Indiana Division of Aging
FFY 2026-2027
Area Plan on Aging
Templates and Attachments

Effective October 1, 2025 to September 30, 2027

You must use this format and template as your final submission to the Division of Aging in the order of the documents provided. Please reference the Guidelines document and instructions contained within as you complete your Plan. The Area Plan Required Components Checklist is included to assist in ensuring a complete submission.

Section 1 - Narrative

Section 1: Context: *limit to no more than 8 pages*

Mission and Agency Overview

West Central Indiana Economic Development District, Inc., doing business as Thrive West Central, was founded in 1968 as the Economic Development District for West Central Indiana. Thrive also currently serves as the Rural Planning Organization for West Central Indiana, maintains a two-county Rural Transit Program through Indiana Department of Transportation's 5311 Rural Transit Program, operates as a Housing leader in the greater West Central Indiana region and in 1974 was established as the Area Agency on Aging for PSA7, including Clay, Parke, Putnam, Sullivan, Vermillion and Vigo Counties.

Thrive serves as a dynamic regional leader dedicated to strengthening community assets and enhancing the overall quality of life in West Central Indiana. Through innovative problem solving, high-quality service delivery, and strong collaborative partnerships, we work to support vibrant, resilient communities.

Mission: To create thriving communities by improving the quality of life and economic prosperity for all.

Vision: To be a trusted regional partner that focuses on creating opportunities for the betterment of all who live in West Central Indiana.

Organizational Values:

At Thrive we focus first on the growth and well-being of our employees as a means of achieving success for clients, community partners, and our employees. As servants to our community, we are the most successful when everyone in the organization is committed to the concept and understands the serving role of all employees, regardless of titles. We are committed to five core values that link who we are as the Thrive Team to our mission of improving the quality of life in West Central Indiana. Each core value provides an essential component to how we behave and perform our job duties.

1. Innovation – We uphold a growth mindset that focuses on turning challenges into opportunities and ideas into unique solutions to improve the lives of those we serve. WE COMMIT to be creative, progressive, and forward-thinking

2. Collaboration – We build partnerships that unite the community around achieving common goals. We ensure our collective success by recognizing and valuing each client, employee, and community member's contribution. WE COMMIT to respect, listen, and honor diversity in people, ideas, and opinions.

3. Integrity – We act for the benefit of the society at large. We leverage our 60 years of experience as we look to build sustainable, long-lasting solutions for future generations. WE COMMIT to be honest, ethical, authentic, and accessible in our decision-making, service delivery, and employee engagement.

4. Excellence – Our customers inspire us and drive our growth and development. We demonstrate

our genuine care for our community and each other by consistently delivering quality service while maintaining high standards of compassion and empathy in our roles, responsibilities, and relationships. WE COMMIT to accountability, reliability, and achievement of results that propel the quality of life forward in West Central Indiana.

In our role as the Area Agency on Aging (AAA) for Planning and Service Area (PSA) 7, our mission is to empower older adults, individuals with disabilities, at-risk populations, and their families. We achieve this by providing comprehensive information and connecting them to vital community-based services that promote independence, dignity, and well-being.

Planning and Service Area (PSA) Overview
Our PSA covers approximately 2,390 square miles, spanning six counties: Clay, Parke, Putnam, Sullivan, Vermillion, and Vigo in West Central Indiana. The region includes 38 incorporated cities and towns, with the largest population centers being:

Terre Haute (Vigo County): ~60,600

Greencastle (Putnam County): ~10,300

Brazil (Clay County): ~8,000

Clinton (Vermillion County): ~4,700

Sullivan (Sullivan County): ~4,100

Rockville (Parke County): ~2,500

According to the American Community Survey (ACS) and state demographic projections, the total PSA population in 2020 was estimated at 223,100, and is projected to grow to 228,400 by 2030, marking a modest 3.2% increase.

Adults aged 60 and older will represent a significant portion of this growth, with this population projected to peak at approximately 59,100 individuals (26.75%) by 2030. The aging trend reflects broader national patterns and underscores the growing demand for aging services in the region.

Vigo County has the highest concentration of older adults, accounting for 44.8% of the PSA's total 60+ population.

Parke County has the smallest share, with 8.3% of the 60+ population.

Women make up approximately 54.3% of the older adult population.

The minority older adult population is estimated at 4.3%, with expectations of continued gradual diversification.

The PSA is predominantly rural, with an estimated 162,500 residents (73%) living in rural areas outside of Terre Haute, which has a population of around 60,600.

Agency Role and Services
Thrive West Central is committed to delivering a comprehensive range of services that promote

independence, self-sufficiency, and aging in place for older adults and individuals with disabilities. Core services include:

Information & Referral / Options Counseling
Through the Aging & Disability Resource Center (ADRC), we provide personalized guidance to help individuals access community-based supports.

Health and Wellness Programs
We offer evidence-based programs focused on fall prevention, chronic disease management, nutrition, and social engagement.

Care Management & Program Eligibility Assessments
Our care managers oversee eligibility determinations and care coordination for CHOICE, Health and Wellness and TBI Waivers funded through Medicaid, Title III, and SSBG services.

In-Home Services Coordination
We support access to services such as attendant care, respite, home-delivered meals, home modifications, and personal emergency response systems (PERS).

Caregiver Support Services
Programs designed to assist family caregivers through respite care, education, and connection to resources.

Transportation Services
Helping individuals maintain access to essential appointments and community activities, directly in four of the six counties in our PSA and through financial support to community partners in the remaining two counties.

Regional and Statewide Collaboration

Thrive West Central is a proud member of Indiana's Aging Network, a coalition of the state's 15 Area Agencies on Aging serving all 92 counties. As a regional leader in aging and disability services, we are committed to preventing unnecessary institutionalization and promoting independence, dignity, and community integration for all residents.

We remain focused on our vision of a region where older adults and people with disabilities lead active, engaged, and independent lives—supported by a responsive and equitable system of care.

Section 2: Plan Development and Public Input: *limit to no more than two pages*

Thrive West Central utilizes a thoughtful and inclusive approach to long-term planning that emphasizes setting clear priorities and incorporating meaningful community input—particularly from those facing the greatest social and economic challenges. This approach ensures transparency, strengthens accountability, and supports a responsive system that addresses the distinct needs of older adults across the region.

Planning Process:
The agency's planning process is both collaborative and data-informed, involving ongoing

engagement with stakeholders, service providers, community organizations, and older adults. Conducted on a two-year cycle, the process includes assessing current services, identifying service gaps, and developing strategic goals that align with the evolving needs and priorities of the aging population.

The needs assessment is the first step in the planning process- The 2024 Community Assessment for Older Adults (CASOA) was conducted by the National Research Center (NRC). This survey provided valuable insight into the needs of adults aged 60 and older, as well as an evaluation of the strengths and gaps in existing community-based programs and services. The assessment focused on seventeen topics of livability within six key areas: (1) Productive Activities, (2) Community Design, (3) Employement and Finances, (4) Equity and Inclusivity, (5) Health and Wellness, and (6) Information and Assistance. Overall community quality is also assessed.

Surveys were mailed to a random selection of 3,000 older adult households. A total of 258 surveys were completed providing an overall response rate of 9%, which is down from the last CASOA survey participation.

Of the 17 aspects of livability examined, the aspects found to be strongest in the region related to areas of Safety (average positive score of 65%), Social Engagement (50%), and Physical Health (49%). The areas showing the greatest need for improvement related to Information on Available Older Adult Services (22%), Employment (24%) and Housing (25%).

Overview of the Planning Process

Internal Assessment

As part of an internal initiative to identify program needs and opportunities, supervisors and staff across all departments—including ADRC, Care Management, Transportation, and others—were asked to conduct comprehensive reviews and assessments of their respective programs. These internal evaluations largely reinforced the findings of the CASOA survey. Additionally, the process served as a valuable opportunity to actively involve frontline supervisors in the development of this plan. Each department contributed by outlining practical strategies to achieve the goals set forth by the Divison of Aging, and establishing measurable indicators to track progress toward desired outcomes.

Listening Sessions

Following the struugle to obtain community involvement for the last Area Plan coming out of COVID, Thrive West Central focused efforts on how to obtain feedback from the most vulnerable populations, older adults and their caregivers, individuals with the greatest social and economic needs, persons with disabilities and those residing in rural communites, which is more than 85% of Thrive's geographical PSA.
Aging Leadership and other staff gathered input during a series of listening sessions that were focused in the areas that older adults congregate in each county. Acengy staff focused on meeting people where they are, in an accessible setting where they are comfortable. Listening sessions and public feedback were held at senior centers, congregate dining sites, sites of evidence-based health promgramming, town halls, Senior Medicare Patrol (SMP) presentations and public libraries.

Stakeholder Engagement

To gather community and stakeholder input during the development of this Area Plan, the Agency implemented several outreach efforts:

Published articles and advertisements in major news outlets across the PSA to inform the public about the Area Plan's development and invite feedback and comments. Ran once on April 22nd.

Posted information on the Agency's website for a 30-day period, including how to provide plan feedback and contact details for individuals wishing to speak directly with a staff member. Posted April 21st- May 21st.

Both of the above efforts included information for the largest public feedback session on May 12th, from 5pm-6pm prior to the scheduled board meeting with all Agency Leadership staff will be present.

Presented the planning process to both the Aging and Disabled Advisory Council and the Thrive West Central Board of Directors to ensure engagement and input from key advisory bodies.

Section 3: Quality Management: *limit to no more than two pages*

Quality Management Program (QMP)
Aging & Disabled Services Division

Purpose

The Quality Management Program (QMP) provides a formal, structured approach to continuously improve the effectiveness, efficiency, and quality of services delivered to older adults and individuals with disabilities. The QMP is applicable to all departments within the Aging & Disabled Services Division and is designed to promote accountability, data-driven decision-making, and ongoing performance improvement across all programs and functions.

By integrating a culture of quality into daily operations, the QMP ensures that services are responsive to client needs, regulatory standards are met or exceeded, and that improvements are sustained over time.

Continuous Improvement Framework

The QMP is built upon a four-step model of continuous process improvement that encourages a systematic, repeatable cycle of evaluation and refinement:

Use Data to Identify Problems and Opportunities
Collect and analyze data to pinpoint areas where service delivery or internal processes can be improved.

Implement and Monitor Corrective Action/Changes
Develop and apply strategic interventions or changes based on identified issues. Monitor implementation for consistency and effectiveness.

Measure the Effectiveness of Implemented Actions/Changes

Use both qualitative and quantitative metrics to evaluate the outcomes of corrective actions and ensure desired results are being achieved.

Repeat the Cycle Until Desired Results Are Achieved
Continue refining and reassessing processes until objectives are met and sustainable improvements are embedded into operations.

Procedures and Tools

To support this continuous quality improvement cycle, the following tools and procedures are employed by supervisors, managers, and leadership across the division:

Random Client Record Reviews
Conducted regularly by the Quality and Training Manager as well as the Director of Care Management to ensure documentation accuracy and service compliance.

Monthly Division and Department Statistics
Used to track key performance indicators and service volume trends across programs.

Monthly CaMSS and external tracking reporting
Provide program-specific data that supports evaluation of service delivery effectiveness and federal reporting requirements.

Customer Satisfaction Surveys
Gather feedback directly from program participants to assess service satisfaction, identify unmet needs, and detect emerging issues.

Annual Policy and Procedure Reviews
Ensure internal guidelines remain current, relevant, and compliant with state and federal regulations.

External Program Audits and Reviews
Periodic evaluations by outside agencies offer objective insights and validate internal quality efforts.

Activity and Referral Reports
Provide insight into client engagement, referral patterns, and service utilization rates.

Vendor and Program Monitoring Reports
Evaluate the performance, compliance, and quality of contracted service providers.

Staff Competency and Development Monitoring
Includes credentialing, orientation completion, and tracking of continuing education to ensure staff meet professional standards.

Evidence-Based Best Practices and Regulatory Compliance
Serve as benchmarks for clinical and operational standards, guiding service enhancement initiatives.

The Quality Management Program is central to the mission of the Aging & Disabled Services

Division. It provides a reliable framework for identifying inefficiencies, resolving problems, and elevating service quality. By embedding continuous quality improvement into all levels of operations, the QMP not only ensures compliance and accountability but also enhances client satisfaction, supports workforce development, and promotes innovation in the delivery of care to some of our most vulnerable populations.

Section 2 - 2026-2027 Goals and Strategies

GOAL 1: Ensure consistent, quality, and timely information and access to long-term services and supports.

Connections:
Key Topic Area*: Expanding Access to HCBS*

23-26 State Plan Goal: *1. Assure access to high-quality home and community-based services and resources for older adults and their caregivers to support increased independence and quality of life*.

MPA: *Reducing Barriers*

Dementia Strategic Plan: *Identify strategies to increase access to home and community-based services for individuals with dementia*.

Agency programs and services that address Goal 1:
No Wrong-Door Aging and Disability Resource Center providing Options Counsleing and Information and Referral services
Dementia Outreach Specialist providing information and assistance to appropriately referred individuals
Care Management providing information and facilitating transitions timely for the individuals currently receiving services, providing development oversight of service plan delivery

Strategies:
The ADRC will complete processing of all referrals within two business days providing information and referralsand/or completing Options Counseling.
Information and Assistance callers will be given a short satisfcation survey at the end of their call.
Dementia Outreach Specialist will repsond to inquiries within two business days and make appropriate referrals to the ADRC or other community resources .
Care Management will complete periodic assessments, including caregiver assessments which are completed with an identified caregiver, in complaince with their respective funding sources (quarterly, annual, etc.).

Performance Measures and Fiscal Year Target:

Measure	Purpose	FFY 26 Target	Review Frequency
Percentage of ADRC callers indicating they received the information they were seeking.	To assess and provide information appropriate to the	**90%**	Annually

	caller's need (from consumer's perspective).		
Number of warm handoffs from LCAR completed in real time	To provide a seamless, No Wrong Door experience for individuals seeking services	**Volume TBD per the FAQ**	Annually
Number of caregivers who receive a caregiver assessment including but not limited to the Caregiver Assessment in the State's case management system and/or HCBS Monitoring Tool for ABC Community, and subsequent number of assessed caregivers who receive service plans, and subsequent number of caregivers who receive referrals to community resources or are placed on a waiting list for services.	To provide support for caregivers and provide timely data that support efforts to identify utilized and needed services for caregivers and individuals with dementia	**95% of identified caregivers**	Annually
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GOAL 2: Strengthen and expand Older Americans Act Core Programs, ensuring high quality, efficient and effective home and community-based programs and services are available throughout the PSA to older adults and their family caregivers.

Connections:
Key Topic Areas: *Older Americans Act Core Programs; Greatest Economic Need and Greatest Social Need; Caregiving*

23-26 State Plan Goals**:**

- *2. Improve health, well-being, and equity in all aspects of service access and delivery.*
- *3: Optimize the physical, emotional, and financial well-being of caregivers to strengthen their ability to provide ongoing supports and delay or prevent care recipient institutionalization.*

MPA: *Age-Friendly Communities; Each Journey Supported; Reframe Aging*

Dementia Strategic Plan: *Identify strategies to increase access to home and community-based services for individuals with dementia.*

Agency programs and services that address Goal 2:

Thrive delivers core programs under the Older Americans Act (OAA) to individuals facing the greatest economic and social challenges. These programs include nutrition assistance, health promotion services, and support for caregivers. Thrive prioritizes low-income individuals, people with limited transportation options, those with physical or cognitive impairments, and residents of rural communities. To enhance and expand the reach of OAA programs, Thrive collaborates with local senior centers, seniors housing complexes, the Alzheimer's association and local healthcare systems.

Strategies:

To target rural populations with food insecurity, Thrive will recruite congreate meal sites in the two counties currently not being served.

To address poor nutrition and poor health literacy, Thrive will provide congregate and home delivered meal clients with more robust nutrition education materials monthly as well as implement a process for making referrals for nutrition counseling.

By continuing to show strong feduciary responsibility and by managing and forecasting accurately, Thrive will increase the number of home accessibility and safety interventions by 25% over the current year.

Thrive remains committed to expanding its presence in rural counties, with a strong focus on

increasing outreach, health promotion, and educational efforts for residents in these areas. By deepening our engagement and raising awareness of available resources, we aim to better connect rural communities with the services and support they need.

Thrive will use new client and annual congregate dining nutrition risk survey information to identify those participants who indicate that they are socially isolated and engage with and encourgae them to participate more frequently. We will leverage our relationship with the meal site staff as well as external partners who may wish to provide outeach at the sites to encourage participation. For home delievry, there is not currently a system in place to meet the measure of 8 deliveries per month with our contracted partner(s).

Performance Measures and Fiscal Year Target:

Measure	Purpose	FFY 26 Target	Review Frequency
Of all congregate meal consumers identified as high nutrition risk, percentage receiving nutrition counseling.	To determine whether consumers who are at risk for poor nutrition and health status receive nutrition counseling so that they have the opportunity to improve their health literacy and information for optimal nutrient intake.	**10-15%**	Quarterly
Number of older adults receiving home accessibility and safety interventions (i.e. home modifications, CAPABLE, handy chore, etc.).	To create safe, accessible environments for aging in place.	**25% increase**	Annually
Increased participation in health promotion programming in communities with Greatest Social Need and Greatest Economic Need measured by reported unit and client data.	To increase health awareness, knowledge, and prevention efforts among older Hoosiers.	**250 participants annually**	Quarterly
Of home delivered meal participants served who may be socially isolated, the percentage	To enhance social interaction and connectedness for older Hoosiers to mitigate the negative health	**50% for congregate**	Quarterly

receiving meal deliveries at least 8 times per month, at a minimum. Of congregate meal participants served who may be socially isolated, percentage eating 15 meals at meal site in a month.	effects associated with social isolation.	**participants**	
Percentage of missing data points: poverty status, household status, and nutrition risk score for congregate participants below 10%.	To increase compliance and availability of data that helps to determine participants that may be at risk for poor nutrition, including food insecurity and malnutrition, social isolation, and economic needs.	**Below 10%**	Quarterly
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GOAL 3: Protect and enhance the rights and prevent the abuse, neglect, and exploitation of older Hoosiers.

Connections:
Key Topic Areas: *Older Americans Act Core Programs*

23-26 State Plan Goal: *5: Promote statewide partnerships for advocacy and protection of older adults*.

MPA: *Age-Friendly Communities; Reframe Aging*

Agency programs and services that address Goal 3:

Thrive provides annual information on Abuse, Neglect, and Exploitation (ANE) to each participant. Participants are assessed for potential signs of ANE at each assessment and as needed. If necessary, Thrive employees make referrals to the local Ombudsman and legal aid services. A legal aid kiosk is also available in the lobby of Thrive's main office. Thrive collaborates closely with Adult Protective Services and makes referrals when appropriate. Additionally, Thrive refers cases to local police departments as needed.

Strategies:

During the annual assessment all program participants are provided FSSA's Abuse, Negelct and Exploitation fact sheet and the individual is informed on what to do if ANE is suspected.

Thrive will continue to assess participants for signs of ANE at each assessment and as needed.

Thrive will provide education and training to staff of signs and prevention of ANE.

Thrive will continue to develop relationships with local legal and protective services.

Performance Measures and Fiscal Year Target:

Measure	Purpose	FFY 26 Target	Review Frequency
Revise/Devise outreach about availability of legal assistance	To increase the percentage of older Hoosiers that are aware of the availability of legal assistance	Increase % of Older Hoosiers that say they are aware of services by 5% from last survey	Annually

Increase coordination with LSP – e.g. meet once per quarter	To increase coordination of services that address the specific needs of your particular PSA	4 meetings	Quarterly
Total number of nursing facilities visited by an Ombudsman not in response to a complaint, in all four quarters of the reporting period.	To be a regular presence in nursing facilities in order to build relationships and establish trust with residents to encourage them to voice their concerns/complaints	**36 visits a year, at least twice at each nursing facility in the service area**	Quarterly
Recruit and train new certified volunteer Ombudsmen by the end of the federal fiscal year	To enhance Ombudsman program reach and advocacy efforts	**A maximum of 1**	Quarterly
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GOAL 4 (AAA GOAL):
Thrive will continue efforts to transform Area 7 into a supportive and dementia capable community.

Agency programs and services that address Goal 4:
Our dementia outreach specialist provides dementia education and awareness initiatives including Dementia Friends, Dementia Live, Dementia Friendly Business Training, and programs from the Alzheimer's Association.

To combat isolation and arm caregivers with resources, our dementia outreach specialist connects care partners with local, regional, and national resources including those from the Alzheimer's Association, Alzheimer's Foundation, and Teea Snow's Positive Approach to Care.

Thrive facilitates dementia friendly gatherings such as Connections Cafes where people living with dementia, their care partners, and others interested in brain health can connect. These cafes are offered in collaboration with senior centers, healthcare providers, and local government. Thrive also attends health fairs to share resources and raise awareness.

Strategies:
Continue to connect with community partners to host community education programs.

Make support calls to caregivers and share curated information on dementia care. Conduct Teepa Snow "Getting to Know Dementia" community training in partnership with Sisters of Providence of Saint Mary of the Woods.

Continue to increase awareness of and participation in Connections Cafes by using social media and other media outlets.

Provide free memory screening through the Alzheimer's Foundation in order to promote early diagnosis and treatment.

Performance Measures and Fiscal Year Target:

Measure	Purpose	FFY 26 Target	Review Frequency
Total number of participants in community education sessions and dementia friendly gatherings	Increase capacity of our residents to support PLWD	60 participants	Quarterly

Total number of care partners supports offered through phone, email, or in person contact	**Increase capability of care partners to care for people living with dementia in their homes**	**12**	**Quarterly**
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Section 3 - Governing Board

Note: *CFR § 1321.63 (d) prohibits the advisory council from operating as the governing board (board of directors) and individuals may not serve on both the advisory council and the board of directors for the same entity.*

Provide a listing of the AAA Board of Directors members, as well as annual board meeting schedule information. For each member, include the individual's title (e.g., President, Chairperson) and indicate with an asterisk (*) if the member is an elected official.

Total Number of Board Members, including any vacancies: 31

Name	Title	County	Term Dates MM/YYYY – MM/YYYY
Andy Stone	Private Sector Appointee	Clay	12/31/2025
Brian Wyndham	Mayor	Clay	12/31/2027
Cory Lookebill	Private Sector Appointee	Clay	12/31/2026
Larry Moss	Councilman	Clay	12/31/2026
Marty Heffner	Commissioner	Clay	12/31/2028
Todd Barton	Mayor	Montgomery	12/31/2027
Cameron Martin	Councilman	Parke	12/31/2028
Chadd Jenkins	Private Sector Appointee	Parke	12/31/2026
Jim Meece	Commissioner	Parke	12/31/2026
Melissa Buell	Private Sector Appointee	Parke	12/31/2026
Kerry Williams	Councilman	Putnam	12/31/2028
Kristin Clary	Private Sector Appointee	Putnam	12/31/2028
Lynda Dunbar	Mayor	Putnam	12/31/2028
Rick Woodall	Commissioner	Putnam	12/31/2026
Bob Davis	Commissioner	Sullivan	12/31/2026
Doug Bates	Councilman	Sullivan	12/31/2026
JD Wilson	Mayor	Sullivan	12/31/2028
Tim Garrett	Private Sector Appointee	Sullivan	12/31/2026
Kara Skinner	Private Sector Appointee	Vermillion	12/31/2028
Misty Hess	Commissioner	Vermillion	12/31/2028
William 'Bill' Rennels	Councilman	Vermillion	12/31/2026

Brandon Sakbun	**Mayor**	**Vigo**	**12/31/2027**
Brendan Kearns	**Private Sector Appointee**	**Vigo**	**12/31/2027**
Dave Williams	**Private Sector Appointee**	**Vigo**	**12/31/2025**
Mark Clinkenbeard	**Commissioner**	**Vigo**	**12/31/2026**

Annual Board Meeting Schedule	
Date	**Location/Address**
May 12, 2025	**Thrive West Central / 2800 Poplar St STE 9A, Terre Haute, IN 47803**
July 14, 2025	**Thrive West Central / 2800 Poplar St STE 9A, Terre Haute, IN 47803**
September 8, 2025	**Thrive West Central / 2800 Poplar St STE 9A, Terre Haute, IN 47803**
November 10, 2025	**Thrive West Central / 2800 Poplar St STE 9A, Terre Haute, IN 47803**

Explain any expiring terms – have they been replaced, renewed, or other?

The end of each member's term is noted above. Private Section Representatives have annual terms. Elected officials have terms that conincide with their office terms.

Montgomery County is part of Thrive's economic development district, but is not part of the AAA service area. This accounts for the Board representation for that county.

Section 4 - Advisory Council

Provide the following details regarding AAA Advisory Council members.

Total number of Advisory Board members (including vacancies) = **15**

N/A	Information	Total
☐	Total number of members over 60 years of age*	**4**
☐	Total number of family caregivers, which may include older relative caregivers*	**2**
☐	Total number of Title III recipients*	**0**
☐	Total number of elected public officials (or their designee)*	**0**
☐	Total number of health care provider representatives, including providers of veterans' health care (if appropriate)*	**2**
☐	Total number of Veteran health care providers (separate from above)	**1**
☐	Total number of service provider representatives, which may include legal assistance, nutrition, evidence-based disease prevention and health promotion, caregiver, long term care ombudsman, and other service providers *	**4**
☐	Total number of persons with leadership experience in private or volunteer sector*	**3**
☐	Total number of local elected officials*	**0**
☐	Total number of older adult advisory council members that reside in rural areas	**3**
☐	Percentage of minority older adults on advisory council (vs. total advisory council members)	**1**
	Frequency of Advisory Council meetings	**Quarterly**

At least 50% of the Advisory Council must be members aged 60 and over. If this requirement is not met, describe plans to increase representation from older adults and targeted completion date for compliance.

This requirement is met. Continue to use

Those categories of representation noted with an asterisk (*) above are required (OAA Section 306 (a)(6)(D)). If your Advisory Council is missing any representation above, include a description of recruitment methods and targeted completion date for compliance.

Continue to use networking, persentations to community organizations, and social media to obtain more nominations to the Council Direct contact with elected officials in the six-county area appealing for volunteers to join the Council. Work with Care Managers of Title III recipients to recruit from among enrolled individuals. Will be complete by June 30, 2025.

Briefly describe the local governing board's process to appoint Advisory Council members.

Individuals who were nominated (or self-nominated) were provided an overview of the role and expectations of an Advisory Council member. If, after review, they continued to wish to serve, they were appointed.

Briefly describe the Advisory Council's role in developing the Area Plan, including in relation to public hearings.

The Advisory Council has reviewed the current Area Plan goals and provided feedback informing our next Area Plan. Public forums have been held in each county to obtain information and feedback from community members.