



# Illinois CARE Connections - Aging



# What is Illinois Care Connections - Aging?

The Illinois Department on Aging (IDoA) is committed to continuing to support individuals who are at risk of being socially isolated and/or experiencing loneliness by continuing to implement the Illinois Care Connections Program. iPads, Tablets and when necessary Internet Hot Spots will be provided to Seniors over 60 to increase social engagement and social connectedness with family and friends on a first come first serve basis.

# Who is eligible to receive technology devices through Illinois Care Connections?

- Seniors at least 60 years and older participating in the Community Care Program

# Are there any financial eligibility requirements for participants?

- No

# Can individuals complete the application process themselves?

- No. Only IDoA and/or their approved provider organizations statewide can submit an application on the participant's behalf.

# Which devices are being offered?

Apple iPad 32GB

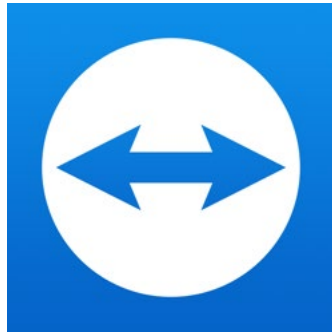


Samsung Tablet 32GB



# What apps will be installed?

TeamViewer QS

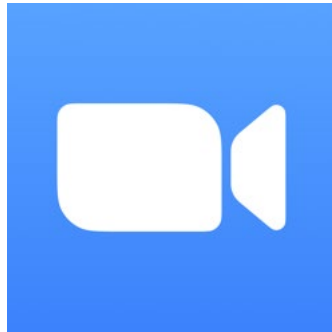


ConnectWise Control

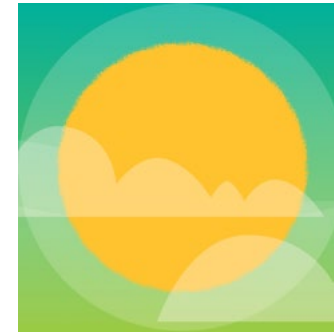


# Installed apps continued

Zoom Cloud Meeting



COVID Coach



# Installed apps continued: Android

Hangouts – Android Specific





# Installed apps continued: Apple

FaceTime – iPad Specific



# Where do you apply at?

<https://care.iltech.org>  
<https://www.iltech.org>



Facebook icon CONTACT US

**iatp** Illinois Assistive Technology Program

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**iatp** Illinois Care Connections - Aging IDoA Illinois Department on Aging

Requests can only be made by an authorized agency with a valid Agency Code  
\* = required

**Referring Agency**

Referring Agency Code \*:

Referring Agency Name \*:

**Referring Agency Point of Contact**

First Name \*:

Last Name \*:

Address Line 1 \*:

Address Line 2:

State \*:

# Asterisk \*

- Means REQUIRED



# Referring Agency Information

## Referring Agency

Referring Agency Code \*:

Referring Agency Name \*:

# Referring Agency Point of Contact

## Referring Agency Point of Contact

First Name *:	<input type="text"/>
Last Name *:	<input type="text"/>
Address Line 1 *:	<input type="text"/>
Address Line 2:	<input type="text"/>
State *:	<input type="text" value="Illinois"/>
County *:	<input type="text"/>
City *:	<input type="text"/>
Zip *:	<input type="text"/>
Phone Number *:	<input type="text"/>
Email Address *:	<input type="text"/>

# Is this participant new to your agency?

(The participant is the individual for whom the device is being requested)

Is the participant new to your agency? \*

☐ **Yes** ☐ **No**

# Participant Information

First Name *:	<input type="text"/>
Last Name *:	<input type="text"/>
Address Line 1 *:	<input type="text"/>
Address Line 2:	<input type="text"/>
State *:	<input type="text" value="Illinois"/>
County *:	<input type="text"/>
City *:	<input type="text"/>
Zip *:	<input type="text"/>
Phone Number (landline):	<input type="text"/>
Phone Number (mobile):	<input type="text"/>
Alternate Phone Number (Family, Friend, Support Staff):	<input type="text"/>
Email Address:	<input type="text"/>

# Participant Information (continued)

Age \*:

Gender \*:

Race \*:

Ethnicity \*:

Sexual Orientation \*:



# Services and Supports

Participant Receives services or supports through the:

- Community Care Program
- One of the following OAS programs/services

Participant Receives services or supports through the: \*

☐ Community Care Program

☒ One of the following Older Adult Services programs/services:

Participants must be individuals receiving services, have an open case or participate in one of the following Older Adult Services programs/services:

☐ Title 3: C1 (nutrition providers), C2 (home delivered meals), 3D (health education and promotion), 3E (caregiver support)

☐ Title 7: legal services, open Adult Protective Services case, Long Term Care Ombudsman case/engagement

☐ Participating/enrolled in a program that is funding from the AAA 'Social isolation grant funding' (i.e. friendly visitor/calling; memory cafes)

# General Screening Questionnaire - Reason

What is the **main** reason for participant being referred? (choose one) \*

- ☐ Communicate with family/friends
- ☐ Purchase food and other household items
- ☐ Telehealth Appointments
- ☐ Recreation
- ☐ Other (please specify)

# General Screening Questionnaire – Tablet and Telephone

Does the participant currently use a tablet type device? \*

☐ **Yes** ☐ **No**

What kind of telephone does the participant use?

☐ **Landline** ☐ **Mobile (Cell)**

# General Screening Questionnaire – Internet Access

- If you select Yes

Does the participant currently have Internet Access? \*

☒ Yes ☐ No

If yes, who is the Internet provider?:

# General Screening Questionnaire – Support

Is there someone in the home or who otherwise is available to assist the participant with technical problems like resetting internet, rebooting or troubleshooting electronic equipment? \* ☐ Yes ☒ No

If No, Does the participant have family or friends that regularly come visit? (check all that apply)

- ☐ In the neighborhood
- ☐ Locally
- ☐ Within 50 miles
- ☐ Farther than 50 miles

# General Screening Questionnaire – Support Types

Would the participant be able to participate in technical assistance via the following modalities: (check all that apply)

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- ☐ Phone
- ☐ Webinar
- ☐ Written instructions (paper or via email)

# General Screening Questionnaire – Support Types - Written

Would the participant be able to participate in technical assistance via the following modalities: (check all that apply)

- ☐ Phone
- ☐ Webinar
- ☒ Written instructions (paper or via email)

☒ Is there a language other than english that the participant would require written training materials?

Please select the preferred language\*

- ☐ Spanish
- ☐ Russian
- ☐ Hindi
- ☐ Polish
- ☐ Chinese w/ traditional characters
- ☐ Other (please specify)

# Functional Assessment: Cognitive/Memory

Cognitive/Memory – Will the participant be able to do sequential memory tasks for turning device on/off, navigating menus and activating applications (apps)? \*

☐ Yes ☒ No

If no, how would you rate the participants' cognitive/memory skills? \*

☐ Poor ☐ Somewhat Limited ☐ Good ☐ Unsure



# Functional Assessment: Motor Skills/Dexterity

Motor Skills/Dexterity – Will be able to find and manipulate buttons; can learn and perform gestures (i.e. tapping, swiping)? \*

☐ Yes ☒ No

If no, how would you rate the participants' motor/dexterity skills? \*

☐ Poor ☐ Somewhat Limited ☐ Good ☐ Unsure

# Functional Assessment: Hearing

Hearing – Will the participant be able to hear audio output of the device? \* ☐ Yes ☒ No

If no, how would you rate the participants' hearing/understanding speech? \*

☐ Poor ☐ Somewhat Limited ☐ Good ☐ Unsure

# Functional Assessment: Vision

Vision – Will the participant be able to see and/or read the screen? \*

☐ **With magnification**

☐ **Without magnification**

☒ **Unsure**

If unsure, how would you rate the participants' vision/reading text skills? \*

☐ **Poor** ☐ **Somewhat Limited** ☐ **Good** ☐ **Unsure**

# Functional Assessment: Other

Please describe any other functional limitations that could impact the participant's ability to use equipment provided to reduce social isolation.

# Hardware

Hardware (please select one): \*

- ☐ iPad with case/stand, headphone and keyboard
- ☐ Android Tablet with case/stand, headphone and keyboard
- ☐ Not Sure which device will best meet the participants needs

# Applications

Applications (check all that are needed):

- ☐ Apps for Connecting with Family and Friends: (iPad's and Android Tablets will have Facetime, Google Hangouts, and or Zoom)
- ☐ Internet Access (12 months of service provided and then participant is responsible for assuming cost)

# Other Assistive Technology Devices

In case other funding becomes available please provide information about other Assistive Technology Devices the participant may need to help alleviate social isolation and maintain safety and independence in their home.

**Submit Referral**



# Recap

- To be eligible to receive a device the participant must be enrolled in your respective agencies services.
- There are no financial requirement components to receive a device.
- Participants cannot submit requests only participating agency representatives.
- Each participant can only receive ONE device.
- The devices do not have any extended warranties or accidental breakage coverage.

# Important addresses

Website: [www.iltech.org](http://www.iltech.org)

Referral Website: <https://care.iltech.org>

Email: [iatp.care@iltech.org](mailto:iatp.care@iltech.org)

# UCLA-3 Loneliness Scale

Along with providing equipment for participants through IDoA, IATP will contact participants to ask the UCLA-3 Loneliness Scale questions. This project has a study component that will be able to provide information to the IDoA along with HHS/ACL about the successfulness of providing participants with devices to combat social isolation.

The UCLA-3 Loneliness Scale is a three question survey that requestors will need to answer. There is no wrong answer to the survey questions, and the answers will not affect the participant getting a device.

# UCLA-3 Questions

The responses to the questions will be scored as follows:

Response	Score
Hardly Ever	1
Some of the Time	2
Often	3

**1. How often does the participant feel that they lack companionship? \*:**

**2. How often does the participant feel left out? \*:**

**3. How often does the participant feel isolated from others? \*:**

The score for each individual question is tallied together to give you a possible range of scores from 3 to 9.

**Total Score:**

# UCLA-3 Pre and Post Follow Up Survey

During the request process we will ask the requestor to answer the 3 UCLA loneliness scale questions.

After the participant has had the device for roughly 45 days, IATP will be in contact to take a post follow up survey asking the same three questions and also including a satisfaction survey.

If the participant is difficult to get in contact with we may be asking the requestor for assistance to perform this post follow up survey.