment plan.) Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for the consumer for a specified time period.

**Centers for Medicare & Medicaid Services (CMS)** – This federal organization, known until 2001 as the Health Care Financing Administration, oversees the **Medicare** and **Medicaid** programs. The organization’s primary goal is to ensure effective, up-to-date health care coverage and to promote quality care, with little or no co-payment, for beneficiaries. It also provides information to assist consumers in choosing a variety of types of service providers through its website at [www.medicare.gov](http://www.medicare.gov).

**Certification** – In **Medicare** and **Medicaid**, certification refers to approval for providers to participate in those programs. Licensed facilities or agencies might elect not to be **Medicare-** or **Medicaid-**certified if they plan to provide services only to private-paying

residents. Requirements for certification are specified by the federal government for each type of Medicare and Medicaid provider.

**Community-Based Services** – Services designed to help older and disabled people remain independent and in their own homes. These services include activities provided by senior centers, transportation, home-delivered meals or congregate meals, visiting nurses and/or home health aides, adult day care, and homemaker services.

**Congregate Meals** – OAA program offering hot meals in a friendly, congregate setting, such as a senior center, community center or church basement. These meals are often free or offered on the basis of donations or sliding-fee scales.

**Conservatorship** – A legal arrangement granted by the court in which a person chooses an individual to make personal decisions on his/her behalf. The person for whom the conservatorship is arranged must be mentally competent, but physically unable to manage his or her own affairs.

**Consumer Direction** – An approach to the delivery of **home and community-based services** allowing informed consumers to make choices about and direct the services they receive. Consumers can assess their own needs, determine how and by whom these needs should be met – including hiring family members and friends – and monitor the quality of services received.

**Continuing Care Retirement Community** – A community offering multiple, continuing levels of care (**independent living, assisted living, skilled nursing care**) – that is, a continuum of care – in different facilities within the same area or campus, giving residents the opportunity to remain in the same community if their needs change. These communities provide residential services (meals, housekeeping, laundry), social and recreational services, health care, personal care, and nursing care. CCRCs require payment of a monthly fee and, possibly, a large lump-sum entrance fee.

**Continuum of Care** – A term for the entire spectrum of specialized health, rehabilitative, and residential services available to the frail and chronically ill; that is, home services, independent living, assisted living and nursing home care.

**Custodial Care** – Nonskilled, **personal care** that does not include services typically provided by a doctor and/or nurse. Such care includes help with **activities of daily living: bathing, dressing, eating, transferring, ambulation, and toileting**, for example. In most cases, **Medicare** does not pay for custodial care.

**Deficiency** – A finding from a government inspection that a nursing home failed to meet one or more federal or state requirements.

**Dementia** – A term describing a group of diseases (including Alzheimer's Disease) characterized by memory loss and other declines in mental and sometimes emotional functioning.

**Disability** – A limitation in physical, mental, or social activity. There are varying types (functional, occupational, learning), degrees (partial, total), and durations (temporary, permanent) of disabilities.

**Dual Eligibility (sometimes referred to as “dually eligible”)** – A term for persons eligible for **Medicare (Part A and/or Part B)** and who are also eligible for **Medicaid**. **Medicaid** pays for premiums, deductibles, and co-payments required by **Medicare**. There are seven categories of dual eligibility (see **Medicaid Only, QMB, QMB Plus, SLMB, SLMB Plus, QI, & QDWI**)

**Durable Medical Equipment** – Equipment such as hospital beds, wheelchairs, and prosthetics used at home. May be covered by **Medicaid, Medicare**, or private insurance.

**Durable Power of Attorney** – A legally binding document that names a person (called an "attorney-in-fact") who will act, in case of incapacity, as someone’s agent and make decisions on that person’s behalf. The power of the attorney-in-fact can be restricted to specific areas (such as health care) or can cover broad decision-making responsibilities.

**Eldercare Locator** – A nationwide information and referral service sponsored by the Administration on Aging. Call (toll-free) 1-800-677-1116 Monday through Friday from 9 a.m. to 8 p.m., E.S.T., to obtain information about services for older persons in your community or anywhere in the country. Also available on-line ([www.eldercare.gov](http://www.eldercare.gov)).

**Emergency Response System (ERS)** – A call button – usually worn by the older individual – which can be pushed to get help from family, friends, or emergency assistance in case of emergency. ERSs can be purchased or rented.

**Estate Recovery** – States are required by law to “recover” funds from certain deceased **Medicaid** recipients’ estates up to the amount spent by the state for all **Medicaid** services.

**Fee-for-Service** – The formal term for the billing/payment system used by **Medicare** and private health insurance. Medical providers bill for whatever services they provide.

**For-profit** – Organization or company in which profits are distributed to shareholders or private owners. More than two-thirds of nursing homes are for-profit, though that is the case for fewer than one-third of hospitals.

**Geriatrics** – A branch of medicine focusing on the physiology and ailments associated with the aging process.

**Gerontology** – The study of the physical, psychological and social aspects of aging.

**Geriatrician** – Physician who is certified by the American Board of Internal Medicine of Family Practice in the care of older people.

**Guardianship** – Legal arrangement in which the court appoints a surrogate decision-maker to act on someone’s behalf because that person has been declared incompetent.

The arrangement may include guardianship of the person, estate (finances), or both. The guardian may or may not know this person, depending on the situation at the time of the appointment.

**Health Care Proxy** – Basically the same as Power of Attorney, that is: A person (called an "attorney-in-fact") given the legally binding right to make decisions concerning another's health care in the case of incapacity.

**Health Maintenance Organization (HMO)** – A health-care care organization offering a range of health services to its members for a set rate, but, in attempts to control costs, requires its members to receive care only from health care professionals who are part of the organization's selected network of providers. (See also **Medicare HMOs**)

**Homebound** – One of the requirements to qualify for **Medicare Home Health Care**. In this context, the term means that someone is generally unable to leave the house, and, if the person does leave home, it is usually only for a short time (e.g., for a medical appointment) and requires much effort. Individuals may attend adult day programs, religious services, or occasional special social outings and still be considered homebound.

**Home Care/In-Home Services** – Generally non-medical long-term care services received at home. For example: **homemaker, personal care, home-delivered meals, chore services, or emergency response systems.**

**Home-Delivered Meals** – Sometimes referred to as "meals on wheels," home delivered meals are warm meals, prepared to government specifications, delivered to homebound persons who are unable to prepare their own meals.

**Home Health Care** – Medical care delivered at home that includes a wide range of health-related services such as assistance with medications, wound care, and intravenous (IV) therapy.

**Home Health Agency** – An organization providing medically skilled home-care services, such as **skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.**

**Homemaker Service** – A service providing assistance with meal preparation, shopping, light housekeeping, laundry and other tasks helping clients maintain life in their own homes.

**Hospice** – Services for the terminally ill provided in the home, a hospital, or a long-term care facility. Includes home health services, volunteer support, grief counseling, pain management and other forms of care aimed at helping terminally ill persons (and their families) live out their lives as dignified, meaningfully and fulfilling as possible.

**Independent Choices** – A national demonstration project allowing beneficiaries to use Medicaid funds to hire service providers/helpers of their own choice, instead of using

traditional services provided by agency workers. Beneficiaries can hire family members, friends, and neighbors to assist with intimate personal care tasks and have more voice regarding how and when services are provided.

**Independent Living** – A living arrangement maximizing independence and self-determination, especially for older persons and younger persons with disabilities living in a community instead of in a medical facility.

**Independent Living Facility** – Rental unit wherein services are not included as part of the rent, although services may be available on site and purchased by residents for an additional fee.

**Instrumental Activities of Daily Living (IADL)** – Household/independent living tasks that include using the telephone, taking medications, money management, housework, meal preparation, laundry, and grocery shopping.

**Irrevocable Burial Account** – When determining eligibility for **Medicaid**, the state allows consumers to set aside money in a trust or with a funeral director for burial expenses as part of a pre-paid burial plan.

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** – An independent, non-profit organization that evaluates and accredits nearly 15,000 health care organizations and programs in the United States.

**Level of Care (LOC)** – Amount of assistance required by consumers that may determine their eligibility for programs and services. Levels include: protective, intermediate, and skilled. In order to qualify for Medicaid nursing home or home & community-based services, an individual must meet a nursing home level of care.

**Levy-Funded Programs** – Home care service programs for older adults that are funded by county property tax levies. Services and fees vary by program. Currently, there are five states raising funds for senior services through property-tax levies: Kansas, Louisiana, Michigan, North Dakota and Ohio.

**Life Care Community** – A type of **Continuing Care Retirement Community (CCRC)** requiring a lump-sum payment in return for a lifelong contract covering all levels of care. It often includes payment for acute care and physician's visits. Little or no change is made in the monthly fee, regardless of the level of medical care required by the resident, except for cost of living increases.

**Limited Guardianship** – A legal arrangement whereby the court appoints a surrogate decision-maker. But, this arrangement limits his or her authority to make specific decisions and/or limits the length of time the guardianship is to be in place.

**Living Trust** – A trust that is set up while someone (called the *grantor* or *trustor*) is still alive. Assets are transferred to the trust, and the grantor names a “trustee” who controls the assets in the trust as well as the “beneficiaries” who will inherit the trust after the grantor has died. This trust may be *revocable* (meaning that the grantor may change the

terms of the trust or take back assets) or *irrevocable* (meaning that the trust may not be touched by the grantor). This trust may also be considered when determining the grantor's eligibility for **Medicaid**.

**Living Will** – A document stating a person's preferences for future medical decisions, including the withholding or withdrawing of life-sustaining treatments; such as artificial nutrition and hydration or the use of equipment, such as ventilators and respirators. (See also advance directive)

**Long-Term Care (LTC)** – The broad spectrum of medical and support services provided – often for years or decades in duration – to persons who have lost the capacity to function on their own due to a chronic illness or condition. Long-term care can consist of care in the home and community by family members who are assisted with voluntary or employed help, adult day health care, or care in **assisted living** or **skilled nursing facilities**.

**Long-Term Care Insurance** – Insurance policies covering long-term care services (such as nursing home and home care), typically those that **Medicare** and **Medigap** policies do not cover. Policies vary in terms of what they will cover, and premiums vary accordingly. Coverage may be denied based on health status or age. Only a small portion of the U.S. population (fewer than 5 percent ) are covered by this type of insurance.

**Managed Care** – A method of organizing and financing health care services that emphasizes cost-effectiveness and coordination of care. Managed care organizations (including HMOs, PPOs, and PSOs) receive a fixed amount of money per client/member per month (called capitation), no matter how much care a member needs during that month. This system generally requires members to receive treatment from an approved list of health care facilities and physicians agreeing to provide services at set rates.

**Meals-on-Wheels** – Also known as home-delivered meals, this service provides warm meals, prepared to government specifications, delivered to homebound persons who are unable to prepare their own food.

**Medicaid (Title XIX of the Social Security Act )** – Federal and state-funded program of medical assistance to low-income individuals of all ages, initiated in 1965. There are strict income-eligibility requirements for **Medicaid**. Federal Medicaid expenditures in 2006 were approximately \$186 billion, and more than \$300 billion when including state Medicaid appropriations.

**Medicaid Waiver Programs** – **Medicaid** programs that provide home-care and community-based alternatives to nursing home care. These programs have the potential to reduce overall **Medicaid** costs by providing services in innovative ways, or to groups of people not covered under the traditional **Medicare** program. These programs are often approved on a demonstration basis, and generally have limited slots available.

**Medicare (Title XVIII of the Social Security Act )** – Federal health insurance program for persons age 65-and-over (and certain disabled persons under age 65). Consists of four

parts: **Part A** (hospital insurance); **Part B** (optional medical insurance that covers physicians' services and outpatient care, in part, and requires beneficiaries to pay a monthly premium); **Part C** (also known as **Medicare Advantage, see below**); and **Part D** (prescription drug coverage). Medicare expenditures were roughly \$325 billion in 2006. The program was signed into law on the same day as Medicaid (July 30, 1965) in the Truman Library in Independence, Missouri, in honor of former President Harry Truman's earlier efforts to extend health care to low-income Americans.

**Medicare Advantage** – Option under **Medicare** that gives consumers a choice of plans including managed care and fee-for-service plans. Options consist of: traditional fee-for-service, **HMOs**, HMOs with POS, PPOs, PSOs, private **fee-for-service**, religious/fraternal benefit society plans, and medical savings accounts. Current **Medicare** beneficiaries are not required to change plans unless they so desire. If you have one of these plans, you don't need a **Medigap** policy. Medicare Advantage is also known as **Medicare Part C**. Previously, this plan was referred to as Medicare+Choice.

**Medicare HMOs** – Under **Medicare** HMOs (health maintenance organizations), members pay their regular monthly premiums to **Medicare**, and **Medicare** pays the HMO a fixed sum of money each month to provide **Medicare** benefits (e.g. hospitalization, doctor's visits, and more). **Medicare** HMOs may provide extra benefits over and above regular **Medicare** benefits (such as prescription drug coverage, eyeglasses, and more). Members do not pay **Medicare** deductibles and co-payments; however, the HMO may require them to pay an additional monthly premium and co-payments for some services. If members use providers outside the HMO's network, they pay the entire bill themselves unless the plan has a point-of-service option.

**Medigap** – Private health insurance used to pay costs that are not covered by **Medicare**, such as deductibles and co-payments. Depending on the benefits package purchased, this supplemental insurance may pay for some limited long-term care expenses. This works only with the original Medicare plan.

**National Association of Area Agencies on Aging (n4a:)** – The membership organization for the 655 area agencies on aging and a voice in the nation's capital for the 243 Title VI Native American aging programs in the U.S. Headquartered in Washington, D.C., this association advocates on behalf of all area aging agencies and Native American tribal units (Title VI programs) to ensure that the necessary resources are available to older Americans and those who serve them.

**National Association of State Units on Aging (NASUA)** – Founded in 1964, the National Association of State Units on Aging is a non-profit association representing the nation's 56 officially designated state and territorial agencies on aging. Its mission is to advance social, health, and economic policies responsive to the needs of a diverse aging population. NASUA also strives to enhance the capacity of its membership to promote the rights, dignity and independence of – and expand opportunities and resources for – current and future generations of older persons, adults with disabilities and their families.

**National Citizens' Coalition for Nursing Home Reform (NCCNHR)** – A coalition of concerned citizens advocating and lobbying for improved conditions in nursing homes across the country. Formed in 1975, NCCNHR provides information and leadership on federal and state regulatory and legislative policy development and models and strategies to improve care and life for residents of nursing homes and other long term care facilities. Ongoing work addresses issues such as inadequate staffing and poor working conditions in nursing homes, as well as residents' rights issues

**Needs Assessment** – An evaluation of physical and/or mental status by a health professional, usually a nurse. This assessment, together with the attending physician's notes, determines the level of functional and cognitive incapacity of the patient, and is used to create a care plan and make decisions about the possible need for **home health care**, an **assisted living facility**, or a **skilled nursing facility**.

**Non-Profit** – An organization that reinvests all financial surpluses back into that organization. Only about one-third of American nursing homes are non-profit. By comparison, roughly three-fourths of American hospitals are non-profit.

**Nursing Home** – A facility licensed by the state to offer residents **personal care** as well as skilled nursing care on a 24-hour basis. **Nursing homes** provide nursing care, **personal care**, room and board, supervision, medication, therapies, and rehabilitation. Rooms are often shared, and communal dining is common. There are close to 17,000 nursing homes in America (roughly two-thirds for-profit) caring for approximately 1.5 million persons.

**Occupancy Rate** – A measure of inpatient health facility use, most commonly associated with nursing homes and hospitals, determined by dividing available bed days by **patient days**. It measures the average percentage of a hospital's or nursing home's beds occupied and may be institution-wide or specific for one department or service. The current U.S. nursing home occupancy rate is approximately 86 percent.

**Older Americans Act** – Federal legislation specifically addressing the needs of older adults in the United States. Provides funding for aging services (such as **home-delivered meals**, congregate meals, **senior centers**, employment programs) promoting the independence and quality of life for older Americans and those who care for them. Creates the structure of the federal Administration on Aging, State Units on Aging, and local agencies that oversee aging programs. Signed into law 16 days before Medicaid/Medicare on July 14, 1965. The OAA budget has steadily grown from \$7 million in 1966 to \$1.87 billion (including Dept. of Labor funds) in 2007.

**Ombudsman (aka LTC Ombudsman)** – Trained professional or volunteer who advocates for the rights of older people receiving long-term care services (both in a nursing home facility or at home) and who investigates and mediates their concerns about their rights and care.

**Personal Care** – Assistance with **activities of daily living** as well as with self-administration of medications and preparation of special diets.

**Planning and Service Area(s) (PSAs)** – Multi-county regions of the state wherein aging services are coordinated by **Area Agencies on Aging**. Set up by 1973 amendment to the Older Americans Act, PSAs are overseen by their respective state units on aging.

**Post-Acute Care** – Care that improves the transition from hospital to the community by helping patients recuperate following discharge from an acute-care hospital. Care settings include: skilled nursing facilities, the home (through home health agencies), long-term care hospitals, and inpatient rehabilitation facilities. Services include: home nursing, personal care, childcare, allied health services, and home health care.

**Pre-Admission Review** – Assessment required by some states of all people living independently in the community who wish to enter a nursing home. This ensures that home and community-based long-term care options are presented to all older people who are able to take advantage of them.

**Preferred Provider Organization (PPO) – Managed care** organization that operates in a similar manner to an **HMO**, or **Medicare HMO**, except that this type of plan has a larger provider network and does not require members to receive approval from their primary care physicians before seeing a specialist. It is also possible to use doctors outside of the network, although there may be a higher co-payment.

**Private Fee-for-Service** – Health plan covering care from any hospital, physician, or covered provider.

**Program of All-Inclusive Care for the Elderly (PACE)** – The PACE program is a unique, capitated **managed care** benefit for the frail elderly provided by a **not-for-profit** or public entity featuring a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center, and is supplemented by in-home and referral services in accordance with participants' needs.

**Provider** – Individual or organization that provides health care or long-term care services (e.g. doctors, hospital, physical therapists, home health aides, and more). Roughly 29,000 providers in this country are involved with distributing OAA services each year.

**Provider Sponsored Organization (PSO)** – Managed care organization that is similar to an **HMO** or **Medicare HMO**, except that the organization is owned by the providers in that plan and these providers share the financial risk assumed by the organization.

**Qualified Disabled and Working Individual (QDWI)** – Category of **dual eligibility** (See **Dual eligibles/eligibility**). Such a **dual-eligible person** lost **Medicare Part A** benefits because he/she returned to work, but is eligible to enroll in and purchase **Medicare Part A**.

**Qualified Medicare Beneficiary (QMB)** – Category of **dual eligibility** (See **Dual eligibles/eligibility**). Individual enrolled in a **Medicaid** program that pays for **Medicare** consumer cost-share expenses (**deductibles**, **co-payments**, and **Part B** premiums) for

low-income elders and persons with **disabilities** who qualify for **Medicare Part A**. There are income-eligibility requirements for this program.

**Qualified Medicare Beneficiary Plus (QMB Plus)** – Category of **dual eligibility** (See **Dual eligibles/eligibility**). QMB-Plus eligibles have full **Medicaid** benefits. The QMB-Plus category was created when Congress changed eligibility criteria for QMBs to eliminate the requirement that QMBs could not otherwise qualify for **Medicaid**.

**Quality Improvement Organizations (QIOs)** – QIOs are largely non-profit, community-based organizations whose mission is to collaborate with both **Medicare** providers and beneficiaries to achieve significant and continuing improvement in the quality and effectiveness of health care at the community level. Under the direction of CMS is a national network of 53 QIOs, responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure **Medicare** patients get the right care at the right time, particularly patients from underserved populations.

**Quality of Care** – A measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

**Rehabilitation Services** – Services designed to improve/restore a person's functioning. These include **physical therapy**, **occupational therapy**, and/or **speech therapy**. The services are provided at home or in long-term care facilities. They may be covered in part by **Medicare**.

**Respite Care** – Service in which trained professionals and/or volunteers come into the home – or where care is provided in an institutional setting for a short-term (from a few hours to a few days) – to allow caregivers of an older or **disabled** person some time away from their caregiving roles.

**Senior Center** – A community organization that provides a variety of on-site programs for older adults including recreation, entertainment, congregate meals, and some health services. Usually a good source of information about area programs and services for persons age 60 and over. Over 10,000 senior centers are in operation across the country, with some 6,000 of them receiving OAA funds.

**Skilled Care** – Care requiring skilled medical services (such as injections, catheterizations, and dressing changes) provided by medical professionals, including nurses, doctors, and physical therapists.

**Skilled Nursing Facility (SNF)** – Facility that is certified by **Medicare** to provide 24-hour residential nursing care and **rehabilitation services** in addition to other medical services.

**Social Security** – A federal social insurance program established in 1935 that includes a retirement income program (Title II), **disability**, and survivor and Supplemental Security Income (Title I) benefits, and health insurance through the **Medicare** program.

**Social Services Block Grant services (aka Title XX services)** – Grants given to states, under the Social Security Act, which fund limited amounts of social services for people of all ages (including some in-home services, elder abuse prevention services, and more).

**Specified Low Income Medicare Beneficiary (SLMB) – Medicaid** program which pays for **Medicare Part B** monthly premiums for low-income elders and persons with **disabilities** who qualify for **Medicare Part A**. There are income-eligibility requirements for this program.

**Specified Low Income Medicare Beneficiary-Plus (SLMB-Plus)** – SLMB-Plus eligibles have full **Medicaid** benefits. The SLMB Plus category was created when Congress changed eligibility criteria for SLMBs to eliminate the requirement that SLMBs could not otherwise qualify for **Medicaid**.

**Spend Down** – Medicaid financial eligibility requirements are strict, and may require beneficiaries to **spend down income and/or assets** by paying for health care with their own assets or income until they reach the income-eligibility level.

**Spousal Impoverishment Protection** – Federal regulations preserve some income and assets (generally the home, car and \$1,500 in assets) for the spouse of a nursing home resident whose stay is covered by **Medicaid**.

**Sub-Acute Care** – Type of short-term care provided by many long-term care facilities and hospitals that may include **rehabilitation services**, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of sub-acute care is to discharge residents to their homes or to a lower level of care.

**Supplemental Security Income (SSI)** – A federal program (separate from standard Social Security retirement funds paid into by workers) for low-income elderly or disabled persons established in 1972, when Social security folded various Old Age, Blind and Disabled payments into SSI. From its inception, SSI adjusted benefits to reflect increases in inflation and helped to reduce the country's poverty rate. Many states supplement SSI with additional state SSI. In most states, SSI recipients are also automatically eligible for **Medicaid**.

**Support Groups** – Groups of people who share a common bond (e.g., caregivers) who come together on a regular basis to share problems and experiences. The groups may be sponsored by social service agencies, senior centers, religious organizations, as well as organizations such as the Alzheimer's Association.

**Telephone Reassurance** – Program in which volunteers or paid staff call homebound elders on a regular basis to provide contact, support, and companionship.

**Title III services** – Services constituting the heart and soul of the Older Americans Act. These services, provided to individuals age 60 and older, include: congregate and home-delivered meals, supportive services (e.g., **transportation**, information and referral, legal

assistance, and more), in-home services (e.g., **homemaker services, personal care, chore services** and more), and health promotion/disease prevention services (e.g., health screenings, exercise programs, and more). Also, see **Older Americans Act**.

**Title IV** – Involves research on older persons and in the field of aging, including grants for demonstration projects and initiatives related to intergenerational programs, developmental disabilities, housing and alternate funding sources.

**Title V** – Originally dealt with training, but now covers the realm of senior employment. Unlike most OAA programs, senior employment is administered by the U.S. Dept. of Labor through the Senior Community Service Employment Program, and the eligibility starts at age 55 and older for those whose incomes are below 125 percent of the poverty level. (\$10,210 for an individual in 2007). The program targets older persons with poor employment prospects.

**Title VI** – The portion of the OAA providing direct grants to the 243 Native American tribal units (Native American versions of area agencies on aging), was added to the OAA via 1975 and 1978 amendments to the act, though funds were not appropriated until 1980. This title originated in response to concerns that Native Americans were underserved by traditional area agencies on aging. In 1987, further amendments broadened Title VI to serve Native Alaskans and Hawaiians. Roughly \$33 million in OAA funds went to Native Americans (including native Alaskans and Hawaiians) in 2006.

**Title VII** – Formalized and consolidated components of four initiatives related to elder rights, placing them under a new title in efforts to improve communication and more emphatically promote and protect the rights of older Americans. The components are:

1. ombudsman programs overseeing the rights and care of nursing home residents and others receiving long-term care services in their own homes and communities;
2. programs to prevent abuse, neglect and financial exploitation of older persons;
3. elder rights outreach, promoting the education of older persons and those caring for them on rights guaranteed in nursing home residents' bill of rights and other federal and state regulations protecting older persons;
4. benefits outreach and counseling regarding Medicare, Medicaid, pensions and other public benefits and assistance programs that may help older persons.

**Transportation Services** – Service for older adults offering rides to medical appointments and, occasionally, other destinations. These services may include buses, taxis, volunteer drivers, or vans or ambulance services that can accommodate wheelchairs and persons with other special needs.

**U.S. Department of Veterans Affairs (V.A.)** – Offers acute and long-term care benefits (nursing home care and home care) benefits to veterans of the United States Armed Forces, and in some cases, their families. Services are provided by V.A. medical centers across the country.