State of Illinois
Illinois Department on Aging

State Plan on AGING

FY2026-2028

Acknowledgments

The Illinois Department on Aging would like to thank members of the Older Adults Services Advisory Committee (OASAC), Illinois Council on Aging (ICOA), and Community Care Program Advisory Committee (CCPAC) for their ongoing and steadfast commitment and collaboration. Their continued support is invaluable to ensuring high quality long-term care supports and services are available for older Illinoisans, individuals with disabilities, and their caregivers.

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Special Thanks

The Illinois Department on Aging would like to extend a special thank you and recognition to the State's 13 Area Agencies on Aging for supporting outreach efforts including co-hosting listening sessions for caregivers, older adults, and community leaders to ensure their feedback is woven into area plans and the State Plan.

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Verification Of Intent

The State Plan on Aging is hereby submitted for the State of Illinois for the period October 1, 2025, through September 30, 2028. It includes all assurances and plans to be conducted by the Illinois Department on Aging under provisions of the Older Americans Act, as amended, during the period identified. The Illinois Department on Aging has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act and is primarily responsible for the coordination of all state activities related to the purposes of the Act.

This State Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary for Aging.
The State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

6/27/25 — Date

JB Pritzker, Governor

6/27/25 — Date

Mary Killough, Director

Executive Summary

The Older Americans Act of 1965 requires all State Units on Aging (SUA) receiving Older Americans Act funding to prepare and publish a State Plan on Aging. In addition, the Administration on Community Living (ACL) issued State Unit on Aging Directors Letter #01-2025 providing additional guidance to ensure State Plans reflect the updated federal regulatory requirements. The Illinois Department on Aging (IDoA) is designated by ACL as the SUA for the state and prepared the 2026-28 State Plan on Aging to serve as a strategic plan and roadmap for the Aging Network to ensure high quality services continue to meet the current and future needs of older Illinoisans and their caregivers.

IDoA's long-standing mission has been to serve and advocate for older Illinoisans and their caregivers by administering quality and culturally appropriate programs that promote partnerships and encourage independence, dignity, and quality of life. The Aging Network partnerships ensured the State Plan was informed through statewide listening sessions, caregiver listening sessions, and the 13 Area Agencies on Aging three-year plans. The State Plan reflects the diverse regions of the state from the major metropolitan Chicago region to the rural and micro metropolitan areas where older adults, stakeholders, and community leaders have a vested interest in sustaining high quality long-term care supports and services including Older Americans Act services, Home and Community Based services and related programs.

The 2026-28 Illinois State Plan on Aging is a plan for all older Illinoisans as reflected in the statewide initiatives that will prioritize:

- Statewide visibility of the Aging Network to connect Illinoisans with supports and services that encourage independence, dignity, and quality of life;
- Continuous quality assurance and improvement activities that are person-centered while maximizing effectiveness of services delivered through the Aging Network;
- Increase public awareness and knowledge of caregiver needs, as well as resources and services available throughout the state of Illinois to promote increased caregiver engagement in person-centered, trauma informed, and evidence-based programs and services.

In addition to the objectives and strategies to achieve these goals outlined in the State Plan, IDoA will also strive to expand home and community-based services and other initiatives that ensure older adults are supported in their choice to live in their homes and communities. As IDoA implements the State Plan over the next 3 years it does so energized by the parallel development of a Multi Sector Plan for Aging, creation of a Caregiver Portal and the commitment of countless stakeholders, Aging Network partners, the Area Agencies on Aging and advisory councils and committees.

Illinois' Aging Network

Illinois Aging Network provides a fabric of long-term care supports and services that are woven through five major areas including Older Americans Act (OAA) programs, the Persons Who Are Elderly 1915(c) Waiver- Community Care Program, the Office of the State Ombudsman, and the State Unit on Aging operated by the Illinois Department on Aging (IDoA). Together, these programs and agencies form the critical framework to ensure Illinois' older adults have access to quality services that enable them to thrive in their communities.

The Illinois Department on Aging

The Illinois Department on Aging (IDoA) is designated as the State Unit on Aging (SUA) to serve as the central hub for all matters relating to older persons within the state. The Department is also designated by the state's Medicaid Agency as the operating agency (OA) of the Persons Who Are Elderly 1915(c) Medicaid Waiver. The mission of the Department is to **serve and advocate for older Illinoisans and their caregivers** by administering quality and culturally appropriate programs that promote partnerships and encourage independence, dignity, and quality of life. As the SUA and OA, IDoA is responsible for overseeing, monitoring, distributing funding, policy development and implementation, identifying opportunities, partnerships and collaborating with partners and stakeholders.

IDoA receives and distributes federal and state funds crucial to funding the Aging Network's programs and services in support of its overarching Mission. Under the Older Americans Act funding is distributed to the state's 13 Area Agencies on Aging (AAAs) to serve those with the greatest social and economic need within their planning and service area (PSA). AAA services include but are not limited to home delivered/congregate meals, caregiver support and services, legal services, health promotion and disease prevention programs, transportation, and addressing social isolation and loneliness.

IDoA also contracts with Community Care Program (CCP) providers for the provision of Waiver services including case management, in-home homemaker, adult day, emergency home response, and automated medication dispensing. In addition to case management CCP Care Coordinators also play a vital role in ensuring older adults make informed choices as to home and community-based services when discharging from the acute care setting through Choices Screenings.

Collectively the thirteen AAAs, Care Coordination Units (CCUs), and CCP providers ensure older Illinoisans, and their caregivers have access to a coordinated system of long-term care supports and services to serve their unique needs from a person-centered perspective. The coordinated system of the Aging Network also ensures involvement at the community level which is vital to building and sustaining age-friendly communities and fulfilling IDoA's mission.

IDoA programmatic Divisions include:

Advocacy & Prevention responsible for overseeing activities related to adult protective services, elder justice, billing discrepancies, and coordination of activities between Managed Care Providers and Community Care Program providers.

Community Relations & Outreach responsible for operating the Senior Help Line, Benefits Access program, SHIP/SHAP, and community outreach.

Home & Community Based Services oversees the monitoring, quality assurance, and contract administration of Community Care Program providers and administration of the Older Americans Act programs.

Planning, Research & Development is responsible for administering the Persons Who Are Elderly 1915(c) Waiver, overseeing Community Care Program billing, data, and training.

Area Agencies on Aging (AAAs) are strategically located throughout the state. Utilizing federal, state, local, and other funding the AAAs ensure older adults, caregivers, and individuals with disabilities are connected to resources at the local level including but not limited to home delivered/congregate meals, chronic disease self-management programs, information and assistance, caregiver support and training, respite, education and assistance with health insurance and benefits counseling. The AAAs also play a pivotal role as Regional Administrative Agencies (RAA) to the APS program ensuring older adults are protected from abuse, neglect, and exploitation through their advocacy, technical assistance to and monitoring service provision of APS provider agencies, and work on multi-disciplinary teams. There are 13 AAAs including AgeGuide Northeastern, AgeOptions, AgeLinc, AgeSmart Community Resources, Central Illinois Area Agency on Aging, East Central Illinois Area on Aging, Egyptian Area Agency on Aging, Midland Area Agency on Aging, Northwestern Illinois Area Agency on Aging, Senior Services Area Agency on Aging/Chicago Department of Family & Support Services, Southeastern Illinois Area Agency on Aging, West Central Area Agency on Aging, and Western Illinois Area on Aging. Illinois Association of Area Agencies on Aging (I4A) is the statewide organization formed to advocate for Older Americans Act programs on a state and federal level.

Persons Who Are Elderly 1915(c) Waiver is the State's largest Medicaid waiver. Authorized in §1915(c) of the Social Security Act, the program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide. Waiver services currently include comprehensive care coordination, in-home services, adult day services, emergency home response services, and automated medication dispensing. IDoA delivers waiver services under the auspices of the Community Care Program.

Community Care Program is a major initiative aimed to prevent the unnecessary institutionalization of older adults in Illinois. The program is designed to meet the needs of older adults who have difficulty with household and personal care tasks. Funded through both Medicaid and state general fund revenue providers are contracted with IDoA to provide waiver services. Individuals must be age 60 or older, assessed as nursing home eligible, a U.S. citizen or non-citizen within specific categories, an Illinois resident, non-exempt assets of $17,500 or less, apply for and if eligible enroll in Medicaid.

Long-Term Care State Ombudsman Program is authorized under the Older Americans Act to provide advocacy for older adults and disabled individuals residing in long-term care facilities including nursing homes and assisted living. The State Ombudsman also provides advocacy on behalf of individuals residing in Specialized Mental Health Rehabilitation Facilities (SMHRFs) and the home environment pursuant to the Illinois Act on Aging. Situated throughout the state, Ombudsman investigate and resolve complaints, provided education, and work closely with the state's regulatory authority the Illinois Department of Public Health. The Long-Term Care State Ombudsman also advocates for policy changes, initiatives and legislation that are aimed at improving the quality of care and life for older adults receiving institutional long-term care.

Context

Located in the heart of the country's Midwestern region, Illinois is bordered by Lake Michigan to the northeast, Mississippi River to the west, and both the Wabash and Ohio rivers to the south. With a 2020 Census population of 12,812,508[1] Illinois is the sixth largest state in the United States. Illinois' shape lends itself to three distinct geographical regions frequently referred to as Northern, Central, and Southern Illinois. Chicago is in the Northern part of the state, recognized as a Consolidated Metropolitan Statistical Area or "CMSA" given its estimated population of close to 10 million individuals, stretching across not just Illinois but also into the bordering states of Wisconsin and Indiana. [2] Recognized as a world class city, Chicago is densely populated, ethnically diverse, and ever growing. Other metropolitan areas in the northern part of the state include the city of Rockford and Rock Island-Quad City region. Central Illinois is the home of the capital city, Springfield, widely recognized for its connection to Abraham Lincoln and home of the presidential library and museum. Central Illinois, while predominantly agricultural encompasses several metropolitan areas and its communities are home to numerous state universities including the University of Illinois. Southern Illinois is predominantly rural but has several metropolitan areas, the largest of which is the St. Louis Metropolitan Area, encompassing Illinois and Missouri communities. Finally, a major university, SIU Carbondale is in this diverse area of the state.

A. Demographics

Illinois' population is aging, and for the first time in our history, people aged 60 and older make up more than 23% of Illinois' total population with some rural areas of the state nearing almost 1/3 of their population being age 60 and older (US Census ACS, 2023). This is a significant change from 15 years ago when just under 17% of the Illinois' population was 60 or older (US Census, ACS, 2008). Additionally, the number of persons 75 and older has significantly increased over the last 15 years, representing 6.7% of the Illinois' total population in 2023 compared to 5.9% in 2008 (US Census ACS, 2008 and 2023). According to the Administration for Community Living (ACL), most older adults do not live in a nursing home. An estimated 99% of persons aged 65-74, 97% of persons ages 75-84, and 92% of persons ages 85 and older live in the community demonstrating the importance of the home and community-based services provided under the umbrella of Illinois Aging Network (ACL, 2024). (See Chart 1, Appendix F).

B. Greatest Economic Need

When looking at the state through the lens of older adults in greatest economic need, over the last 15 years, Illinois has seen an 82% increase in the number of older adults in poverty, going from 157,250 in 2008 to 286,453 statewide in 2023. Stated differently, in 2008, 7.23% of Illinois' older adults were living in poverty compared to 9.82% in 2023. (US Census ACS, 2008 and 2023). While all PSAs saw an increase in older persons with greatest economic need from 2008 to 2023, PSAs 1 (105% increase), 2 (204% increase), and 13 (142% increase) had the largest growth in number of persons experiencing poverty.

C. Greatest Social Need

Greatest social need indicators have also increased over time, with factors traditionally considered to illustrate greatest social need being minority status, age 75 and older, age 60 and older living alone, and age 60 and older living in rural areas. The new Older Americans Act rules have further defined persons in greatest social need to include (1) physical and mental disabilities; (2) language barriers; (3) cultural, social, or geographical isolation, including due to: (i) racial or ethnic status; (ii) Native American identity; (iii) religious affiliation; (iv) sexual orientation, gender identity, or sex characteristics; (v) HIV status; (vi) chronic conditions; (vii) housing instability,

[1] https://data.census.gov/profile/Illinois?g=040XX00US17

[2] U.S. Bureau of Labor Statistics. (2021). Metropolitan and micropolitan statistical area reference map. Metropolitan and Micropolitan Statistical Area Reference Maps

food insecurity, lack of access to reliable and clean water supply, lack of transportation, or utility assistance needs; (viii) interpersonal safety concerns; (ix) rural location; or (x) any other status that: (a) restricts the ability of an individual to perform normal or routine daily tasks; or (b) threatens the capacity of the individual to live independently; or (4) other needs as further defined by state and area plans based on local and individual.

1. Physical and Mental Disabilities

Across the state, more than a 1/3 of older adults, age 65 and older, experience physical and mental disabilities, according to the US Census 2022 American Community Survey, 5-year estimates. In addition to physical and mental disabilities, some older adults also experience increasing difficulties with hearing, vision, cognition, ambulation, independent living, and self-care. (See Charts 2 & 3 Appendix F).

Many older adults who are experiencing difficulties receive assistance through IDoA's Community Care Program (CCP) to complete activities of daily living and instrumental activities of daily living. As of December 2024, CCP was serving 133,229 (inclusive of fee for service and managed care) older Illinoisans statewide through 41 Care Coordination Units (CCU), 412 in-home provider agencies, 64 Adult Day Service programs (ADS), and a choice of contracted providers for Emergency Home Response Services (EHRS) and Automated Medication Dispensers (AMD). This program serves as an alternative to nursing home placement by supporting older adults with person-centered plans, allowing older adults to continue live and thrive in their home and community. (See Appendix F, Chart 4).

2. Language Barriers

Illinois is home to people of diverse world-wide ancestral origins, while English is the primary language spoken (75.7%), 14.1% speak Spanish, 5.8% speak other Indo-European language, 3.1% speak Asian and Pacific Islander languages, and 1.3% speak other languages (US Census, ACS 1-year, S1601, 2023). As indicated by Table 5 in Appendix F, there are older adults, age 60 and older, who have language barriers in every PSA, with the largest populations located in Chicago (PSA 12), Suburban Cook (PSA 13, and the collar counties (PSA 2) (US Census, ACS, 5-year estimates, 2022). In recent years, IDoA began translating materials and surveys into more than 10 languages including Spanish, Arabic, Punjabi, Kirundi, Vietnamese, Korean, Hindi, Urdu, Russian, Polish, Mandarin, Chinese, Ukrainian. (See Appendix F, Chart 5).

3. Racial and Ethnic Status

Other significant changes in the older population include the 136% increase in the number of age 60 and older persons who are minorities, from 349,196 in 2008 to 822,540 in 2023 (US Census, ACS, 2023). However, the impact of lifelong structural inequities becomes more evident when comparing age 60 and age 75 and older, with decreases in percentages of Black, indigenous, Hispanic older adults, and older adults who are two or more races, while the percentage of older white adults increases demonstrating reduced life expectancy for these racial and ethnic groups (See Appendix F, Chart 6).

4. Native American Identity

In April 2024, the U.S. Department of the Interior placed portions of the Shab-eh-nay Reservation land into trust for the Prairie Band Potawatomi Nation, making it the first and only federally recognized Tribal Nation in Illinois. In July 2024, IDoA met with council leaders to learn more about the tribe. IDoA then met with the American Indian Health Service of Chicago (AIHSC) to gain insights into the needs of indigenous older people. Current trauma (food insecurity, homelessness, grief, high suicide rates, missing persons, and homicide) and generational trauma (boarding schools, being forced off reservations into urban centers, and more) led the concerns expressed from Dr. Mensah and staff from AIHSC. These concerns compound over time and lead to deteriorating health and chronic conditions as well as shortened life expectancy as demonstrated in the racial and ethnic status section above. The Department looks forward to connecting elder American Indians in Illinois with the AAAs and Older Americans Act services.

5. Religious Affiliation

Illinois' older adults, age 65 and older, hold diverse religious affiliations, according the 2014 Pew Research Center Religious Landscape Study. (See Appendix F, Chart 7).

6. Sexual Orientation and Gender Identity

More than 4.3% of the Illinois total population identifies as LGBTQ (LGBT Demographic Data Interactive, 2019), a quarter of which are age 50 and older (SAGE & AARP, 2021). Geographically, most of the LGBTQ+ population is housed in the urban areas of Chicago, Suburban Cook County, the Collar Counties of Chicagoland and other urban areas of the state, however, there are many older persons who identify as LGBTQ+ across the state including in rural areas. Homophobia and transphobia have been a dominant reason for economic insecurity, decreased health and wellbeing, housing insecurity, social isolation, and loneliness for members of the LGBTQ+ community (SAGE & AARP, 2021).

When LGBTQ+ identity intersects with other marginalized identities, persons experience further discrimination with long-term social and health consequences including, shorter life expectancy (particularly BIPOC and trans populations), increased risk of violence, chronic stress (from code switching, self-concealment, microaggressions, direct aggression, etc.), lack of social support/formal support networks, risky coping mechanisms, and increased incidence rates of suicide and HIV (National Sexual Violence Resource Center, 2012).

7. HIV Status

Older adults living with HIV and those who identify as LGBTQ+ often face systemic barriers that impact their quality of life. The stigma associated with HIV, compounded by age-related discrimination and homophobia, can lead to social isolation, health disparities, and inadequate access to care. According to the Centers for Disease Control and Prevention (CDC), older adults are one of the fastest-growing populations of people living with HIV, highlighting the urgent need for inclusive policies and programs.

The AIDS foundation of Chicago cites the Getting to Zero Illinois initiative which provides HIV data for priority populations across Illinois. As of 2021, there were 16,689 people aged 50 and older living with HIV, of which 39% are Black, 33% are white, and 18% are Latino/a persons (Getting to Zero Illinois, 2023).

8. Chronic Conditions

While there are older people who are aging in good health, many people aged 65 and older are managing at least two chronic conditions. Reported as impairments in the CCP, older adults may be managing hypertension, high cholesterol, arthritis, depression, Alzheimer's disease and dementia (11%), and chronic obstructive pulmonary disease. The Illinois Department of Public Health (IDPH) cites cancer, diabetes, heart disease, stroke, Alzheimer's disease, and pulmonary conditions as the top six chronic conditions leading to death. Table 1 below reports IDPH data for provisional top five leading causes of death for persons aged 60 and older in Illinois in 2024:

Table 1: Provisional Top Five Leading Causes of Death in Illinois for Persons Age 60+, 2024

Underlying Cause of Death, by Rank	Number of Deaths	Percentage of Total Deaths
Diseases of heart (heart disease)	22,319	23.7%
Malignant neoplasms (cancer)	20,260	21.5%
Cerebrovascular diseases (stroke)	6,726	7.1%
Chronic lower respiratory diseases	4,498	4.8%
Alzheimer's Disease	3,584	3.8%
Total All Deaths	**94,110**	**100%**

Data provided by Division of Health Data & Policy, Office of Policy, Planning, & Statistics, Illinois Department of Public Health, April 23, 2025, and reports provisional data for deaths of persons 60+ in Illinois in 2024.

A burden associated with some chronic conditions is a higher incidence of falling, which can lead to emergency room visits and hospitalizations, especially as age increases as evidenced by the 2013 data set from Illinois Department of Public Heath (IDPH). See Appendix F, Chart 8.

D. Increase in Prevalence of Alzheimer's Disease and Related Dementias

The Alzheimer's Association (2024) reports that 251,000 people aged 65 and older are living with Alzheimer's in Illinois, 12% of the population. The 2024 Alzheimer's Facts and Figures report states that a recent study found disparities in prevalence of having an Alzheimer's dementia diagnosis when looking at race with 19% of Blacks, 14% of Hispanics, and 10% of Whites aged 65 and older having a diagnosis of Alzheimer's (Alz. Assoc, 2024). Additionally, 6.1% of people aged 45 and older have subjective cognitive decline (Alz. Assoc, 2024). Further disparities related to social determinants of health (access to economic stability, quality education, social and community context, good health and quality healthcare, and safe neighborhood and built environment) also increases risk factors for developing later life dementia as well as early on-set dementia (Majoka & Shimming, 2021). For Illinois 2020 county-level data on the prevalence of Alzheimer's Disease and Related Dementias (ADRD) see Appendix F, Chart 9. (Alz. Association, 2023; Dhana, et al., 2023

Cook County has the highest prevalence of ADRD with 13.6% of older adults experiencing dementia (Alz Assoc, 2023; Dhana et al, 2023). After Cook County, the far southern Illinois counties, Alexander (13%), Pulaski (13%), Masaac (12.7%) as well as St. Clair County (12.7%) in southwestern Illinois have the highest percentages of older Illinoisans with ADRD (Alz Assoc, 2023; Dhana et al, 2023). In central Illinois, Adams County (12.1%) and Ford County (12.1%) are also slightly higher than average (Alz Assoc, 2023; Dhana et al, 2023). Notably, Hardin (9.7%), Putnam (9.8%), and McHenry (9.7%) Counties have the lowest percentages of older persons with ADRD (Alz Assoc, 2023; Dhana et al, 2023).

As Illinois plans for the growth in older adults with ADRD it is critical to consider the impact on both paid and unpaid caregivers to assist an older person manage parts of their life to maintain independence and be able to stay in their home and community, which is where most people want to live.

E. Unwinding From the Public Health Emergency

Although the COVID-19 public health emergency (PHE) expired on May 11, 2023, the lasting effects of the pandemic and unwinding activities continue to impact the Aging Network, all aspects of long-term care support and services, the workforce, and older adults.

1. Funding

a. **Older Americans Act.** Beginning in FFY24 and for the subsequent ten years, Illinois' OAA appropriations will be decreased. More specifically, as the number of older persons in Illinois has declined ***compared to other states,*** funding for Titles III-B, III C-1, and III C-2 will be reduced for FFY24 and future years. As a result, FFY24 OAA funding for meals was decreased by $1.38M. Future funding will experience no more than a .25% reduction of funds for each fiscal year starting in FY25 for ten years that will impact Title III-B, Title III C-1 (Congregate), and C-2 (Home Delivered Meals), (42 U.S.C 3024 (a)(3)(D)(ii)).

b. **American Rescue Plan Act.** Over the 2025 fiscal year, the remnants of the American Rescue Plan Act (ARPA) funding that significantly bolstered the Aging Network since 2022 will officially end. This funding allowed the state to serve the profound increased demonstration of need expressed by older Illinoisans across both Older Americans Act programs and the Medicaid-waiver program (Community Care Program

(CCP)). Although a no-cost extension was granted to ensure ARPA funds are fully maximized, IDoA and the AAAs must be prepared to meet the growing demand for nutrition based on pre-pandemic funding.

2. Persons Who Are Elderly 1915(c) Medicaid Waiver

The Centers for Medicare & Medicaid Services extended flexibilities under Appendix K of the Persons Who Are Elderly 1915(c) Waiver during the PHE including allowing legally responsible individuals (spouses) to serve as caregivers for older adults, the use of remote assessments, Medicaid continuous enrollment, and Medicaid presumptive eligibility. The unwinding of these flexibilities continues to impact the CCP as participants are reassessed for eligibility in the presence of an increased overall demand for home and community-based services.

3. Community Care Program

On May 12, 2023, with the end of the PHE, Illinois' Healthcare and Family Services (HFS) increased the asset level to $17,500, a dramatic increase to the $2,000 allowance for assets historically used to determine eligibility. While there was not an increase in the income, the increase in asset allowance is now reflective of the allowable asset level for CCP. This increase has allowed more older Illinoisans to benefit from Medicaid, and for the state to claim against Medicaid for CCP, where the state receives about 50 cents on each dollar spent from federal funds, reducing state funding needs. This has increased the number of CCP participants covered by Medicaid by more than 14,000 from pre-pandemic numbers and a decrease in non-Medicaid/GRF supported CCP participants by more than 12,000 from pre-pandemic levels.

4. Care Coordination and Direct Care Workforce Shortages

Although direct care workforce shortages pre-dated the PHE, the impact of COVID, subsequent unwinding and competition for this valued workforce post PHE continues to be a concern that must be addressed using a multi-faceted, collaborative approach. CCU and direct care workforce shortages continue to impact the Aging Network across the state with the southern part and some urban areas of the state demonstrating significant challenges recruiting and retaining care coordinators. To address these issues, the Department is utilizing several strategies including participating in a cross-sector Peer Learning Collaborative (PLC) sponsored through the Administration for Community Living's Direct Care Workforce Strategies center. The PLC opportunity has enabled the Department to address Direct Care Workforce (DCW) needs in partnership with other state agencies, including the Department of Healthcare and Family Services (HFS), Department of Human Services (DHS), and Department of Commerce and Economic Opportunity (DCEO). Additionally, the state partnered with subject matter experts from the Public Health Institute, the Rockingstone Group and representatives from California, Connecticut, and Kansas. The Illinois team realized tangible outcomes from the PLC opportunity including development of a core learning curriculum that will span across the state's waivers and pave the way for specialized training and certification.

In addition, the Department engaged with ADvancing States and Human Services Research Institute (HRSI) to undertake an extensive survey of CCP In-Home (INH) providers aimed at understanding characteristics of the workforce, drivers of retention, turnover, worker needs and benefits. ADvancing States and HRSI recently developed the National Core Indicators-Aging & Disability State of the Workforce Survey (NCI-AD SoTW) to complement the long-standing National Core Indicators-Intellectual and Developmental Disabilities State of the Workforce Survey (NCI-IDD SoTW). The NCI-AD SoTW is designed to collect data on Direct Care Workers (DCWs) serving the aging and disabilities population in home and community-based services (HCBS) settings. The survey looks at topics such as DCW wages and benefits, retention, network demand and missing capacity, DCW characteristics, and other important metrics.

In 2024 in collaboration with the CCPAC Training Subcommittee, the Department undertook an extensive survey of in-home workers in ten languages to understand and address training needs. Close to 5,500 home care aides from across the State responded to the survey providing the Department with powerful data to drive changes aimed at ensuring the workforce is prepared to meet the complex needs of older adults receiving CCP services. Home care

aides provided valuable feedback on preferred method of training, means of access to training, and gaps in training topics that will help shape a new standardized training curriculum currently in the beginning stages of development by IDoA and an academic partner.

Finally, as the Department looks forward to ensuring a well-compensated, highly trained, and robust workforce exists to meet the need of our increasingly older adult population seeking home and community-based services a new rate study will be conducted as required by the Persons Who Are Elderly 1915(c) Waiver. An updated rate study is crucial to understand the impact of multiple rate increases over the past years, the impact of the pandemic on rates, and to "rebalance" as required by federal CMS.

F. Multi-Sector Plan for Aging

On August 13, 2024, Governor J.B. Pritzker signed an Executive Order (EO) authorizing the creation of a Multi-Sector Plan for Aging (MPA). The EO established an MPA Task Force committee made up of state agencies and a Community Advisory Council whose members are appointed by the Governor. The MPA Task Force includes representatives from 15 state agencies to ensure the MPA makes cross-sector recommendations. The Community Advisory Council is comprised of 25 members with subject matter expertise in areas such as the social determinants of health, the Aging Network, long-term care supports and services, geriatric care, social work, housing, and education.

The MPA is intended to be a comprehensive strategic plan that includes measurable outcomes for calendar years 2026 through 2036 with the goal of strengthening Illinois as an aging-friendly state. The plan will make recommendations for actions to strengthen the care infrastructure and support caregivers, improve the quality, accessibility, and availability of long-term services and supports to ensure older persons remain in their homes and communities, expanding access to technology, and advance health equity.

The Department is well on its way to developing the state's MPA in collaboration with the members of the MPA Task Force and Community Advisory Council partnered with the University of Illinois Chicago, and the Health, Medicine, and Policy Group whose expertise will be invaluable to the Department, MPA Task Force, and Community Advisory Council.

G. Federal Rule Making Impacting all Aging Network Programs

1. **Older Americans Act.** On February 14, 2024, ACL released revised Older Americans Act rules, overhauling the rules for the first time since the 1980's. The new rules update definitions, state agency and AAA responsibilities, functions of the Legal Assistance Developer, monitoring and oversight, and service requirements. Over the last year, IDoA has met with the AAAs to digest the required changes and develop a collaborative, strategic plan to ensure compliance. Starting in FY26, Illinois will be implementing these rule changes across the AAA network

2. **Ensuring Access to Medicaid**. In addition to the Older American rule changes, on April 22, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the Ensuring Access to Medicaid Rules (commonly referred to as "Access") impacting Fee-For-Services (FFS) HCBS and Managed Care systems of care. The rules will significantly impact the Department's Waiver and CCP. The overarching goals are to increase transparency and accountability; standardize data and monitoring; create opportunities for active participation by the recipients of care; and improve holistic access to care. The new rules encompass new provisions governing person-centered planning, participant grievance procedure, critical incident systems, HCBS quality measurements, and payment adequacy to DCWs, access to care, transparency, and changes to the states' Medicaid Advisory Committee structure. Although the implementation dates for the rules

extend through 2030, the Department is aggressively working to evaluate the necessary state statutory, regulatory, policy, and systems changes to ensure timely compliance

3. **Adult Protective Services.** On May 8, 2024, the first set of federal rules applicable to Adult Protective Services (APS) programs were issued by Department of Health and Human Services, Administration for Community Living. The new rules are designed to promote high-quality APS and improve consistency in services across states. The rules will require alignment of state and federal standards, improvement in data collection/sharing, alignment of key provisions with the Access rules, require a tiered assessment system with timelines, provide multiple avenues for the reporting of adult maltreatment and self-neglect, require policies emphasize person-directedness and the least restrictive alternatives as core values within APS programs and the submission of a State Plan specific to APS. State Units on Aging have until May 8, 2028, to reach compliance. However, like other rule makings IDoA is aggressively working towards compliance prior to the compliance date with the majority of mandates already achieved/implemented.

Public Input

Caregiver Roundtables

In 2023, IDoA partnered with the AAAs to convene 23 Caregiver Roundtables across the state to hear from family caregivers and professional DCWs. (Appendix G). These collaborative conversations helped the state identify three statewide initiatives while also informing the FY25 Area Plan three-year cycle which in turn provided a foundation to develop strategies and objectives for this State Plan.

Statewide Initiatives Roundtables & Listening Sessions

In partnership with the AAAs, IDoA convened 9 in-person and 3 virtual State Plan on Aging Roundtables in 2024 that further validated the direction of the statewide initiatives as well as the program goals that were developed by the AAAs. IDoA also solicited feedback from the Older Adults Services Advisory Committee (OASAC), Community Care Program Advisory Committee (CCPAC), and Illinois Council on Aging.

Additional Listening Sessions

IDoA solicited feedback from the Illinois Public Health Association and HIV and Aging Policy Corps in connection with the State Plan on Aging and in consideration of these individuals encompassed under the Federal and State definitions of greatest social need. Feedback provided six focus areas, two of which are related to the function of the Illinois State Plan on Aging and fall within the authority of the IDoA. The recommendations related to the State Plan on Aging include increasing access to mental health services and expanding social support and community engagement programs.

Public Hearings

IDoA solicited public feedback to the proposed State Plan by conducting public hearings in the City of Chicago (May 19, 2025), Illinois, Lombard, Illinois (May 19, 2025), and Carbondale, Illinois (May 21, 2025). In addition, IDoA convened a virtual hearing on May 22, 2025. IDoA values the robust feedback received from older adults, caregivers, Aging Network partners and providers, and stakeholders. As a result of stakeholder feedback IDoA incorporated several strategies to strengthen the State Plan. Responses to all comments received are available for viewing on IDoA's website INSERT LINK HERE.

Focus Areas

The ACL provided guidance to states developing State Plans with an effective date of October 1, 2025, or after requiring the inclusion of four topic areas: Older Americans Act (OAA) Core Programs; Greatest Economic Need and Greatest Social Need; Expanding Access to Home and Community-Based Services; and Caregiving. These topic areas are consistent with the State's approach to developing strategies across the Aging Network to "optimize the State's long-term services and supports system for older adults and their caregivers" (ACL, OMB #098-0083, 2024 and State Unit on Aging Director's Letter #01-2025).

Focus Area 1. Older Americans Act (OAA Core Programs)

Older Americans Act Funding

The SUA receives funding from the Department of Health & Human Services, Administration for Community Living as authorized under Title III, V, and VII of the OAA. This funding supports a wide range of social services and programs for Illinois' adults over the age of 60, those with Alzheimer's Disease, and caregivers. Services include congregate and home-delivered nutrition services, family caregiver support, community service employment, the Long-Term Care Ombudsman Program, and services to prevent the abuse, neglect, and exploitation of older persons. Recognizing the negative impact of poverty and structural inequities on health, economic security, and social opportunities over people's lifetime and in older age, older Americans' services are targeted to persons with greatest economic and greatest social needs (defined in Focus Area 2). Overarchingly, the State Plan seeks to build on accomplishments made in these critical programs during the previous three-year plan to ensure Illinois is an age and dementia friendly state. To do so Illinois developed three statewide initiatives/goals: 1) to increase outreach and visibility and access to services; 2) to driving quality improvement through a person-center lens, and: 3) to increase public awareness and knowledge of caregiver needs

Focus Area 2. Greatest Economic Need and Greatest Social Need

On February 14, 2024, ACL published the final rules applicable to the administration of OAA programs. Included in the rules is a requirement for states to develop a definition of both the Greatest Economic Need and Greatest Social Need in recognition that these definitions may have changed in the 36 years since the last amendments to the OAA. Re-evaluating the definition of these terms ensures that services meet the needs of those served by OAA programs throughout the state and at the local level. Illinois has adopted the federal definitions of both **Greatest Economic Need** and **Greatest Social Need** (42 CFR § 1321.3)**.** In doing so this provides the AAAs with the flexibility to prioritize and tailor services based on the greatest economic and social need of individuals located in their PSA.

Focus Area 3. Expanding Access to Home and Community-Based Services (HCBS)

Community Care Program Overview

IDoA CCP is statutorily authorized to provide services authorized under the Persons Who are Elderly 1915(c) Medicaid Waiver or "Waiver". The Waiver is the largest in the State with more than 133,000 older adults receiving waiver services including 55,228 Managed Care participants. This program serves as an alternative to nursing home placement by supporting older adults with person-centered plans, allowing older adults to continue live and thrive in their home and community. IDoA is designated as the Operating Agency (OA) by the State Medicaid Agency (Healthcare and Family Services) (HFS). As the OA, IDoA contracts with home and community-based providers to ensure the delivery of services under the Waiver. In March of 2024, IDoA held contracts with 71 Adult Day providers, 6 Automated Medication Dispenser providers, 7 Emergency Home Response Service providers, 514 In-Home Service providers and 61 Care Coordination Units.

Beyond establishing contractual relationships, IDoA's responsibilities include but are not limited to ensuring quality and program integrity through monitoring, policy development, provider training, promulgating administrative rules, and payment for services rendered. Perhaps most crucial to serving as the OA and administering the CCP is the responsibility to weave this program together with the Aging Network, OAA services and related state funded initiatives to ensure a comprehensive, coordinated, and sustainable system of long-term care support and services.

As the demand for HCBS increases IDoA must also be poised to seamlessly expand access, add services to the Waiver when feasible and drive initiatives aimed at ensuring and adequate, well-trained workforce exists to accommodate increased growth.

Comprehensive Care Coordination

CCUs and Managed Care Organizations (MCOs) provide comprehensive care coordination for older Illinoisans served through the Medicaid waiver program. This includes the development of a person-centered plan of care with the older adult and family caregiver (if there is one). This person-centered plan of care reviews multiple domains and helps to prompt older adults to think about goals outside of the services provided under the waiver that can be coordinated through local community resources. These plans often include helping older adults access mental health services, HDMs or other nutrition services like community food banks, getting set up with curb-to-curb or door-to-door transportation (if available), accessing the local senior center programs including evidence-based health promotion programs like fall prevention and chronic disease management, as well as other services that they may be of interest to the participant.

For persons who may not qualify for CCP, but need in-home services, referrals are often made to the Title III B Chore program (if available in their area) as well as to Medicare or Medicaid paid home health programs for acute healthcare needs that are outside of the scope of CCP and Chore services.

Care coordination activities also benefit family caregivers from referrals to Title III-E programs including information, assistance, counseling, support groups, respite, and supplemental services such as TCARE and Trualta. Additionally, if CCP participants prefer family caregivers or persons who are legally responsible to be their paid CCP caregiver (and this person agrees), Illinois allows this, which helps the older adult benefit from being cared for by trusted family and helps the family caregiver reduce the economic burden associated with caregiving, a responsibility that can often be for more than 2 years, and more than 20 hours a week.

Expanding Waiver Services

In 2024, IDoA amended the Waiver to provide for enhanced EHRS services ensuring older adults have access to technology in the home to detect falls and GPS devices. Included among IDoA's State Plan goals are amending the Waiver to allow for teleassessment, adding assistive technology, and respite services.

Program of Choice

Participants utilizing CCP services have numerous options to ensure high quality in-home care. Under IDoA's administrative rules and policies applicable to the program in addition to requesting a preferred worker from an in-home service agency participants may utilize a family home care aid (FHCA) and more recently approved by CMS a legally responsible individual (such as a spouse). These person-centered options allow for program expansion while simultaneously addressing the direct care workforce crisis.

Increase in Asset Limit

As described in the Context section of the State Plan, in May of 2023 the asset limit for Medicaid eligibility in Illinois was increased from $2,000 to $17,500. Although the increase moved the asset limit in line with the

existing CCP threshold this nevertheless had the desired effect of increasing the number of older adults who met Medicaid eligibility – a precursor to accessing CCP services. It is an overarching goal of the State to ensure individuals with the greatest social and economic need can receive Medicaid benefits. Indeed, this was the genesis for the Older Adults Services Advisory Committee. The number of CCP participants increased from 40,639 in January of 2021 to 55,888 in January of 2025. During this same time MCO participants increased from 47,673 to 55,228.

Coordination of Care Acute and Long-Term Care Facilities

The AAAs and the CCP Care Coordinators play a vital role in outreaching to individuals across numerous settings other than the community including the acute care and long-term care settings. Care Coordinators are statutorily mandated to conduct "Choices for Care Screenings" for individuals facing long-term care placement. This face-to-face connection ensures older adults are educated about home and community-based options, services under the OAA, and the Waiver/CCP Program. When individuals are discharged before a Care Coordinator can offer a screening, they are offered options in the nursing facility. These early interventions by the CCU ensure older adults are connected to the Aging Network using a comprehensive approach. AAAs can also serve as "prime agencies" responsible for coordinating with the State's Olmstead Compliance Officer to assist older adults with disabilities successfully transition to the community.

Focus Area 4. Caregiving

Illinois has more than 1.3 million family caregivers, which is about every one out of five adults (CDC, 2019). While older persons used to have more than seven potential caregivers, that number has fallen to four in recent years (CDC, 2019). The economic impact of family caregiving adds additional stress as many family caregivers spend around 20 hours a week providing care and 13% of caregivers spend more than 40 hours a week providing care (CDC, 2019).

Most (58%) of caregivers are women (CDC, 2019). Looking at caregivers by race, 23.1% of Whites, 24.3% of Blacks/African Americans, 17.9% of Hispanics, and 10.2% of Asians/Pacific Islanders are caregivers (CDC, 2019). In the LGBTQ community, 21% of older LGBT have provided care to friends compared to 6% of non-LGBT older adults (AARP & SAGE, 2021). Also, 54% of LGBT elder care recipients receive care from their partner (AARP & SAGE, 2021).

Often caregivers have health concerns of their own: 64.2% of caregivers have chronic health conditions; 29% of caregivers have depression; and 14.3% of caregivers are in poor physical health (CDC, 2019). Of people aged 65 and older, a U.S. Health and Human Services (HHS) study found that 70% will need long term services and supports, most will depend on family and friends, however, 48% will need to pay for care services and of this 24% will need more than 2 years of paid care services, and 15% will spend more than 2 years in a nursing home (Johnson, 2019).

The Alzheimer's Association (2024) estimates that 312,000 family caregivers bear the burden of the disease in Illinois, contributing 481 million hours of unpaid care which is a value of $9.85 billion dollars. In response to this need the State has initiated numerous initiatives aimed at strengthening and supporting the direct care workforce that encompasses both paid and unpaid caregivers, implementing the recommendations of the National Strategy to Support Family Caregiving, and coordinating caregiving efforts across the Aging Network.

Strengthening & Supporting Caregivers

Funding

Since 2022, the state has provided $5 million dollars each fiscal year to help expand services funded through the National Family Caregiver Program (Title III-E). While the number of caregivers served through the OAA services

fluctuates with increased visibility and demand for these programs. IDoA anticipates seeing a 10% increase in persons served over the course of the FY26-28 period.

Illinois Caregiver Assistance and Resource Portal

In the Spring of 2024, Illinois' General Assembly passed the Illinois Caregiver Assistance and Resource Portal Act (320 ILCS 70, et seq.). The Act requires IDoA, in consultation with HFS, the Department of Public Health, and the Department of Veterans' Affairs, to create and maintain an Illinois Caregiver Assistance and Resource Portal (Portal). The Portal will serve as a centralized and trusted online platform offering a wide range of resources related to caregiving, including, but not limited to:

- Information on state and federal programs, benefits, and resources on caregiving, long-term care, and at-home care for Illinois residents who are 50 years of age or older
- Information from non-profit organizations providing free-of-charge caregiving support and resources
- Tools and guides for developing and implementing caregiving plans
- Direct contact information for relevant Illinois agencies, organizations, and other State-licensed long-term care, aging, senior support services, and at-home care providers
- Educational materials, articles, and videos on caregiving best practices
- Accommodations for users with different language preferences, ensuring the information is accessible to diverse audiences

As IDoA builds out a user-friendly portal, Illinois' caregivers will have resources at their fingertips including HCBS that support family caregivers, nursing home care, services and programs offered by AAAs, relevant health care and financial assistance programs, caregiver education, and local support group opportunities for caregivers. In addition to the Act, the Department included the requirement to increase visibility of caregiver services as one of the statewide initiatives for this State Plan on Aging 3-year planning cycle. Feedback from both the Department's caregiver roundtables and AARP in 2023 revealed that family caregivers are not aware of community caregiver services and supports but need the information quickly in time of crisis. In 2027, as the Portal is completed, an outreach and promotional campaign will be launched to celebrate its completion.

AAA Evidence Based Programs

Currently, through a mix of Title III-E and ARPA federal funding as well as state funding, the AAAs are funding TCARE, a caregiver assessment software, through individual contracts. Additionally, using a mix of Title III-E and ARPA some AAAs also contract with Trualta which provides caregiver education. In 2024, the state provided additional funding to Age Options to advance statewide caregiver specialist training. Seeing a noticeable turnover of caregiver specialist, Age Options utilized the funding to partner with Rush University for purposes of developing a uniform caregiver specialist curriculum that could be expanded statewide to all 13 AAAs. As a result, Rush developed two curriculums including general and specific Alzheimer's Disease and Related Dementia courses available to all AAA caregiver specialists.

Illinois Caregiver Coalition

Created by the Area Agencies on Aging, the Illinois Caregiver Coalition's (ICC) Mission is to "Empower Illinois family caregivers and care partners to thrive." (ICC, 2025) The ICC has received funding through the RRF Foundation and IDoA to assist them with their overarching Mission and compassion for creating an "inclusive, statewide, non-partisan coalition to support unpaid and informal caregivers." (ICC, 2025). The Caregiver Coalition has garnered significant interest and support from numerous partners including but not limited to AARP, IDPH, IDHS, HFS, IDVA, Health, Medicine & Policy Research Group, Rush University, Howard Brown Health. The Caregiver Coalition is committed to pursuing the strategies and goals of the 2021 National Caregiver RAISE Act. IDoA works closely with the Caregiver Coalition and the AAAs to develop best practices, support their work, and partner to similarly pursue the goals of the RAISE Act at the state level.

STEWARDSHIP AND OVERSIGHT

Included among Illinois' statewide goals is to "**Drive continuous quality assurance and improvement activities that emphasize person-centered and trauma-informed services while maximizing effectiveness of services delivered through the Aging Network".** Encompassed in this goal are objectives to modernize data systems capable of collecting data to inform program management and the applicable policies and procedures. While IDoA charts a future course with stakeholders to meet its various objectives related to stewardship and oversight it has undertaken other initiatives to ensure programmatic stewardship and oversight.

Currently, Illinois' Aging Network utilizes various software systems such as AgingIS, Salesforce, Serve Tracker, ACORN, My Senior Center, and iCarol to collect required programmatic and fiscal data that must be submitted annually for Older Americans Act Title III and Title VII programs. In addition to the individual software systems utilized by the AAAs, data is currently reported to Shawnee Information Systems using a legacy platform. The AAAs collect data on federally and state funded evidence-based programs such as TCARE, Trualta, Savvy Caregiver, and Caregiver Specialist education. The AAAs also utilize nutrition surveys using pre/post data to evaluate participant needs and satisfaction with meal programs in addition to gain further understanding of social isolation and loneliness. Despite numerous interventions social isolation and loneliness remain top priorities for the Aging Network as the harmful mental and medical consequences of these issues are well-documented. (U.S. Department of Health & Human Services, 2023).

These data collection systems together with AAA needs assessments ensure that federal funding reaches those with the greatest economic and social need:

Table 2: Count and Demographics of Registered and Unregistered Persons Using Older Americans Act Services, FY 2024[1]

Unduplicated Counts Persons Served for All User Types[2]	Number of Users	
Unduplicated Count of Registered Persons	129,937	
Unduplicated Count of Unregistered Persons	401,041	
Total Unduplicated Count of Persons Served	**530,978**	
Breakdown of Older Adults Receiving Services, by Select Categories[3]	**Number of Users**	**Percentage of Persons Served**
60+ Poverty	43,027	33%
60+ Minority	48,891	41%
60+ Living Alone	74,984	63%
75+ Population	67,229	52%
Rural	20,860	16%

1. Data based on Illinois State Performance Report, FFY2024, currently unpublished.
2. Includes Older Adults, Caregivers of Older Adults, and Older Relative Caregivers served by services for each population group. Registered means a service provided using OAA funds in whole or in part for which demographic and consumer characteristics are reported in aggregate to ACL. Unregistered means a service provided using OAA funds in whole or in part for which demographic and consumer characteristics are not reported to ACL.

3. 60+ Living Alone and Minority data only includes Older Adults as comparable data is not available for Caregivers of Older Adults and Older Relative Caregivers. Additionally, older adults may be members of multiple demographic categories and thus counted more than once.

AAA Monitoring

In 2024, IDoA undertook a complete revision of the monitoring manual, monitoring tools, templates, and follow up and technical assistance processes. In FFY25 the OAA regional coordinators began monitoring the AAAs on all federal and state funded programs over a three-year cycle as outlined below. Additional focus areas will be added based on the factors that arise during the 3-year state plan cycle such as public health emergencies, unanticipated funding, and overarching federal guidance. This will ensure that the AAAs and their direct service providers are adhering to rules, policies, and guidelines for both programmatic and fiscal responsibilities for these funded services.

Table 3: Three Year Monitoring Schedule for Area Agencies on Aging

Year 1	Year 2	Year 3
Planning & Coordination	III-B: Community Services	III-B: Access Services
Nutrition Services	III-D Services	III-B: In-Home Services
III-E: Caregiver Services	Equal Distribution	State Discretionary Funds
	SHAP/BAA	

Community Care Program

For the last several years in collaboration with the Department of Innovation & Technology (DoIT), Care Coordinators, and CCP providers IDoA has been investing in a new case management system known as "Aging Cares". This system will replace paper files, improve accuracy in reporting Waiver services, and allow compliance auditing on 100% of participants through data mining in addition to on-site record validation auditing. In December 2024, phase one of go-live was launched with CCUs and CCP providers in the southernmost 4 of the 13 PSAs. A staggered go-live approach will ensure any issues with the system are resolved before implementing in another region of the State.

Adult Protective Services

During 2023, the Office of Adult Protective Services (APS) created a new Quality Assurance (QA) Team whose overarching mission is to standardize and apply consistently all quality assurance tasks through systematic processes which lead to accountability for staff, policy and program improvements, identification of training needs, and improved services for clients. Through a combination of onsite monitoring and data collection, sampling of cases by independent reviewers, peer review, and technical assistance the state ensures older adults requiring adult protective services receive the highest quality service possible.

The intention of these activities is to identify best practices among provider agency operations while ensuring operations are compliant with applicable procedures including providing additional training and support where needed. The QA Team partners with the AAAs (RAA's) and IDoA APS Coordinators to ensure quality assurance concerns are addressed in a timely manner to remove any barriers to delivery of high-quality APS service state-wide. Additionally, the involved staff will work closely with the provider agency staff to support the development

of quality processes and practices through training and targeted technical assistance. This system of quality assurance also ensures network providers are equipped with the knowledge and skills needed to effectively support and protect vulnerable adults and adults with disabilities.

Continuous Improvement

Illinois has a strong history of embracing continuous quality improvement throughout its programs. On an annual basis IDoA undertakes a comprehensive survey of the recipients of care through the CCP. In 2024, the survey was translated into Spanish and Russian and distributed to 21,364 older adults. In the previous year the survey yielded 6,225 responses and indicated increasing satisfaction with supports and services provided under the Waiver and CCP. The AAAs frequently solicit feedback from recipients to ensure services are high quality, person-centered and meeting the needs of those with the greatest economic and social need.

In addition to surveying participants, IDoA recently undertook extensive surveys of in-home workers and CCP providers to improve training for DCWs and gain insight into the drivers associated with turnover and retention concerns.

Through its various advisory committees IDoA has embraced a spirt of collaboration and transparency aimed at continuous improvement of quality of service, identifying strategies to expand and improve services, and garner support for legislative and rule changes. Beginning in 2024 IDoA began holding provider retreats for the purpose of identifying innovative service models and strategies to expand services and build a culture of continuous improvement throughout the Aging Network.

GOALS, OBJECTIVES, STRATEGIES & OUTCOMES

Based on the findings and recommendations from the State Plan on Aging Roundtables, IDoA/AAA Caregiver Roundtables, and Area Plans of the 13 AAAs the following goals, strategies, and objectives were developed. Using a thematic analysis of the 13 AAAs Area Plans and roundtables qualitative data was synthesized to ensure a comprehensive statewide lens is used for the State Plan.

Although the State has overarching goals, these represent a shared vision between IDoA, the 13 AAAs and Aging Network. IDoA looks forward to implementing the strategies from a holistic perspective and in partnership with the AAAs, CCP providers, CCUs and the many stakeholders whose advocacy for older adults is crucial to implementing a successful State Plan.

In addition to the areas of focus required by ACL to be included in the State Plan, the SUA developed three statewide goals that were subsequently woven throughout the AAA's Area Plans. The objectives, strategies and outcomes developed below draw on the Area Plans and represent those applicable to the SUA and the comprehensive Aging Network.

Statewide Goal/Initiative #1: Increase statewide visibility of the Aging Network to connect Illinoisans with supports and services that encourage independence, dignity, and quality of life as we age.

Objective 1.1 Increase public awareness of Aging Network services through effective outreach, marketing, and technology.

Strategies

1. Utilize multiple communication channels to reach target audiences.
2. Forge partnerships with other organizations serving the target population.
3. Modernize, develop and distribute marketing materials in multiple languages.
4. Utilize creative marketing strategies like digital marketing, and text messaging.
5. Conduct a statewide survey to identify preferred communication strategies.
6. Develop and launch a statewide marketing campaign.

Outcomes

Short-term: Increased number of partnerships with community organizations.

Intermediate: Increased number of older adults receiving OAA assessments, CCP assessments, and coordination of services as evidenced by Older Americans Act Performance System (OAAPS), Medicaid enrollment, and CCP data.

Intermediate: Increased number of individuals from underserved communities accessing Aging services as evidenced by data collection.

Intermediate: Modernized and accessible IDoA website as evidenced by increase in website activity.

Intermediate: Increased number of outreach events through partnerships with sister agencies (IDPH, DHS, DVA).

Long-term: Identify preferred communication strategies among recipients of services of sufficient sample size and responses to guide future outreach.

Long-term: Pilot programs to connect with older adults and caregivers using text messaging and digital platforms to increase utilization of Aging's long-term care supports and services.

Objective 1.2 Develop and implement a statewide integrated data management system for the AAAs, direct service providers and CCP providers to ensure uniform data points and increased ability to refer across programs and services with closed loop referrals.

Strategies

1. Coordinate with AAAs and Aging Network providers to identify a data management system that allows for a seamless flow and integration of data.
2. Coordinate with the State Medicaid Agency to ensure the data management system meets the requirements of the Access and APS Rules.

Outcomes

Short-term:	Assess current system capacity and integration of data.
Intermediate:	Develop comprehensive crosswalk demonstrating strengths, weaknesses, and gaps in current data collection systems across programs.
Intermediate:	Coordinate with the State Medicaid Agency and Waiver Operating Agencies to ensure the data management system is capable of transmitting data responsive to the requirements of the Access and APS Rules.
Long-term:	Launch a comprehensive statewide data management system.
Long-term:	Demonstrate an increase in the number of older adults and caregivers accessing the spectrum of long-term care supports and services.

Objective 1.3 In partnership with the Area Agencies on Aging, CCP Providers and Illinois Department of Public Health (IDPH) increase health awareness and use of technology to access services.

Strategies

1. Coordinate with AAAs and Aging Network providers to identify gaps and barriers to referring individuals to the Department's assistive technology program.
2. Provide education to Aging Network providers as to available technology and assistive devices for older adults.
3. Collaborate with IDPH to explore partnerships with local health departments and increase access to assistive technology and telehealth.

Outcomes

Short-term:	Develop a new screening tool to ensure those with greatest social and economic need are assessed for referral to the Department's assistive technology grant program.
Intermediate:	Increased number of referrals for both CCP and non-CCP participants to AAA supports and services and other sources of assistive technology and education.
Long-term:	Increase in number of older adults receiving assistive technology.
Long-term:	Increase the number of older adults accessing virtual and telehealth services.

TITLE III-B GOALS FROM AREA PLANS

Objective 1.4 Support Older Adults and Caregivers Seeking to Thrive in Community.

Strategies

1. Increase outreach efforts to underserved communities in urban, suburban, and rural areas of the state.
2. Increase service to Limited English Proficient (LEP) individuals (e.g., providing language interpretation services, identifying community-based sites for service delivery).
3. Increase volunteers from those with greatest social and economic need to provide friendly visiting and options counseling.

4. Strategically plan and advertise events in advance to increase community participation.

Outcomes

Short-term:	Increase utilization of resources in underserved communities.
Intermediate:	Increased number of community-based sites for service delivery.
Long-Term:	Increased number of volunteers at community level.

Objective 1.5 Improve Service Quality and Effectiveness using data driven decision making.

Strategies

1. Use data to monitor current programs and future platforms.
2. Implement data-driven practices to ensure accountability and effectiveness.
3. Quality Assurance:
   a. Implement client satisfaction surveys across all services.
   b. Conduct program evaluations to determine participant satisfaction, outcomes, and inform service delivery improvements.
   c. Conduct quality assurance reviews of program performance.

Outcomes

Short-term:	Identify available data sources and reports.
Intermediate:	Adjust policies, practice, and service delivery based on data.
Long-term:	Evaluate client satisfaction, service delivery, and quality assurance.
Long-term:	Utilize a feedback loop to collect additional data and quality metrics.

Objective 1.6 Increase Service Utilization.

Strategies

1. Provide streamlined access to the Title III B Gap program, decreasing call wait times for Information and Assistance.
2. Enhance the online presence of Information and Assistance offices.

Outcomes

Short-term:	Increase participation in educational programs by 10% within the next year.
Short-term:	Increase the number of participants in Telephone Reassurance.
Intermediate:	Increase the number of new senior center or focal point participants.
Long-term:	Increase attendance of the 60-74 age range at each senior center or focal point by 10%.
Long-term:	Increase the number of Information and Assistance clients by 5%.

Objective 1.7 Decrease Social Isolation and Loneliness.

Strategies

1. Expand social connections using virtual senior center programming and recreational programs, friendly visiting and other evidence-based programs.
2. Develop resources that foster social connections among older adults with the greatest social and economic need by increasing use of community centers or social clubs.
3. Increase opportunities for mental health screenings at senior centers, focal points, and community health fairs.

Outcomes

Short-term: Increased individual use of evidence-based programs that address social isolation and loneliness.

Intermediate: Demonstrate increase in number of older adults and caregivers accessing programs that reduce social isolation and loneliness.

Long-term: Sustained enrollment in evidence-based programs and mental health screenings.

Objective 1.8 Provide In-Home Services that address the unmet needs of older Illinoisans**.**

Strategies

1. Home-Based Services
    a. Provide chore housekeeping, home repair, and home preservation services.
    b. Expand chore lawncare services to include gutter cleaning, bush and tree trimming, and spring and fall clean-up.
    c. Enhance outreach, recruitment, and retention of community volunteers.
2. Provide transportation services to help older adults maintain independence.
3. Caregiver Support:
    a. Provide respite care, caregiver training, and support groups.
    b. Provide Information and Assistance services to caregivers.
4. Increase referrals and coordination with providers in the Community Care Program.

Outcomes

Short-Term: Increase number of referrals for home-based services.

Short-Term: Coordinate with CCP to increase awareness and participation in services such as Adult Day.

Intermediate: Increased transportation to medical appointments, senior centers, and community events.

Long-Term: Reduction in number of older adults seeking institutionalization.

Objective 1.9 Promote Health and Wellness.

Strategies

1. Develop and launch a comprehensive educational campaign about the importance of health screenings.
2. Offer evidence-based, healthy programming and services.
3. Increase access to health screenings through OAA programs.
4. Create a shared referral form with health care providers.

Outcomes

Short-term: Increase the number of older adults receiving health screenings.

Intermediate: Strengthen connections with health partners and providers.

Long-Term: Sustained number of older adults accessing health screenings and evidence-based programs.

Objective 1.10 Build Capacity and Collaboration.

Strategies

1. Fostering Partnerships
    a. Build partnerships with community organizations, faith-based institutions, and other service providers.
    b. Collaborate with existing entities and providers within the service area.

c. Partner with pro-bono providers to expand access to legal services.

2. Capacity Building
    a. Provide training and technical assistance to grantees.
    b. Build the capacity of schools and districts to effectively serve students with who may be family caregivers for older family members.

Outcomes

Short-term: Increase number of age and dementia friendly communities in Illinois.
Intermediate: Expand opportunities for older adults and caregivers throughout communities.
Long-term: Increased number of legal providers servicing older adult clients on a pro-bono basis.

Objective 1.11 Address Trauma and Promoting well-being.

Strategies

1. Implement a trauma-informed care training program across the state to better recognize and respond to trauma-related behaviors, including structural inequities, generational trauma, and the lifelong impact of Adverse Childhood Experiences (ACEs).
2. Ensure facilitators of peer engagement programs for older adults with the greatest social need.

Outcomes

Short-term: Identify academic and subject matter experts to provide trauma-informed training programs and certifications for Aging Network providers.
Intermediate: Provide training to AAA staff including caregiver specialists.
Long-Term: Extend training opportunities for trauma informed care and cultural sensitivity to peer engagement staff, Aging Network providers, and volunteers.

TITLE VI. PRAIRIE BAND POTAWATOMI NATION ACROSS TITLE III PROGRAMS

Objective 1.12 Ensure collaboration with the AAAs and Prairie Band Potawatomi Nation across Title III programs.

Strategies

1. Outreach to Tribal Leaders on a regular cadence to provide technical assistance, support and resources.
2. Encourage dialogue between the Prairie Band Potawatomi Nation Tribal Leaders with Tribal leaders in other states.

Outcomes

Short-term: A regular dialogue with action item occurs between the SUA, AAAs, and Tribal Leaders.
Intermediate: SUA representatives attend regional and national events to learn best practices to ensure collaboration and support to the Prairie Band Potawatomi Nation.
Long-Term: Actionable steps are outlined to amend the Area Plan(s) as necessary.

Objective 1.13 The Department will work with Prairie Band Potawatomi Nation to apply for Title VI funding under the Older Americans Act.

Strategies

1. The SUA will facilitate conversations with the appropriate Department of Health & Human Services Divisions to provide technical assistance and support to apply for Title VI funding under the Older Americans Act.
2. The SUA will ensure timely revisions to Area Plans and Grant Agreements.

Outcomes

Short-term: Effective coordination of communication with federal partners.
Intermediate: Development of a timeline and submission of appropriate documentation.
Long-term: Coordination with the Prairie Band Potawatomi Nation to develop a plan to ensure resources are aimed at targeting the full spectrum of available services under the OAA.

TITLE VII OMBUDSMAN

Objective 1.14 To increase awareness among residents of long-term care facilities, assisted living facilities, specialized mental health rehabilitation waiver participants and Dual Eligible Special Needs Plans (DSNP) individuals regarding the availability for advocacy to receive the care that they need, want and deserve.

Strategies

1. Conduct statewide outreach by hosting in person and virtual hearings at events where older adults, healthcare providers, social service providers, and community leaders are present.
2. Continue to collaborate and partner with sister agencies to host training sessions on Ombudsman role as an advocate for older adults.
3. Continue to attend resident council meetings and encourage participation by long-term care residents.

Outcomes

Short-term: Increased visibility of the Ombudsman program as evidenced by increased outreach and interaction with stakeholders.
Intermediate: Conduct joint training sessions to share knowledge and improve quality of care and life of long-term care residents.
Long-term: Increased number of older adults connecting with the Ombudsman.

TITLE VII OMBUDSMAN – HOME CARE (HCOP)

Objective 1.15 To increase awareness among waiver participants and Dual Eligible Special Needs Plans (DSNP) individuals regarding the availability for advocacy to receive the care that they need, want and deserve.

Strategies

1. Provide training to the MCOs on the HCOP regarding the role and responsibility of the home care ombudsman and how to connect participants to the program
2. Provide training to the CCUs on the HCOP program including the role of Ombudsman and how to connect participants to our program
3. Using developed relationships with other State entities, request exposure for the HCOP program on their websites where Waiver services and DSNP are featured.
4. Revise the literature to be more succinct to help bring greater awareness of Ombudsman to Home Care participants;
5. Increase outreach and education at events where older adults and health care providers, social service providers, and community leaders are present.

Outcomes

Short-term:	Increased collaboration among stakeholders and state agencies.
Intermediate:	Increased awareness of HCOP on various websites.
Intermediate:	Increase in referrals by identified entities, in order to increase program exposure.
Long-term:	Greater awareness and utilization of the HCOP as evidenced by data collection and outcomes.

Statewide Goal #2. Drive continuous quality assurance and improvement activities that emphasize person-centered and trauma-informed services while maximizing effectiveness of services delivered through the Aging Network.

Objective 2.1 Conduct extensive data collection and analysis to evaluate client satisfaction.

Strategies

1. Utilize multiple sources of data to track progress, identify trends, and inform program adjustments.
2. Ensure a client-centered approach to the collection of data.
3. Provide staff with training and development opportunities to meet specific qualifications and standards to ensure quality service.
4. Ensure transparency in sharing of data and analysis to foster collaboration.

Outcomes

Short-term:	Improvement in client satisfaction with services as evidenced from increased use of services and feedback.
Intermediate:	Revision of policies and procedures based on high quality data.
Intermediate:	AAA staff demonstrate increased knowledge and skills as evidenced in credible certifications applicable to trauma-informed and person-centered care.
Long-term:	Robust feedback and engagement with stakeholders surrounding data analysis.

Objective 2.2 Ensure a regular cadence of reporting and monitoring to identify trends, areas for improvement, and potential issues.

Strategies

1. Regularly monitor provider performance to ensure compliance with program standards and guidelines.
2. Provide ongoing technical assistance to new and experienced providers in areas where trends are identified.
3. Implement corrective actions for providers who are not meeting performance targets.
4. Ensure compliance with relevant rules and policies.

Outcomes

Short-term:	Improved provider performance as evidenced by high quality services and compliance with applicable rules and policies.
Intermediate:	Performance targets routinely met with minimal corrective action.
Long-term:	Sustained compliance with applicable rules, policies, and procedures.
Long-term:	Increased participant satisfaction with supports and services as measured by survey results and feedback.

Objective 2.3 Build a culture of mutual collaboration and effective communication between AAAs, direct service providers, and Aging Network partners.

Strategies

1. Conduct regular meetings and encourage communication to foster collaboration among providers, grantees, and other stakeholders.
2. Provide ongoing technical assistance and support to direct service providers to assist them in meeting program goals.

Outcomes

Short-term:	Increased attendance and participation in regional and state meetings resulting in actionable steps to improve quality of services.
Intermediate:	Utilize data to demonstrate progress towards meeting goals and evaluating impact of technical assistance.
Long-term:	Demonstrated quality improvement across programs as measured by performance metrics and compliance indicators.

Objective 2.4 Streamline processes by leveraging technology for data collection, analysis, reporting, and service delivery (e.g., telehealth).

Strategies

1. Identify new technology platforms to enhance service delivery and data collection to drive evidence-based programs.
2. Survey older adults to understand the technology needs and barriers to ensure access to telehealth.

Outcomes

Short-term:	Utilize new technology that streamlines processes and expands service delivery to older adults and caregivers.
Intermediate:	Conduct a statewide survey of older adults that yields robust responses than can be utilized to understand the needs, gaps, opportunities.
Intermediate:	Utilize new technology to launch evidence-based programs to reach older adults where they work, play, and live.
Long-term:	Reduce the digital divide and expand access to technology for older adults and caregivers as evidenced by feedback and uptake of technology.

Objective 2.5 Ensure high quality federal and state funded programs are provided throughout the State.

Strategies

1. Implement a monitoring plan for each year of the 3-year cycle:
    a. Year 1: Planning & Coordination, Nutrition Services, III-E/Caregiver Services
    b. Year 2: III-B Community Services, III-D, Equal Distribution, SHAP/BAA
    c. Year 3: III-B Access Services, III-B In-Home Services, State Discretionary Funds
2. Complete development of a comprehensive data management system.

Outcomes

Short-term:	Utilize Data Dashboards for each AAA and statewide to track program performance and fiscal activity.
Intermediate:	Provide platform for the Department to report real time data to leadership, oversight agencies, and external stakeholders.
Intermediate:	Improve efficiency and eliminate multiple reporting systems.

Long-Term: Create seamless referral network using a closed loop referral system across funded providers.

Long-Term: Create a data driven aging network with uniform data points across the state that will articulate accountability for state and area plan goals as well as produce trends of services and resources that are needed, wanted, and preferred.

TITLE III C-1 GOALS FROM AREA PLANS

Objective 2.6 Increase Access and Participation to Improve the Health Status of Older Illinoisans.

Strategies

1. Expand service reach by increasing the number of community dining sites.
2. Improve Accessibility
    a. Work with providers in rural communities to improve seniors' access to food and enrich their social experiences.
    b. Collaborate with senior centers in adjacent areas to provide meals and educational components in targeted rural areas.
    c. Implement the WOW (Without Walls) program in at least one rural community lacking a senior center presence.
3. Increase local and in-kind funding to assist with service expansion and meeting community needs.

Outcomes

Short-term: Increase participation of younger/older adults at congregate dining sites by 10% statewide.

Intermediate: Develop a presentation on the congregate meal program and present it at least three community events and/or at faith-based communities annually to increase awareness.

Intermediate: Monitor the number of meals monthly to determine if strategies are needed to prevent waitlists due to funding changes.

Long-term: Increase local funding and in-kind funding to assist in expanding services and meeting community needs.

Objective 2.7 Improve Service Quality and Effectiveness While Addressing Nutritional Needs.

Strategies

1. Utilize data to monitor progress while reducing the percentage of missing nutrition risk data.
2. Quality Assurance
    a. Implement a uniform satisfaction survey throughout the state to analyze strengths and weaknesses of congregate Meal programs.
    b. Develop a system to provide feedback on congregate Meals.
3. Ensure client choice and satisfaction by offering as many meal choices as possible.

Outcomes

Short-term: Increased number of nutritional risk forms and evaluation of data.

Intermediate: Conduct statewide satisfaction survey of congregate dining sites.

Long-term: Increased shift from home delivered meal to congregate dining sites.

Long-term: Decrease nutritional risk in older adults participating in congregate dining.

Title III-C-2 Goals from Area Plans

Objective 2.8 Increase Food Security & Service Quality While Ensuring Sustainability.

Strategies

1. Explore options for shelf-stable/frozen meals for emergencies and diverse dietary needs
    a. Integrate locally grown produce and culturally appropriate meals.
    b. Assess and address the feasibility of hot meal options for all frozen meal delivery routes.
2. Client Satisfaction & Feedback
    a. Create a uniform satisfaction survey to analyze strengths and weaknesses.
    b. Develop a system to gather feedback on HDM services from participants.
    c. Develop a strategy to transition short-term HDM recipients to congregate meals.
3. Health & Wellness
    a. Enhance the nutritional quality of HDM.
    b. Establish connections with MCOs to increase referrals for health and social services.
4. Ensure routinized schedule of reassessment occurs to ensure number of meals are still appropriate and discuss congregate options where feasible.
5. Data & Monitoring
    a. Reduce missing client data in the Older Americans Services Data Management System, and other data systems that integrate into this system, including AgingIS.
    b. Monitor meal provision and expenses to ensure adequate funding and prevent waitlists.
6. Funding sustainability:
    a. Develop strategies to address potential funding gaps including increasing local funding through local government including townships, villages, cities, and counties.

Outcomes

Short-term:	Increase variety in meals based on participant preference.
Short-term:	Establish relationships with owners of locally grown produce to increase nutritional value and palatability of meals.
Intermediate:	Develop a client evaluation form for home delivered meal participants.
Intermediate:	Conduct a satisfaction survey of HDM participants in the PSA.
Intermediate:	Increased number of participant assessments.
Long-Term:	Increased number of HDM participants transitioning to congregate dining.
Long-Term:	Elimination of wait lists on a sustained basis.
Long-Term:	Sustainable local revenue identified to fill funding gaps.

Title III-D Goals from Area Plans

Objective 2.9 Empower older adults to improve their health through meaningful and targeted evidence-based programming and services that represent the needs expressed by the local population.

Strategies

1. Promote evidence-based health and wellness programs through a variety of outreach methods and platforms.
2. Expand access to evidence-based programs by offering in additional locations and exploring community partnerships.

3. Ensure high-quality services are provided using evidence-based programs and trained facilitators.
4. Collect meaningful data and evaluate outcomes of programs to ensure they are effective and meeting the needs of older adults.
5. Increase the number of volunteer coaches.

Outcomes

Short-term:	Improved awareness of programs resulting from outreach.
Intermediate:	Increased number of evidence-based programs with multiple methods of participation.
Intermediate:	Evaluate data to improve existing programs and add new programs of interest to older adults.
Long-term:	Sustained increase in number of participants using evidence-based programs

TITLE VII ELDER JUSTICE & ADULT PROTECTIVE SERVICES

Objective 2.10 Increase program literacy among affected populations (caseworkers, mandated reporters, other service providers.

Strategies

1. Engage Aging network in a survey regarding self-reported areas of knowledge gaps, discomforts, and training needs.
2. Engage state partner agency (Division of Developmental Disability - DDD) to identify existing training resources.
3. Identify new training material needs working with DDD and create/deploy to network.
4. Conduct ongoing data collection around training needs to the network to frontline staff have the most up to date knowledge.

Outcomes

Short-Term:	Establish formal relationship with DDD through an IGA for data sharing.
Short-Term:	Increase Aging Network knowledge of working with the disability population.
Intermediate:	Deployment of existing DD trainings and establishment of new trainings based on findings.
Long Term:	Provide ongoing trainings based on continuous data collection to ensure that frontline staff are equipped to provide quality services to the DD population.

Objective 2.11 Increase public awareness of the APS program and reporting requirements.

Strategies

1. Complete a needs assessment with existing network partners to identify gaps and challenges when working with mandated reporters and other service providers.
2. Identify professional organizations for mandated reporters to disseminate informational materials regarding APS and reporting requirements.
3. Provide assurances that reporter identity is confidential and state statute indemnity provision to ensure mandated reporters feel comfortable reporting.
4. Work with RAAs in the 13 PSAs to create a comprehensive list of referred other service providers to ensure that there is an efficient and comprehensive line to connecting APS clients with services.
5. Further develop trade-specific materials outlining the APS program specific to where those professionals will likely contact with older adults and adults with disabilities who may be experiencing abuse.

6. Amend the abuse reporting process to indicate if the reporter is a mandated reporter to better understanding where there are lacks in reporting.

Outcomes

Short-Term:	Improved knowledge of the information needs for those who are mandated reporters and collaborative service providers.
Short-Term:	Better established connections with other service providers to ensure that up to date information is shared quickly and easily.
Intermediate:	Increase in intakes from mandated reporters of all professions.
Long-Term:	Widespread knowledge of the APS program and services that it can provide to both the client as well as other service providers.

Statewide Goal/Initiative #3: Increase public awareness and knowledge of caregiver needs, as well as resources and services available throughout the state of Illinois to promote increased caregiver engagement in person-centered, trauma informed, and evidence-based programs and services.

Objective 3.1 Engage in a campaign of proactive dissemination of materials and education.

Strategies:

1. Utilize direct outreach through home visits, nutrition programs and Adult Day sites.
2. Offer workshops and targeted training sessions for caregivers.
3. Participate in community events like health fairs, vendor fairs, and networking meetings.
4. Collaborate with other aging advocacy organizations.
5. Partner with non-traditional organizations to reach new populations.
6. Utilize various channels and multiple languages to conduct outreach.
7. Develop and distribute informative toolkits for community organizations.
8. Conduct media campaigns during National Family Caregiver Month and Older Americans' Month.
9. Coordinate efforts at the state and local level to support inter-generational programs and initiatives.

Objectives:

Short-term:	Increased number of caregivers accessing Aging Network supports and services as demonstrated by program reports and data collection.
Intermediate:	Develop and disseminate updated brochures identifying resources.
Intermediate:	Increased number of inter-generational programs and initiatives.
Long-term:	Identify accredited caregiver training resources and workshops to offer to caregivers through the AAAs.
Long-term:	Launch the Caregiver Portal on IDoA's website.

Objective 3.2 Address Specific Family Caregiver Needs.

Strategies

1. Address critical needs like transportation, home modifications, and legal assistance.
2. Address common family caregiver challenges such as social isolation, loneliness, burnout, and financial strain.
3. Offer a diverse range of services to meet the unique needs of individual caregivers.
4. Reduce caregiver burden by focusing on solutions that directly reduce the physical and emotional demands on caregivers.

5. Ensure a trauma-informed approach to recognize the potential for trauma in caregiving situations and providing services that are sensitive to these experiences.

Outcomes

Short-term: Increased caregiver utilization of services and programs.
Intermediate: Increased uptake of Trualta by AAAs.
Long-term: Integration of resources and data collection to streamline program evaluation.

Objective 3.3 Ensure a framework of supportive resources & networks are accessible to caregivers at the local and statewide level.

Strategies

1. Connect caregivers with support groups and peer-to-peer networks for emotional support and shared experiences.
2. Leverage existing relationships with key stakeholders to expand resources and networks that are person-centered.

Outcomes

Short-term: Increased number of caregiver utilization of support groups and networking.
Intermediate: Expand locations where caregiver resources are available through coordination with hospitals, long-term care facilities, physicians' offices and libraries.
Long-term: AAA and local level caregiver information available on Caregiver Portal.

Objective 3.4 Utilize a data-driven approach to evaluate caregiver programs.

Strategies

1. Utilizing TCARE assessments to identify gaps in caregiver services and inform referral decisions
2. Track and monitor participation in programs to evaluate the effectiveness of outreach efforts.
3. Conduct regular evaluations to assess the effectiveness of marketing strategies and make necessary adjustments.

Outcomes

Short-term: Increased caregiver participation in TCARE, Trualta, and evidence-based programs offered by the AAAs.
Intermediate: Conduct follow-up Statewide needs assessment to evaluate services.
Long-term: Increased integration of services offered by the Aging Network.

Objective 3.5 Develop and launch the Illinois Caregiver Assistance and Resource Portal.

Strategies

1. Identify existing caregiver resources that are crucial to creating a centralized and useful hub.
2. Collaborate with IDPH, HFS, DHS, DVA to link caregiver resources on the portal.
3. Continued networking with nationwide subject matter experts and peer learning collaboratives to identify best practices and strategies.
4. Explore viable options to maintain and update the Portal.

Outcomes

Short-term: Essential elements of Portal operational by June 1, 2026.
Intermediate: Secure adequate staffing and resources to maintain and update the Portal.
Long-term: Final Portal operational by July 1, 2027.

TITLE III-E GOALS FROM AREA PLANS

Objective 3.6 Improve Service Delivery and Caregiver satisfaction.

Strategies

1. Increase Accessibility & Utilization
    a. Increase participation in various programs (TCARE, support groups, counseling).
    b. Increase awareness of services through outreach and marketing.
    c. Reduce wait times for services.
    d. Increase the number of caregivers utilizing services.
2. Enhance Service Quality:
    a. Implement trauma-informed care training.
    b. Ensure caregiver support services are effective and meet needs.
    c. Improve accuracy and consistency of grantee reporting.
    d. Fully utilize gap-filling allocations.
3. Improve Client Satisfaction:
    a. Implement uniform satisfaction surveys.
    b. Gather client feedback to improve service design.

Outcomes

Short-term:	Improved data tracking and program evaluation.
Short-term:	Improved outreach and marketing in communities.
Intermediate:	Launch trauma informed training for caregivers.
Intermediate:	Increased number of caregivers accessing services and programs.
Long-term:	Optimized and integrated services that demonstrate reduce burden on caregivers and less intent to place in long-term care.

APPENDIX A: STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES

Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G) (i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—…

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual

or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

(5)

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

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

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

effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4)(A)(i) (I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas;

(5) provide assurances that the area agency on aging will coordinate planning,

identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) provide assurances that

(A) the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are

Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency; an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(B) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(C) an area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

- health and human services;
- land use;

- housing;
- transportation;
- public safety;
- workforce and economic development;
- recreation;
- education;
- civic engagement;
- emergency preparedness;
- protection from elder abuse, neglect, and exploitation;
- assistive technology devices and services; and
- any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2)(A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3)(A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and

assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and

containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with

existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited

English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on
(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27)(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, Cost of Administration of State Plans

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order…

Mary Killough, Director

September 16,2025

Date

APPENDIX B: INFORMATION REQUIREMENTS

Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (d) requires each State Plan must include a description of how greatest economic need and greatest social need are determined and addressed by specifying:

(1) How the State agency defines greatest economic need and greatest social need, which shall include the populations as set forth in the definitions of greatest economic need and greatest social need, as set forth in 45 CFR § 1321.3; and

(2) The methods the State agency will use to target services to such populations, including how OAA funds may be distributed to serve prioritized populations in accordance with requirements as set forth in 45 CFR § 1321.49 or 45 CFR § 1321.51, as appropriate.

"*Greatest economic need*" means "the need resulting from an income level at or below the Federal poverty level and as further defined by State and area plans based on local and individual factors, including geography and expenses" (45 CFR § 1321.3).

"*Greatest social need*" means the need caused by the following noneconomic factors as defined in 45 CFR § 1321.3.

A State agency's response must establish how the State agency will:

(1) identify and consider populations in greatest economic need and greatest social need;

(2) describe how they target the identified the populations for service provision;

(3) establish priorities to serve one or more of the identified target populations, given limited availability of funds and other resources;

(4) establish methods for serving the prioritized populations; and

(5) use data to evaluate whether and how the prioritized populations are being served.

RESPONSE

The state defines greatest economic need as "the need resulting from an income level at or below the poverty threshold established by the Bureau of the Census." To ensure services are provided to individuals with not just the greatest economic but also greatest social need, the state defines need as "being caused by noneconomic factors that restrict an individual's ability to perform normal daily tasks or that threaten their capacity to live independently.

The state and Area Agencies on Aging (AAAs) utilize several strategies to identify Illinois' older adults meeting these definitions are targeted for service provision including utilizing the Intrastate Funding Formula, conducting needs assessments in the PSAs in advance of preparing area plans, utilizing evidence-based programs that yield data and conducting robust outreach events in communities served through Older Americans Act programs. In addition to these strategies, the state and AAAs translate assessments, brochures, and educational materials to ensure individuals with limited English-speaking proficiency receive effective information concerning available services and supports in their communities.

In addition, Section 20-15(a) of the Data Governance and Organization to Support Equity and Racial Justice Act 20 ILCS 65/20-15(a)) requires Illinois Department on Aging (IDoA) to report statistical data on the racial, ethnic, age, sex, disability status, sexual orientation, gender identity, and primary or preferred language demographics of program participants for each major program the IDoA administers. The

Department has undertaken aggressive initiatives to collect this statistical data across programs to further the assurance that preference is given to those with the greatest economic and social need.

Native Americans: Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (g):

Demonstration that the determination of greatest economic need and greatest social need specific to Native American persons is identified pursuant to communication among the State age and Tribes, Tribal organizations, and Native communities, and that the services provided under this part will be coordinated, where applicable, with the services provided under Title VI of the Act and that the State agency shall require area agencies to provide outreach where there are older Native Americans in any planning and service area, including those living outside of reservations and other Tribal lands.

RESPONSE

On April 19, 2024, the U.S. Department of the Interior recognized the Prairie Band Potawatomi Nation as the first federally recognized tribal nation in the State of Illinois. The Potawatomi Nation is in the northwest corner of the State of Illinois, and as such is situated in PSA 1. The Department conducted initial outreach with Potawatomi leaders for purposes of recognizing their status as a tribal nation and to familiarize them with services provided under Title VI of the Older Americans Act.

Given the proximity of the Potawatomi Nation to the Chicago Metropolitan Statistical Area, the Department has also conducted initial outreach with the American Indian Health Services of Chicago to learn more about the current and future needs of indigenous older people including those with the greatest social and economic need.

Finally, the Northwestern Illinois Area Agency on Aging and City of Chicago Area Agency on Aging have incorporated strategies in their Area Plans to conduct outreach within their respective PSAs as the Potawatomi Nation develops a strategic plan during this State Plan cycle.

Activities to Increase Access and Coordination for Native American Older Adults

OAA Section 307(a)(21): The plan shall —

. . .

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

45 CFR § 1321.53:

(a) For States where there are Title VI programs, the State agency's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in § 1322.13(a), must explain how the State's aging network, including area agencies and service providers, will coordinate with Title VI programs to ensure compliance with sections 306(a)(11)(B) (42 U.S.C. 3026(a)(11)(B)) and 307(a)(21)(A) (42 U.S.C. 3027(a)(21)(A)) of the Act. State agencies may meet these requirements through a Tribal consultation policy that includes Title VI programs.

(b) The policies and procedures set forth in (a) of this provision must at a minimum

address:

(1) How the State's aging network, including area agencies on aging and service providers, will provide outreach to Tribal elders and family caregivers regarding services for which they may be eligible under Title III and/or VII;

(2) The communication opportunities the State agency will make available to Title VI programs, to include Title III and other funding opportunities, technical assistance on how to apply for Title III and other funding opportunities, meetings, email distribution lists, presentations, and public hearings;

(3) The methods for collaboration on and sharing of program information and changes, including coordinating with area agencies and service providers where applicable;

(4) How Title VI programs may refer individuals who are eligible for Title III and/or VII services;

(5) How services will be provided in a culturally appropriate and trauma-informed manner; and

(6) Opportunities to serve on advisory councils, workgroups, and boards, including area agency advisory councils, as set forth in § 1321.63.

RESPONSE

On April 19, 2024, the U.S. Department of the Interior recognized the Prairie Band Potawatomi Nation as the first federally recognized tribal nation in the State of Illinois. The Potawatomi Nation is in the northwest corner of the State of Illinois, and as such is situated in PSA 1. The Department conducted initial outreach with Potawatomi leaders for purposes of recognizing their status as a tribal nation and to familiarize them with services provided under Title VI of the Older Americans Act.

Given the proximity of the Potawatomi Nation to the Chicago Metropolitan Statistical Area, the Department has also conducted initial outreach with the American Indian Health Services of Chicago to learn more about the current and future needs of indigenous older people including those with the greatest social and economic need.

The Northwestern Illinois Area Agency on Aging and City of Chicago Area Agency on Aging have incorporated strategies in their Area Plans to conduct outreach within their respective PSAs as the Potawatomi Nation develops a strategic plan during this State Plan cycle.

The Department will ensure policies and procedures applicable to Native American Indians served under the Older Americans Act encompass outreach and education, technical assistance, referral processes, and opportunity to serve on commissions, councils and other workgroups throughout the Aging Network.

Low Income Minority Older Adults

OAA Section 307(a)(14):

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

RESPONSE

Based on the most recent data available (2017-2021 American Community Survey (ACS) Special Tabulation (Table S21014B)), there were an estimated over 2.8 million persons 60 years of age and older that reside in Illinois.

The number of low-income minority older individuals in the state represents 9.15% of the population age 60 and over; 5.31% of older individuals in the state speak English "not well" and "not at all".

Based on the most recent data available (2017-2021 ACS Special Tabulation; Table S21056), the number of low-income minority older individuals in the state is 109,982. Of these low-income minority older adults, 25,977 (23.6%) have limited English proficiency. The following table reflects the number of low-income minority older individuals with limited English proficiency:

60+ in Illinois	2,826,665	% of 60+ in Illinois
60+ Low Income	258,740	
60+ Low Income Minority (LIM)	109,982	
60+ LIM Speak English "not well"	16,513	.91%
60+ LIM Speak English "not at all"	9,464	

The State Plan describes the methods used to service the needs of low-income minority older individuals and those with limited English-speaking proficiency in the objectives and strategies section. The Department translates outreach materials in eleven (11) languages spoken in each PSA when distributing materials and translates surveys to older adults in multiple languages. In addition, the Department and AAAs utilize translation services to provide real time assistance to individuals reaching out by telephone.

Rural Areas – Hold Harmless

OAA Section 307(a)(3): The plan shall—

…

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE

The Illinois Department on Aging allocates Title III and State General Fund revenues appropriated for distribution to the thirteen Area Agencies on Aging based on a formula (Intrastate Funding Formula or IFF) in accordance with the Older Americans Act and its regulations. The IFF ensures that rural areas of the State will expend in future years no less than the amount expended for services in fiscal year 2000. In addition, through the IFF, the Department ensures preference is given to providing services to older individuals with the greatest economic and social need including but not limited to older individuals residing in rural areas of Illinois.

Below are projected costs of providing such services:

Estimated Title III Services Cost for Rural Population by Federal Fiscal Year					
Federal Fiscal Year	**Title III Funding**				
	B[1]	**C1[2]**	**C2**	**D**	**E**
2026	$1,939,991	$2,396,039	$1,853,439	$129,826	$952,871
2027[3]	$2,206,153	$2,724,770	$2,107,726	$147,638	$1,083,602
2028[3]	$2,259,962	$2,791,227	$2,159,134	$151,239	$1,110,031
2029[3]	$2,316,461	$2,861,008	$2,213,113	$155,020	$1,137,782

1. Title IIIB calculation is less IIIB Ombudsman allocation

2. Title III-C1 calculation is less IDoA Administrative Expenses

3. FFY27-FFY29 calculations consider a 1.79% increase in Rural Population based on OMB-Bulletin-23-01 and a 2.6% Cost of Living Increase each year.

Rural Areas – Needs and Fund Allocations

OAA Section 307(a)(10):

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

RESPONSE

The Illinois Department on Aging allocates Title III and State General Fund revenues appropriated for distribution to the thirteen Area Agencies on Aging based on a formula (Intrastate Funding Formula or IFF) in accordance with the Older Americans Act and its regulations. The IFF ensures that rural areas of the State will expend in future years no less than the amount expended for services in fiscal year 2000. In addition, through the IFF, the Department ensures preference is given to providing services to older individuals with the greatest economic and social need including but not limited to older individuals residing in rural areas of Illinois.

Assistive Technology

OAA Section 306(a)(6)(I):

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the area agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE

The Department has administered an assistive technology program "Illinois Care Connections" since August 2020. The program expanded to include eligibility for not only participants enrolled in the Community Care Program (CCP) but also non-CCP participants with a demonstrated need. Referring sources include all 13 Area Agencies on Aging (AAAs), CCP Care Coordinators, and Adult Day Service Providers. The Department distributes information about the program in collaboration with the AAAs through annual reports, educational initiatives in the local community, and on the website. Caregiver specialists at AAAs are also educated about the availability of assistive technology through the program.

Minimum Proportion of Funds

OAA Section 307(a)(2):

The plan shall provide that the State agency will —…

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

RESPONSE

The Department will maintain the minimum percentages for the three-year plan period. The following percentages will apply during FY 2026-2028:

Access	33.1%
In-Home	0.04%
Legal	3.02%

Although the percentage of Title III-B funds appears low compared to the number of older adults eligible for in-home services, these services are provided under the Persons Who Are Elderly 1915c Medicaid Waiver/Community Care Program. The Illinois Department on Aging is designated by the State Medicaid Agency to serve as the Operating Agency for the Waiver to ensure older adults are offered home and community-based services in lieu of institutional care. The CCP is funded through a combination of state and federal funding to provide waiver services including in-home care, adult day care, emergency home response services, and automated medication dispensing. The estimated state FY25 expenditures for the program are $1.4M.

Assessment of Statewide Service Delivery Model

OAA Section 307(a)(27):

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the

number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services

RESPONSE

Illinois' population is aging, and for the first time in our history, people aged 60 and older make up more than 23% of Illinois' total population with some rural areas of the state nearing almost 1/3 of their population being age 60 and older (US Census ACS, 2023). This is a significant change from 15 years ago when just under 17% of Illinois' population was 60 or older (US Census, ACS, 2008). Additionally, the number of persons 75 and older has also had a significant increase over the last 15 years, increasing to 6.7% of the Illinois' total population in 2023 from 5.9% in 2008 (US Census ACS, 2008 and 2023). According to the Administration for Community Living (ACL), most older adults do not live in a nursing home. An estimated 99% of persons aged 65-74, 97% of persons ages 75-84, and 92% of persons aged 85 and older live in the community demonstrating the importance of the home and community-based services provided under the umbrella of Illinois Aging Network (ACL, 2024). (See Chart 1, Appendix F). When looking at the state through the lens of older adults in greatest economic need, over the last 15 years, Illinois has seen an 82% increase in the number of older adults in poverty, going from 157,250 in 2008 to 286,453 statewide in 2023. Stated differently, in 2008, 7.23% of Illinois' older adults were living in poverty compared to 9.82% in 2023. (US Census ACS, 2008 and 2023). While all Planning and Service Areas (PSAs) saw an increase in older persons with greatest economic need from 2008 to 2023, PSAs 1 (105% increase), 2 (204% increase), and 13 (142% increase) had the largest growth in number of persons experiencing poverty.

Greatest social need numbers have also increased over time, with factors traditionally considered to illustrate greatest social need being minority status, age 75 and older, age 60 and older living alone, and age 60 and older living in rural areas. The new Older American Act rules have further defined persons in greatest social need to include (1) physical and mental disabilities; (2) language barriers; (3) cultural, social, or geographical isolation, including due to: (i) racial or ethnic status; (ii) Native American identity; (iii) religious affiliation; (iv) sexual orientation, gender identity, or sex characteristics; (v) HIV status; (vi) chronic conditions; (vii) housing instability, food insecurity, lack of access to reliable and clean water supply, lack of transportation, or utility assistance needs; (viii) interpersonal safety concerns; (ix) rural location; or (x) any other status that: (a) restricts the ability of an individual to perform normal or routine daily tasks; or (b) threatens the capacity of the individual to live independently; or (4) other needs as further defined by state and area plans based on local and individual level.

The Goals, Objectives, and Strategies section of this State Plan anticipate the growth in the number of older adults in the State, particularly those with the greatest social and greatest economic need. In May 2024, Governor Pritzker issued an Executive Order authorizing the Multi-Sector Plan for Aging (MPA) to

create a strategic plan that anticipates the growth and demand for long-term care supports and services. Situated within the Illinois Department on Aging, it is anticipated the MPA and State Plan will complement each other to address the future needs of older Illinoisans.

Shelf Stable, Pick-Up, Carry-Out, Drive-Through, or Similar Meals Using Title III Congregate Nutrition (C-1) Service Funding (Optional, only for States that elect to pursue this activity)

45 CFR § 1321.87(a)(1)(ii):

Title III C-1 funds may be used for shelf-stable, pick-up, carry-out, drive-through, or similar meals, subject to certain terms and conditions:

(A) Such meals must not exceed 25 percent of the funds expended by the State agency under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(B) Such meals must not exceed 25 percent of the funds expended by any area agency on aging under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(iii) Such meals are to be provided to *complement* the congregate meal program:

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

(B) To older individuals who have an occasional need for such meal; and/or

(C) To older individuals who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need; and

45 CFR § 1321.27 (j):

If the State agency allows for Title III, part C-1 funds to be used as set forth in §1321.87(a)(1)(i), the State agency must include the following:

(1) Evidence, using participation projections based on existing data, that provision of such meals will enhance and not diminish the congregate meals program, and a commitment to monitor the impact on congregate meals program participation;

(2) Description of how provision of such meals will be targeted to reach those populations identified as in greatest economic need and greatest social need;

(3) Description of the eligibility criteria for service provision;

(4) Evidence of consultation with area agencies on aging, nutrition and other direct services providers, other stakeholders, and the general public regarding the provision of such meals; and

(5) Description of how provision of such meals will be coordinated with area agencies on aging, nutrition and other direct services providers, and other stakeholders.

RESPONSE

During the COVID period from 2020 to 2022, when in person services were restricted, many congregate meal programs temporarily transitioned to a pickup or "Grab and Go" distribution method. Grab and Go benefits many older adults in the community that may not be able to attend a meal in the congregate setting due to scheduling challenges, health issues and/or household needs. During this time, more than one million Grab and Go meals were served statewide. Following the ending of the PHE, some nutrition providers have continued to offer Grab and Go meals as an option for participants, however overall Grab and Go meals has declined with only five of the thirteen areas in the state continuing to offer this option. From FY 2023 to FY 2024, Grab and Go Congregate meals saw a 79% decrease in the number of meals being served by this method. Overall, Grab and Go meals accounted for less than 1% of the meal service provision in FY 2024. The state anticipates a continual decline in Grab and Go

numbers as more individuals return to Congregate settings.
The following chart outlines the number of Congregate and Grab and Go meals over the last five fiscal years demonstrating a decrease in congregate meals during the pandemic and a gradual increase in congregate meals as sites opened back up. It also includes the number of Congregate Meals that were classified as Grab and Go since this became an alternative option for meal service delivery in FY 2023.

Table B-1: Congregate and Grab and Go Congregate Meals by Fiscal Year, FY 2020 to 2024

Fiscal Year	Total Congregate Meals	Grab and Go Congregate Meals
2020	942,793	0
2021	211,496	0
2022	756,084	0
2023	1,473,383	59,069
2024	1,859,945	12,327

Data from 2025 HDM Report. October 1, 2023-September 30, 2024, Report Date March 2025.

Illinois Department on Aging strongly encourages opportunities for socialization along with meal consumption; therefore, in order to be claimed as a Congregate Grab and Go meal the participant must be congregating at home, participating in in-person or virtual interaction in the home including one-to-one or group interaction arranged by the nutrition provider such as Google Meet, Zoom, FaceTime, or a similar program, or have participated in activities at the site prior to picking up a meal in order for the meal to be claimed as a Congregate meal.

In 2023, with the ending of the PHE, the Department provided guidance to the AAAs and direct service providers regarding the continued provision of Grab and Go meals. In addition, training was provided during the Department's quarterly Nutrition Advisory Council meeting and reporting tools were updated to allow for separate reporting of Grab and Go meals under both the Congregate and Home Delivered Meal programs.

When a participant expresses interest in Grab and Go meals, site nutrition staff provide them with the "Registration Form for Grab and Go Meals" and instructions which can be completed independently or by staff. Registration forms are completed on an annual basis or more often if there are significant changes in the participant's health or service needs.

AAAs are monitored annually for compliance. As part of the Title III-C monitoring, Department staff verify that AAAs have a policy in place to ensure nutrition providers are billing for Grab and Go meals based on Department guidelines (congregate vs HDM). The tool also evaluates whether AAAs have policies and procedures to ensure that service delivery and reporting are conducted in accordance with Department standards. In addition, AAAs are required to provide evidence that they are conducting required monitoring of their contracted nutrition providers either through on-site, desk review or a combination of methods to determine compliance with eligibility, service provision and reporting.

Funding Allocation – Ombudsman Program

45 CFR Part 1324, Subpart A:
How the State agency will coordinate with the State Long-Term Care Ombudsman and allocate and

use funds for the Ombudsman program under Title III and VII, as set forth in 45 CFR part 1324, subpart A.

RESPONSE
The state allocates funding for the Ombudsman program under Title III and VII as exception to the IFF for: Title III-B Ombudsman, Title III-D, Title VII Ombudsman, Title VII Elder Abuse, GRF for Community Based Equal Distribution, and GRF for Ombudsman. Title III-B Ombudsman and Title VII Ombudsman funds are distributed based on the number of LTC Licensed Beds in a PSA per an annual report from the Illinois Department of Public Health. For the GRF for Ombudsman funds, 50% of the funds are distributed using the number of LTC Licensed Beds in a PSA and 50% of the funds are distributed using the number of Licensed LTC Facilities in a PSA.

The Title III-D funds are distributed via a formula proposed by the 13 Area Agencies on Aging and accepted by the Department. The Title III-D formula is as follows: 60+ Population (20%), 60+ Poverty (30%), Percent 60+ Population by Weight (20%), and Percent 60+ Poverty by Weight (30%). The Title VII-Elder Abuse funds are distributed by a formula that provides $3,000 for every Multi-Disciplinary Team in a PSA and the remaining funds are distributed via the IFF. For any state GRF funds received that have no prescribed formula stated in the appropriation, the Department has the authority to determine the methodology to be used to distribute those funds.

The SUA works collaboratively with the State Ombudsman to support their advocacy, soliciting input and feedback in preparation of the State Plan and on other initiatives. Authorized by the Illinois Act on Aging (20 ILCS 105/4.04a), the Illinois Long-Term Care Council serves to ensure that consumers over the age of 60, or persons with a disability age 18-59, residing in facilities licensed or regulated under the Nursing Home Care Act, Skilled Nursing and Intermediate Care Facilities Code, Sheltered Care Facilities Code, and the Illinois Veterans' Homes Code receive high quality long-term care.

The Director of IDoA, as the Chair of the State's Long-Term Care Council, collaborates with the State Ombudsman to promote the Ombudsman office's state-wide initiatives, encourage feedback from members of the Council, and drive change in the long-term care setting. Members of the Council include AAAs, members of the General Assembly, and sister agencies including the State Medicaid Agency and Illinois Department of Public Health. In addition to leveraging the Council's activities to support the work of the State Ombudsman, IDoA works closely with the State Ombudsman as in 2013 their offices also expanded advocacy and representation to older adults and individuals with disabilities to the residential setting under the Home Care Ombudsman program.

Funding Allocation – Elder Abuse, Neglect, and Exploitation

45 CFR § 1321.27 (k):
How the State agency will allocate and use funds for prevention of elder abuse, neglect, and exploitation as set forth in 45 CFR part 1324, subpart B.

RESPONSE
IDoA's Adult Protective Services (APS) Program has jurisdiction to respond to reports of abuse, neglect, exploitation, and self-neglect of older adults and adults with disabilities aged 18-59 who live in a domestic setting. IDoA administers the statewide APS Program under the authority of the Adult Protective Service Act (320 ILCS 20/1 et.seq.) and 89 Ill. Admin. Code 270. IDoA is responsible for establishing, designing, and managing the program including, but not limited to developing policies,

training APS staff, performing quality assurance and analyzing program data. The program is coordinated through 36 contracted provider agencies which are designated by the 13 Regional Administrative Agencies (RAA) (AAAs serving as Regional Administrative Offices for APS) and IDoA. IDoA partners with the RAAs in providing technical assistance and monitoring service provision to APS provider agencies in their planning and service area.

APS provider agencies are responsible for receiving and investigating reports of abuse, exploitation, and self-neglect. The Office of Adult Protective Services engages with a variety of social service agencies to ensure a wholistic approach is taken in the client-centered case planning process. These referred services allow for the risk reported to be mitigated and ensure that the client may remain in the community, if safe to do so. Each APS provider agency has a specified geographic area within the state for which they are responsible for providing services. IDoA is required under the Persons Who are Elderly 1915(c) Waiver administered through the (Community Care Program) to ensure that systems and processes are in place to address situations of abuse, neglect, or financial exploitation (ANE) for waiver participants and participates in quarterly meetings with HFS to share information.

The State agency allocates funding to the RAAs under Title VII and through federal grants and general revenue funds. These funds are used to support technical assistance and monitoring responsibilities as well as public information/education and outreach, training, and assistance in program development. Activities include the participating in Department-sponsored advisory committees, coordinating Fatality Review Team meetings, supporting twenty-four-hour availability in receiving and responding to elder abuse reports, arranging for or providing elder rights related training, and participating in Multi-Disciplinary Teams funded under the Older Americans Act. Currently in Illinois, Title VII funding supports 38 Multi-Disciplinary Teams and 15 Fatality Review Teams throughout the state.

In addition to the duties noted above, the AAAs are required to develop an Elder Rights Plan, within their Area Plan, for each of their respective PSAs. The Elder Rights Plan summarizes how advocacy program activities will be incorporated into the overall home and community-based services system to support vulnerable older adults, adults with disabilities, and caregivers in the PSA. The AAAs must identify and prioritize the activities and services that will be supported through (1) the Adult Protective Services Program (APS), (2) Legal Assistance, (3) the Long-Term Care Ombudsman Programs, and (4) other benefit/insurance assistance, counseling, and outreach programming options. The goal is to enhance and protect the rights of older adults to support autonomy, independence, financial security, and personal wellbeing through a collaborative approach.

Monitoring of Assurances

45 CFR § 1321.27 (m):
Describe how the State agency will conduct monitoring that the assurances (submitted as Attachment A of the State Plan) to which they attest are being met.

RESPONSE
The State has developed an updated Manual for Monitoring of AAA activities together with revised tools, templates, and technical assistance instructions. In addition, the State has updated the monitoring procedures to ensure a robust review of AAA activities across all titles occurs during the three-year Area Plans and State Plan cycle.
The State's Adult Protective Services has developed extensive quality assurance and training programs that are used consistently to ensure the assurances under the State Plan are met.

The State utilizes data and a system of cross-divisional checks and balances to ensure the assurances set forth in this State Plan are met.

State Plans Informed By and Based on Area Plans

45 CFR § 1321.27 (c):
Evidence that the State Plan is informed by and based on area plans, except for single planning and service area States.

RESPONSE
The State analyzed and synthesized all 13 AAA Area Plans to ensure the State Plan was informed by and based on feedback from all AAAs. In addition, the State collaborated with the AAAs during statewide listening sessions for both the State Plan and to gather quantitative and qualitative data from caregivers. This feedback was also synthesized using a thematic analysis to fully capture and guide development of the statewide initiatives, goals, strategies, and outcomes.

Public Input and Review

45 CFR § 1321.29:
Describe how the State agency considered the views of older individuals, family caregivers, service providers and the public in developing the State Plan, and how the State agency considers such views in administering the State Plan. Describe how the public review and comment period was conducted and how the State agency responded to public input and comments in the development of the State Plan.

RESPONSE
The SUA held four listening sessions/public hearings from May 19 to May 28 together with the AAAs to gather feedback from older adults, family caregivers, service providers and the public. The recommendations are woven into the focus areas and statewide initiatives. In addition, the SUA based the goals, strategies, and objectives on data synthesized from the AAA's Area Plans. Three of the public hearings were in person (City of Chicago, Village of Lombard, City of Carbondale) while one virtual hearing was held/In-person public hearings were held in the northern and southern regions of the state to gather public feedback on the proposed State Plan. Designated representatives documented all comments during the hearings. In addition, one virtual hearing was held, with feedback documented in the State Plan. The SUA responded to all comments and posted the same on the public website.

Program Development and Coordination Activities (Optional, only for States that elect to pursue this activity)

45 CFR § 1321.27 (h):
Certification that any program development and coordination activities shall meet the following requirements:
(1) The State agency shall not fund program development and coordination activities as a cost of supportive services under area plans until it has first spent 10 percent of the total of its combined allotments under Title III on the administration of area plans;
(2) Program development and coordination activities must only be expended as a cost of State Plan administration, area plan administration, and/or Title III, part B supportive services;
(3) State agencies and area agencies on aging shall, consistent with the area plan and budgeting cycles, submit the details of proposals to pay for program development and

coordination as a cost of Title III, part B supportive services to the general public for review and comment; and

(4) Expenditure by the State agency and area agency on program development and coordination activities are intended to have a direct and positive impact on the enhancement of services for older persons and family caregivers in the planning and service area.

RESPONSE N/A

Legal Assistance Developer

45 CFR § 1321.27 (l):

How the State agency will meet responsibilities for the Legal Assistance Developer, as set forth in part 1324, subpart C.

RESPONSE

Illinois has employed a full-time Legal Assistance Developer (LAD) since 2018. The LAD plays a vital role with the State Ombudsman, Area Agencies on Aging (AAA), and APS program working closely to advocate for the legal rights of older adults and the Aging Network. Responsibilities of the LAD include but are not limited to working with the AAAs and Title III legal service providers to discuss emerging legal issues and changes in the laws and regulations related to the legal rights of adult; conducting research on matters governing the state's protective services programs and laws; identifying training needs among Title III legal service providers; identifying programs, problems, and issues to facilitate communication among AAAs, APS providers, and the law enforcement community. The LAD monitors legislation impacting the Aging Network and makes recommendations to improve the quality of OAA programs. In addition, the LAD works closely with the State Ombudsman as reflected in the Memorandum of Agreement commemorating their collaborative relationship.

Emergency Preparedness Plans – Coordination and Development

OAA Section 307(a)(28):

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE

The Illinois Emergency Management Agency (IEMA) is assigned the responsibility for coordination of the overall emergency management program for the state of Illinois.

The Illinois Emergency Operations Plan (IEOP) establishes the structure by which Illinois state government coordinates and manages response and recovery to emergencies and disasters. The IEOP provides policies, procedures and guidelines to ensure safe, efficient and timely actions to assist communities in need and incorporates supportive plans for response, recovery, continuity of operations and continuity of government.

The IEOP is developed in cooperation with the Office of the Governor, executive departments and agencies, the Illinois Terrorism Task Force (ITTF), non-governmental, mutual aid, private sector and volunteer organizations – a whole community approach. The IEOP, in its written form, serves to document the anticipated response and recovery efforts of the state to protect public health and safety, critical infrastructure and the environment.

The IEOP describes the Illinois Disaster Management System (IDMS) utilized by the state, which conforms to the National Incident Management System (NIMS). IDMS is used by all state government agencies when the IEOP is implemented for response or recovery operations in any part of the state affected by an emergency or disaster. The IEOP and IDMS identify and assign specific areas of responsibility for performing functions in response and recovery to an emergency or disaster.
During public health emergencies, such as COVID-19, the Illinois Department of Public Health (IDPH), Office of Preparedness and Response provides emergency response planning, training, exercise, emergency response and evaluation services to all IDPH programs, local public health departments, and the healthcare system.

IDoA works closely with the Illinois Emergency Management Agency (IEMA), IDPH and other participating State Agencies through interagency coordination with State Emergency Operations Center (SEOC) under the Illinois Emergency Management Act and the Illinois Emergency Operations Plan (IEOP) in responding to all natural and man-made disasters and public health emergencies. The Department continues to be a signatory of the IEOP, because of the complex needs that exist for frail older adults and the fact that the baby boomers are coming of age. The Department on Aging has a Disaster Coordinator who functions as a liaison and has a seat at the SEOC so the Department can advocate for seniors before, during and immediately after an event.

Emergency Preparedness Plans – Involvement of the head of the State agency

OAA Section 307(a)(29):
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE
IDoA's Director reviews and approves the Agency's emergency plan including the Continuity of Operations Plan that is submitted to IEMA. In addition, the Director approves the Agency's input and participation in the State Public Health Emergency Preparedness and Response Plan.

APPENDIX C: INTRASTATE FUNDING FORMULA (IFF)/FUNDS DISTRIBUTION PLAN

Intrastate Funding Formula

The Illinois Department on Aging allocates Title III and State General Revenue Funds appropriated for distribution to the thirteen (13) Area Agencies on Aging on a formula basis in accordance with the Older Americans Act and its regulations. Section 1321.37 (a) of the Older Americans Act regulations further requires the Department to "review and update its formula as often as a new State plan is submitted for approval." A new State Plan has been developed for federal FY 2026 through FY 2029.
Pursuant to the recent amendments to the Older Americans Act regulations, the Department reviewed the formula independently and in collaboration with the Area Agencies on Aging (AAA) to determine whether the formula should be updated in conjunction with the preparation of the 2026-2029 State Plan. Based on the needs assessments conducted by the AAAs and distribution of funding in each PSA that reaches individuals with the greatest economic and greatest social need the Department has decided not to change the intrastate funding formula at this time.

For purposes of the distribution of funds by the AAAs, **greatest economic** and **greatest social** needs are defined by:

(1) physical and mental disabilities; (2) language barriers; (3) cultural, social, or geographical isolation, including due to: (i) racial or ethnic status; (ii) Native American identity; (iii) religious affiliation; (iv) sexual orientation, gender identity, or sex characteristics; (v) HIV status; (vi) chronic conditions; (vii) housing instability, food insecurity, lack of access to reliable and clean water supply, lack of transportation, or utility assistance needs; (viii) interpersonal safety concerns; (ix) rural location; or (x) any other status that: (a) restricts the ability of an individual to perform normal or routine daily tasks; or (b) threatens the capacity of the individual to live independently; poverty; living alone.

Formula Goals and Assumptions

The goals to be achieved through the intrastate funding formula are as follows:

- To develop a formula consistent with the purpose and requirements of the OAA and its regulations.
- To provide resources across the state for home and community-based services for older persons over the age of 60.
- To target resources to areas of the State with higher concentrations of older persons in greatest economic and social need, with special emphasis on low-income minority older persons.
- To develop a formula that distributes resources solely on the population characteristics of each planning and service area and that will reflect changes in those characteristics among the PSAs as updated data become available.
- To develop a formula that is easily understood.

In reviewing the intrastate funding formula, certain assumptions were made about the formula, its factors, and the effect of the distribution of funds on the service delivery system across the State. Some of the major assumptions implicit in the review of the formula were:

- The weights assigned to the formula factors should represent the emphasis and priority placed on the specific characteristics of persons over the age of 60.
- Funding formula factors must be derived from data, which is quantifiable by planning and service area, be based on data from the Bureau of the Census and characterize at least five percent of the State's population 60 years of age and older.

- Older persons are currently receiving services based on existing historical patterns of service delivery. The effect on older persons presently receiving Title III services should be considered when developing and implementing a formula.
- The low revenue generating potential of rural areas and the high proportion of older persons in rural areas, including low-income older persons, necessitates a greater dependence on the Title III service system to meet the service needs of rural older persons. The funding formula should compensate for these factors.

Additional resources to PSAs with greater concentrations of older persons and older persons in greatest economic and social need will provide those Area Agencies with the necessary resources to implement additional targeting strategies at the regional level. It is the combination of federal, state, regional, and local targeting efforts that will implement this fundamental mandate of the Older Americans Act.

Funding Formula Definitions

Bureau of the Census means the Bureau of the Census, U.S. Department of Commerce.
Housing unit means a house, an apartment, a group of rooms, or a single room occupied as a separate living quarters.
Living alone means being the sole resident of a housing unit.
Minority group means those persons who identify themselves as belonging to a particular ethnic/racial grouping as classified by the Bureau of the Census.
PSA means a Planning and Service Area, which is designated by the Illinois Department on Aging and Illinois Act on the Aging.
Poverty threshold means the income cutoff, which determines an individual's poverty status as defined by the Bureau of the Census.
Rural area means a geographic location not within a Metropolitan Statistical Area (MSA) as defined by the Bureau of the Census.

Funding Formula Factors and Weights

For a particular factor to be included in the intrastate funding formula, it must:
Be derived from data which is quantifiable by PSA;
Be based on data which is derivable from the Bureau of the Census; and
Characterized at least 5 percent of the state's population 60 years of age and older.
The formula contains the following factors:
The number of the state's population 60 years of age and older in the PSAs as an indicator of need in general (60+ population).
The number of the state's population 60 years of age and older at or below the poverty threshold in the PSAs as an indicator of **greatest economic need** (GEN - 60+ Poverty).
As indicators of **greatest social need**, the number of the state's older adults in the PSAs who are:
a) 60-years of age and over and a member of a minority group (GSN - 60+ Minority);
b) 60-years of age and over and living alone (GSN - 60+ Living Alone); and
c) 75-years of age and over (GSN - 75+ Population).
The number of the state's population 60 years of age and older residing in rural areas of the PSAs as a means of assuring that the state will spend for each year of the State Plan, not less than the amount expended for such services for Fiscal Year 2000.
The funding formula factors are weighted as follows:
60+ Population 41.0%
Greatest Economic Need: (60+ Poverty) 25.0% **Greatest Social Need**: 25.0%

Greatest Social Need:
(60+ Minority - 10.0%)
(60+ Living Alone - 7.5%)
(75+ Population - 7.5%)
60+ Rural 9.0%

Application Of the Intrastate Funding Formula

Prior to distribution via the intrastate funding formula, up to 5% for state plan administration is deducted. Area agencies on aging use funds allocated to them through the intrastate funding formula for area plan administration and to fund minimum required expenditures for the Long-Term Care Ombudsman Program.

The intrastate funding formula is:
A= (.41 POP-60 + .25 POV-60 + .10 MIN-60 + .075 LA-60 + .075 POP-75 + .09 RUR-60) X (T)
Where:
A) A = Funding allocation from a specific source of funds to a particular PSA.
B) POP-60 = Percentage of the state's population within the particular PSA age 60 and older.
C) POV-60 = Percentage of the state's population within the particular PSA age 60 and older at or below the poverty threshold.
D) MIN-60 = Percentage of the state's population within the particular PSA age 60 and older and a member of a minority group.
E) LA-60 = Percentage of the state's population within the particular PSA age 60 and older and living alone.
F) POP-75 = Percentage of the state's population within the particular PSA age 75 and older.
G) RUR-60 = Percentage of the state's population within the particular PSA age 60 and older not residing in a MSA.
H) T = The total amount of funds appropriated from a specific source of funds.
The data used in the Intrastate Funding Formula reflects the most current and up-to-date information from the Bureau of the Census, including mid-census estimates when available.

Other Funding Formula Provisions

The only exceptions to the use of the Department's IFF are for the distribution of the following funds: Nutrition Services Incentive Program (NSIP), Title III-B Ombudsman, Title III-D, Title VII Ombudsman, Title VII Elder Abuse, GRF for Community Based Equal Distribution, and GRF for Ombudsman.

The NSIP amount allocated to each AAA is based on the AAA's percentage share of the previous fiscal year's final total number of NSIP meals provided multiplied by the total NSIP award received for the current fiscal year.

Title III-B Ombudsman and Title VII Ombudsman funds are distributed on the basis of the number of LTC Licensed Beds in a PSA per an annual report from the Illinois Department of Public Health. For the GRF for Ombudsman funds, 50% of the funds are distributed using the number of LTC Licensed Beds in a PSA and 50% of the funds are distributed using the number of Licensed LTC Facilities in a PSA.

The Title VII-Elder Abuse funds are distributed by a formula that provides $3,000 for every Multi-Disciplinary Team in a PSA and the remaining funds are distributed via the IFF. For any state GRF funds

received that have no prescribed formula stated in the appropriation, the Department has the authority to determine the methodology to be used to distribute those funds.

The Title III-D funds are distributed via a formula proposed by the 13 Area Agencies on Aging and accepted by the Department. According to information from the HRSA Data Warehouse, every PSA in Illinois contains at least one area that is medically underserved. The Title III-D formula focuses resources to those with the greatest social need and greatest economic need. The Title III-D formula is as follows:

> 60+ Population (20%), 60+ Poverty (30%), Percent 60+ Population by Weight (20%), and Percent 60+ Poverty by Weight (30%).

As a numerical statement, the intrastate funding formula for Title III-D is:
A= (.20 POP-60 + .30 POV-60 + .20 POPW-60 + .30 POVW-60) X (T)
Where:
A) A = Funding allocation from a specific source of funds to a particular PSA.
B) POP-60 = Percentage of the state's population within the particular PSA age 60 and older.
C) POV-60 = Percentage of the state's population within the particular PSA age 60 and older at or below the poverty threshold.
D) POPW-60 = Percentage of the state's population within the particular PSA age 60 and older by weight.
E) POVW-60 = Percentage of the state's population within the particular PSA age 60 and older at or below the poverty threshold by weight.
H) T = The total amount of funds appropriated from a specific source of funds.
The data used in the Intrastate Funding Formula reflects the most current and up-to-date information from the Bureau of the Census, including mid-census estimates when available.

Whenever the Director determines that any amount allotted to an Area Agency on Aging for a fiscal year under this formula will not be used by such Area Agency on Aging for carrying out the purposes for which the allotment was made, the Director may, in accordance with this subsection, make such allotment available for carrying out such purpose to one or more other Area Agencies on Aging to the extent the Director determines that such other Area Agencies on Aging will be able to use such additional amount for carrying out such purpose. Funds will be reallotted to those Area Agencies on Aging, which request and demonstrate the need for additional funds in accordance with procedures developed by the Department. Any reallotment amount made available to an Area Agency on Aging from an appropriation for a fiscal year in accordance with the preceding sentence shall, for the purposes of this title, be regarded as part of such Area Agency's allotment for such year and shall remain available only until the end of that fiscal year. Funds available for reallotment will be:

Those in excess of an Area Agency's allowable carryover amount determined by the financial closeout of the Fiscal Year;
Those carryover funds available to an Area Agency on Aging determined by the financial closeout of the Fiscal Year but not requested by an Area Agency on Aging; and
Those funds offered to the Department for reallotment by an Area Agency on Aging.
If the Director finds that any Area Agency on Aging has failed to qualify under the Area Plan requirements of the Older Americans Act, or Section 230.140 of the Department's administrative rules, the Director may withhold the allotment of funds to such Area Agency on Aging. The Director shall direct the disbursement of the funds so withheld directly to any qualified public or private nonprofit institution or organization, agency, or political subdivision in order to ensure continuity of services pursuant to Section 230.145 of the Department's administrative rules.

The allotment to an Area Agency on Aging may be reduced by the amount of any disallowance if that Area Agency on Aging has expended funds allocated under this Part:

For purposes which an audit report determines to be questionable costs which are deemed disallowed by the Department;
For purposes which an audit report determines to be unallowable; or
For purposes that are otherwise determined to be unallowable according to cost principles contained in applicable OMB Circulars or the approved grant/contract award.
This reduction will occur in the Fiscal Year following the identification of the disallowance.
If an Area Agency on Aging does not expend the required minimum percentage of their Title III-B allocation on access services, in-home services, and legal services as established by the Department, pursuant to the Older Americans Act in a Fiscal Year as determined by the financial closeout report, and no waiver of the requirement has been granted by the Department for that Fiscal Year, the Area Agency on Aging must, for the next fiscal year following the submission of their report, expend the minimum percentage in the reported year. If the Area Agency on Aging does not expend the required expenditure amount, it may be withheld from the Area Agency on Aging during the Fiscal Year following the Fiscal Year in which the shortage is determined.

Table C-1: Federal Planning Allocations for FFY 2025

	TITLE III							TITLE VII		
PSA	B ($)	B Ombuds ($)	C1 ($)	C2 ($)	D ($)	E ($)	TOTAL ($)	Elder Abuse* ($)	Ombuds* ($)	TOTAL ($)
01	809,700	41,505	1,109,313	840,537	51,023	428,578	**3,280,656**	17,225	47,005	**64,230**
02	2,596,223	159,216	3,556,902	2,695,099	171,142	1,374,193	**10,552,775**	34,152	176,288	**210,440**
03	668,489	33,592	915,849	693,948	48,198	353,834	**2,713,910**	7,402	38,435	**45,837**
04	386,065	31,510	528,920	400,768	32,854	204,346	**1,584,463**	5,753	36,007	**41,760**
05	892,614	51,707	1,222,907	926,608	55,165	472,465	**3,621,466**	24,209	59,987	**84,196**
06	216,352	9,509	296,408	224,592	13,650	114,516	**875,027**	4,762	12,332	**17,094**
07	571,325	32,898	782,731	593,083	40,479	302,405	**2,322,921**	15,834	37,624	**53,458**
08	649,056	44,697	889,225	673,775	48,763	343,548	**2,649,064**	7,288	50,310	**57,598**
09	250,035	12,771	342,556	259,558	13,085	132,345	**1,010,350**	4,959	15,849	**20,808**
10	217,647	8,676	298,183	225,936	16,286	115,202	**881,930**	4,771	11,441	**16,212**
11	404,202	17,560	553,769	419,596	28,806	213,946	**1,637,879**	5,858	21,084	**26,942**
12	2,870,874	98,487	3,933,182	2,980,209	241,556	1,519,567	**11,643,875**	26,253	109,461	**135,714**
13	2,422,624	151,929	3,319,065	2,514,888	180,369	1,282,306	**9,871,181**	38,637	166,364	**205,001**
TOTAL	**12,955,206**	**694,057**	**17,749,010**	**13,448,597**	**941,376**	**6,857,251**	**52,645,497**	**197,103**	**782,187**	**979,290**

* Includes amounts for Fatality Review Teams (see Table C-19)

Table C-2: Award Information by Federal Fund Category, FFY 2025

	Title III						Title VII		
TITLE	**B ($)**	**C1 ($)**	**C2 ($)**	**D ($)**	**E ($)**	**TOTAL ($)**	**Elder Abuse* ($)**	**Ombuds* ($)**	**TOTAL ($)**
FY 2025 Funds	14,393,516	19,770,580	13,448,597	941,376	6,857,251	**55,411,320**	197,103	782,187	**979,290**
— IDoA Admin./Adv.	744,253	2,021,570	-	-	-	**2,765,823**	9,855	39,109	**48,964**
= Distribution	**13,649,263**	**17,749,010**	**13,448,597**	**941,376**	**6,857,251**	**52,645,497**	**197,103**	**782,187**	**979,290**

* IDoA Administrative/Advocacy funds will be redistributed to the Area Agencies on Aging to fund Fatality Review Teams rather than retained by the Department.

Table C-3: State Planning Allocations, FFY25

	Planning & Service Grant								Fund Totals		
PSA	Title III Adm Match ($)	Title III Service Match ($)	Community Based Services ($)	Total PSG[1] ($)	HDM ($)	Caregiver Support Services ($)	Community Based Services[2] ($)	LTC Ombuds ($)	State Only ($)	Federal Only ($)	Federal & State ($)
01	109,327	40,481	824,598	974,406	3,456,250	329,613	134,708	199,950	5,094,927	3,344,886	8,439,813
02	351,672	128,672	2,643,992	3,124,336	11,082,120	1,056,870	134,708	671,700	16,069,734	10,763,215	26,832,949
03	90,550	33,131	680,788	804,469	2,853,480	272,128	134,708	155,999	4,220,784	2,759,747	6,980,531
04	52,821	18,607	393,169	464,597	1,647,940	157,159	134,707	147,750	2,552,153	1,626,223	4,178,376
05	120,734	44,414	909,037	1,074,185	3,810,170	363,365	134,708	249,750	5,632,178	3,705,662	9,337,840
06	29,131	10,898	220,333	260,362	923,510	88,072	134,707	50,250	1,456,901	892,121	2,349,022
07	77,389	28,315	581,837	687,541	2,438,730	232,575	134,708	174,750	3,668,304	2,376,379	6,044,683
08	88,269	31,817	660,998	781,084	2,770,530	264,217	134,708	218,850	4,169,389	2,706,662	6,876,051
09	33,693	12,568	254,636	300,897	1,067,290	101,784	134,707	66,450	1,671,128	1,031,158	2,702,286
10	29,481	10,787	221,652	261,920	929,040	88,600	134,707	45,600	1,459,867	898,142	2,358,009
11	54,576	20,208	411,640	486,424	1,725,360	164,543	134,708	91,650	2,602,685	1,664,821	4,267,506
12	388,172	142,987	2,923,696	3,454,855	12,254,480	1,168,673	134,708	359,101	17,371,817	11,779,589	29,151,406
13	329,034	119,191	2,467,199	2,915,424	10,341,100	986,201	134,708	568,200	14,945,633	10,076,182	25,021,815
TOTAL	**1,754,849**	**642,076**	**13,193,575**	**15,590,500**	**55,300,000**	**5,273,800**	**1,751,200**	**3,000,000**	**80,915,500**	**53,624,787**	**134,540,287**

1. PSG stands for Planning and Service Grant
2. For equal distribution among Area Agencies on Aging

Table C-4: Planning & Service Grants for State Initiatives, FFY25

PSA	Total Planning & Service Grant Funds for State Initiatives ($)
01	125,000
02	400,800
03	103,200
04	59,600
05	137,800
06	33,400
07	88,200
08	100,200
09	38,600
10	33,600
11	62,400
12	443,200
13	374,000
TOTAL	**2,000,000**

Table C-5: Nutrition Services Incentive Program Planning Allocations, FFY25

	FFY23				FFY24
PSA	Congregate Meals	Home-Delivered Meals	Total Meals	Percent of Meals	NSIP Allocation ($)
01	64,960	654,132	719,092	5.77%	**340,049**
02	106,001	1,124,556	1,230,557	9.88%	**581,912**
03	64,403	454,502	518,905	4.16%	**245,383**
04	7,499	303,224	310,723	2.49%	**146,937**
05	175,531	689,144	864,675	6.94%	**408,893**
06	37,604	136,512	174,116	1.40%	**82,337**
07	69,462	385,080	454,542	3.65%	**214,947**
08	99,466	656,656	756,122	6.07%	**357,560**
09	30,426	176,167	206,593	1.66%	**97,695**
10	62,634	162,741	225,375	1.81%	**106,577**
11	146,573	353,462	500,035	4.01%	**236,460**
12	437,749	3,984,722	4,422,471	35.49%	**2,091,324**
13	165,254	1,911,215	2,076,469	16.67%	**981,932**
TOTAL	**1,467,562**	**10,992,113**	**12,459,675**	**100.00%**	**5,892,006**

Table C-6: Area Agency on Aging Title III Area Plan Administration & Advocacy Calculation, FFY25

Title III Award Amount from Administration & Advocacy	$55,411,320
(Less IDoA Title III Administration Activities)	*($2,765,823)*
Title III Award Amount Distributed to AAAs	$52,645,497
Maximum AAA Title III Administration Activities (10%)	***$5,264,549***

	Title III			
PSA	**Distribution ($)**	**Percent of Funds Distributed**	**AAA Admin ($)**	**Maximum Admin for Direct Services ($)**
01	3,280,656	6.23%	327,981	1,244,554
02	10,552,775	20.04%	1,055,016	3,939,589
03	2,713,910	5.16%	271,651	1,029,630
04	1,584,463	3.01%	158,463	620,499
05	3,621,466	6.88%	362,201	1,376,792
06	875,027	1.66%	87,392	351,841
07	2,322,921	4.41%	232,167	894,336
08	2,649,064	5.03%	264,807	1,016,682
09	1,010,350	1.92%	101,079	403,876
10	881,930	1.68%	88,444	352,325
11	1,637,879	3.11%	163,727	632,789
12	11,643,875	22.12%	1,164,517	4,264,525
13	9,871,181	18.75%	987,103	3,668,191
TOTAL	**52,645,497**	**100.00%**	**5,264,548**	**19,795,629**

Table C-6: Area Agency on Aging Title VII Area Plan Administration & Advocacy Calculation, FFY25

Title VII Award Amount from Administration & Advocacy	979,290
(Less IDoA Title VII Administration Activities)	*(48,964)*
Title VII Award Amount Distributed to AAAs	930,326
Maximum AAA Title VII Administration Activities (10%)	**93,032**

	Title VII		
PSA	**Distribution* ($)**	**Distribution Less Fatality Review Team Amounts ($)**	**AAA Direct Advocacy Activities ($)**
01	64,230	61,014	6,101
02	210,440	203,141	20,314
03	45,837	42,745	4,275
04	41,760	38,919	3,892
05	84,196	78,406	7,841
06	17,094	14,403	1,440
07	53,458	50,452	5,045
08	57,598	54,524	5,452
09	20,808	18,087	1,809
10	16,212	13,519	1,352
11	26,942	24,085	2,409
12	135,714	130,674	13,067
13	205,001	200,357	20,035
TOTAL	**979,290**	**930,326**	**93,032**

* Includes amounts for Fatality Review Teams

Table C-8: Number of Licensed Long-Term Care Facility Beds by Planning and Service Area, FFY25

	Licensed Beds			Long-Term Care Facilities	
PSA	Number of Beds	% of Total State Beds	Minimum Program Staff*	Number of Facilities	% of Total State Facilities
01	8,631	5.98%	4.3	119	7.35%
02	33,088	22.94%	16.5	354	21.84%
03	6,980	4.84%	3.5	90	5.56%
04	6,548	4.54%	3.3	86	5.31%
05	10,743	7.45%	5.4	149	9.20%
06	1,974	1.37%	1.0	32	1.98%
07	6,843	4.74%	3.4	112	6.91%
08	9,287	6.44%	4.6	132	8.15%
09	2,650	1.84%	1.3	42	2.59%
10	1,798	1.25%	0.9	29	1.79%
11	3,654	2.53%	1.8	58	3.58%
12	20,471	14.19%	10.2	158	9.75%
13	31,579	21.89%	15.8	259	15.99%
TOTAL	**144,246**	**100.00%**	**72.0**	**1,620**	**100.00%**

* Based on current paid staffing levels (1 FTE per 2,000 beds)

Table C-9: Title VII Elder Abuse Worksheet, FFY25

PSA	Multidisciplinary Team Sites	Amount for Multidisciplinary Team(s)* ($)	Amount per IFF ($)	Elder Abuse Allocation ($)
01	4	12,000	4,578	16,578
02	6	18,000	14,679	32,679
03	1	3,000	3,780	6,780
04	1	3,000	2,183	5,183
05	6	18,000	5,047	23,047
06	1	3,000	1,223	4,223
07	4	12,000	3,230	15,230
08	1	3,000	3,670	6,670
09	1	3,000	1,414	4,414
10	1	3,000	1,231	4,231
11	1	3,000	2,285	5,285
12	3	9,000	16,231	25,231
13	8	24,000	13,697	37,697
TOTAL	**38**	**114,000**	**73,248**	**187,248**

* For Title VII: Elder Abuse, Multidisciplinary Teams receive $3,000 per team. Therefore, Amount in Table C-9 is calculated by taking the number of teams in each PSA multiplied by $3,000.

Table C-10: Title III-D Allocations, FFY25

PSA	% of Persons 60+ By				Title III-D Weight*	Title III-D Allocation ($)
	Total State Population	Total State Population in Poverty	Total State Population, by Weight*	Total State Population in Poverty, by Weight*		
01	5.80%	4.91%	7.14%	4.52%	5.42%	51,023
02	25.54%	16.78%	18.02%	14.79%	18.18%	171,142
03	4.32%	4.03%	9.69%	3.71%	5.12%	48,198
04	3.58%	3.28%	4.41%	3.02%	3.49%	32,854
05	6.54%	5.87%	5.87%	5.40%	5.86%	55,165
06	1.12%	1.22%	2.52%	1.18%	1.45%	13,650
07	4.07%	3.83%	6.39%	3.53%	4.30%	40,479
08	5.57%	5.07%	5.73%	4.66%	5.18%	48,763
09	1.30%	1.26%	2.04%	1.16%	1.39%	13,085
10	1.12%	1.19%	4.12%	1.09%	1.73%	16,286
11	2.49%	3.02%	3.91%	2.92%	3.06%	28,806
12	17.66%	31.01%	8.66%	36.98%	25.66%	241,557
13	20.89%	18.53%	21.50%	17.04%	19.16%	180,369
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**941,377**

* FY2025 Title III-D Allocations Funding is being distributed utilizing the following formula to determine Factor Weight:

- 60+ Population- 20%
- 60+ Poverty-30%
- % 60+ Pop by Weight- 20%
- % 60+ Poverty by Weight-30%

These weights are multiplied by the percentages in the table to calculate the Title III-D Weights for each PSA. The Title III-D Weights are then multiplied by the Title III-D distributive amount to calculate each PSA's allocation. This formula uses the Office Management and Budget definition of poverty for the 60+ Poverty factor and the % 60+ Poverty by Weight factor

Table C-11: Demographic Characteristics and Population Divided by Poverty Percentages, by Planning and Service Area for FFY25

		Persons 60+ By					
PSA	Total Population	Population	Poverty	% Population	% of Persons in Poverty	Population/ Weight*	Poverty/ Weight*
01	662,216	167,144	13,396	25.24%	8.01%	32,773	638
02	3,461,719	735,864	45,731	21.26%	6.21%	82,681	2,088
03	457,249	124,551	10,987	27.24%	8.82%	44,483	523
04	401,702	103,235	8,944	25.70%	8.66%	20,242	426
05	809,124	188,538	16,012	23.30%	8.49%	26,934	762
06	115,626	32,350	3,330	27.98%	10.29%	11,554	167
07	440,872	117,250	10,453	26.60%	8.92%	29,313	498
08	655,150	160,373	13,809	24.48%	8.61%	26,291	658
09	143,892	37,524	3,441	26.08%	9.17%	9,381	164
10	114,514	32,106	3,206	28.04%	9.99%	18,886	153
11	270,203	71,719	8,231	26.54%	11.48%	17,930	412
12	2,721,914	508,887	84,545	18.70%	16.61%	39,757	5,219
13	2,503,453	602,017	50,511	24.05%	8.39%	98,691	2,405
TOTAL	**12,757,634**	**2,881,558**	**272,596**	**22.59%**	**9.46%**	**458,916**	**14,113**

* FY2025 Title III-D Allocations Funding is being distributed utilizing the following formula to determine Factor Weight:

- 60+ Population- 20%
- 60+ Poverty-30%
- % 60+ Pop by Weight- 20%
- % 60+ Poverty by Weight-30%

These weights are multiplied by the percentages in the table to calculate the Title III-D Weights for each PSA. The Title III-D Weights are then multiplied by the Title III-D distributive amount to calculate each PSA's allocation. This formula uses the Office Management and Budget definition of poverty for the 60+ Poverty factor and the % 60+ Poverty by Weight factor

Table C-12: Percentage of Persons 60+ by Demographic Characteristics, Weighted Population, and Poverty Amounts, FFY25

		60+ Population By					
PSA	% Total State Population	% of Total State Population	% of Persons in Poverty	Population Weight*	Poverty Weight*	% of Population by Weight*	% of Poverty by Weight*
01	5.19%	5.80%	4.91%	5.10	21.00	7.14%	4.52%
02	27.12%	25.54%	16.78%	8.90	21.90	18.02%	14.79%
03	3.58%	4.32%	4.03%	2.80	21.00	9.69%	3.71%
04	3.15%	3.58%	3.28%	5.10	21.00	4.41%	3.02%
05	6.34%	6.54%	5.87%	7.00	21.00	5.87%	5.40%
06	0.91%	1.12%	1.22%	2.80	20.00	2.52%	1.18%
07	3.46%	4.07%	3.83%	4.00	21.00	6.39%	3.53%
08	5.14%	5.57%	5.07%	6.10	21.00	5.73%	4.66%
09	1.13%	1.30%	1.26%	4.00	21.00	2.04%	1.16%
10	0.90%	1.12%	1.19%	1.70	21.00	4.12%	1.09%
11	2.12%	2.49%	3.02%	4.00	20.00	3.91%	2.92%
12	21.34%	17.66%	31.01%	12.80	16.20	8.66%	36.98%
13	19.62%	20.89%	18.53%	6.10	21.00	21.50%	17.04%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**8.00**	**21.00**	**100.00%**	**100.00%**

* FY2025 Title III-D Allocations Funding is being distributed utilizing the following formula to determine Factor Weight:

- 60+ Population- 20%
- 60+ Poverty-30%
- % 60+ Pop by Weight- 20%
- % 60+ Poverty by Weight-30%

These weights are multiplied by the percentages in the table to calculate the Title III-D Weights for each PSA. The Title III-D Weights are then multiplied by the Title III-D distributive amount to calculate each PSA's allocation. This formula uses the Office Management and Budget definition of poverty for the 60+ Poverty factor and the % 60+ Poverty by Weight factor

Table C-13: Demographic Characteristics of Older Person from 2022 Population Estimates & 2022 American Community Survey 5-Year Estimated Poverty

			Greatest Social Need			
PSA	**60+ Population**	**60+ Poverty**	**60+ Minority**	**75+ Population**	**60+ Living Alone**	**60+ Rural**
01	167,144	13,396	19,440	51,826	42,645	65,896
02	735,864	45,731	160,300	206,769	149,005	-
03	124,551	10,987	10,374	39,821	34,190	68,080
04	103,235	8,944	8,953	32,248	27,675	-
05	188,538	16,012	18,390	58,197	50,820	64,765
06	32,350	3,330	1,226	10,844	8,835	30,913
07	117,250	10,453	7,605	36,067	32,775	45,680
08	160,373	13,809	24,813	47,131	42,540	12,642
09	37,524	3,441	1,588	11,768	10,160	37,524
10	32,106	3,206	986	10,726	8,990	32,106
11	71,719	8,231	5,485	22,705	21,400	37,357
12	508,887	84,545	336,055	149,789	154,105	-
13	602,017	50,511	193,784	180,734	141,555	-
Total	**2,881,558**	**272,596**	**788,999**	**858,625**	**724,695**	**394,963**

Table C-14: Planning and Service Area by Percentage of Demographic Categories, 2022 Population Estimates & 2022 American Community Survey 5-year Estimated Poverty

			Greatest Social Need				
PSA	**60+ Population**	**60+ Poverty**	**60+ Minority**	**75+ Population**	**60+ Living Alone**	**60+ Rural**	**IFF* Weight**
01	5.80%	4.91%	2.46%	6.04%	5.88%	16.68%	6.25%
02	25.54%	16.78%	20.32%	24.07%	20.56%	0.00%	20.04%
03	4.32%	4.03%	1.31%	4.64%	4.72%	17.23%	5.16%
04	3.58%	3.28%	1.13%	3.76%	3.82%	0.00%	2.98%
05	6.54%	5.87%	2.33%	6.78%	7.01%	16.40%	6.89%
06	1.12%	1.22%	0.17%	1.26%	1.23%	7.83%	1.67%
07	4.07%	3.83%	0.96%	4.20%	4.52%	11.57%	4.41%
08	5.57%	5.07%	3.14%	5.49%	5.87%	3.20%	5.01%
09	1.30%	1.26%	0.20%	1.37%	1.40%	9.50%	1.93%
10	1.12%	1.19%	0.13%	1.25%	1.25%	8.13%	1.68%
11	2.49%	3.02%	0.70%	2.64%	2.95%	9.46%	3.12%
12	17.66%	31.01%	42.59%	17.45%	21.26%	0.00%	22.16%
13	20.89%	18.53%	24.56%	21.05%	19.53%	0.00%	18.70%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

* Stands for Intrastate Funding Formula.

Table C-15: Demographic Characteristics of Older Persons, 2021 Population Estimate & 2021 American Community Survey 5-Year Estimated Poverty

			Greatest Social Need			
PSA	**60+ Population**	**60+ Poverty**	**60+ Minority**	**75+ Population**	**60+ Living Alone**	**60+ Rural**
01	164,248	12,159	18,576	49,358	41,280	65,637
02	714,176	43,058	151,890	193,056	146,265	-
03	123,650	10,152	10,095	38,992	33,910	67,378
04	101,481	8,482	8,649	31,235	26,465	-
05	185,686	15,808	17,588	55,928	50,060	63,980
06	31,970	2,774	1,142	10,800	8,330	30,527
07	114,696	9,022	7,290	34,827	31,760	44,419
08	158,647	13,559	24,211	45,713	41,395	12,137
09	37,429	3,343	1,596	11,619	9,645	37,429
10	31,614	3,024	882	10,239	9,005	31,614
11	71,094	7,918	5,210	21,949	20,095	36,943
12	498,445	80,683	326,097	142,387	148,350	-
13	593,499	48,775	193,247	176,345	137,840	-
Total	**2,826,635**	**258,757**	**766,473**	**822,448**	**704,400**	**390,064**

Table C-16: Percentage of Demographic Characteristics, by Planning and Service Area

			Greatest Social Need				
PSA	**60+ Population**	**60+ Poverty**	**60+ Minority**	**75+ Population**	**60+ Living Alone**	**60+ Rural**	**IFF Weight**
01	5.81%	4.70%	2.42%	6.00%	5.86%	16.83%	6.20%
02	25.27%	16.64%	19.81%	23.47%	20.76%	0.00%	19.82%
03	4.37%	3.92%	1.32%	4.74%	4.81%	17.27%	5.17%
04	3.59%	3.28%	1.13%	3.80%	3.76%	0.00%	2.97%
05	6.57%	6.11%	2.29%	6.81%	7.11%	16.40%	6.97%
06	1.13%	1.07%	0.15%	1.31%	1.18%	7.83%	1.64%
07	4.06%	3.49%	0.95%	4.23%	4.51%	11.39%	4.31%
08	5.61%	5.24%	3.16%	5.57%	5.88%	3.11%	5.06%
09	1.32%	1.29%	0.21%	1.41%	1.37%	9.60%	1.96%
10	1.12%	1.17%	0.12%	1.24%	1.28%	8.10%	1.68%
11	2.52%	3.06%	0.68%	2.67%	2.85%	9.47%	3.14%
12	17.63%	31.18%	42.55%	17.31%	21.06%	0.00%	22.16%
13	21.00%	18.85%	25.21%	21.44%	19.57%	0.00%	18.92%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Table C-17: Demographic Characteristics of Older Persons, by Increase/Decrease from 2021 to 2022 American Community Survey 5-Year Population Estimates

			Greatest Social Need			
PSA	**60+ Population**	**60+ Poverty**	**60+ Minority**	**75+ Population**	**60+ Living Alone**	**60+ Rural**
01	2,896	1,237	864	2,468	1,365	259
02	21,688	2,673	8,410	13,713	2,740	-
03	901	835	279	829	280	702
04	1,754	462	304	1,013	1,210	-
05	2,852	204	802	2,269	760	785
06	380	556	84	44	505	386
07	2,554	1,431	315	1,240	1,015	1,261
08	1,726	250	602	1,418	1,145	505
09	95	98	**(8)**	149	515	95
10	492	182	104	487	**(15)**	492
11	625	313	275	756	1,305	414
12	10,442	3,862	9,958	7,402	5,755	-
13	8,518	1,736	537	4,389	3,715	-
TOTAL	**54,923**	**13,839**	**22,526**	**36,177**	**20,295**	**4,899**

Table C-18: Change in Percentage of Demographic Characteristics of Older Persons, by Increase/Decrease from 2021 to 2022 American Community Survey 5-Year Population Estimates

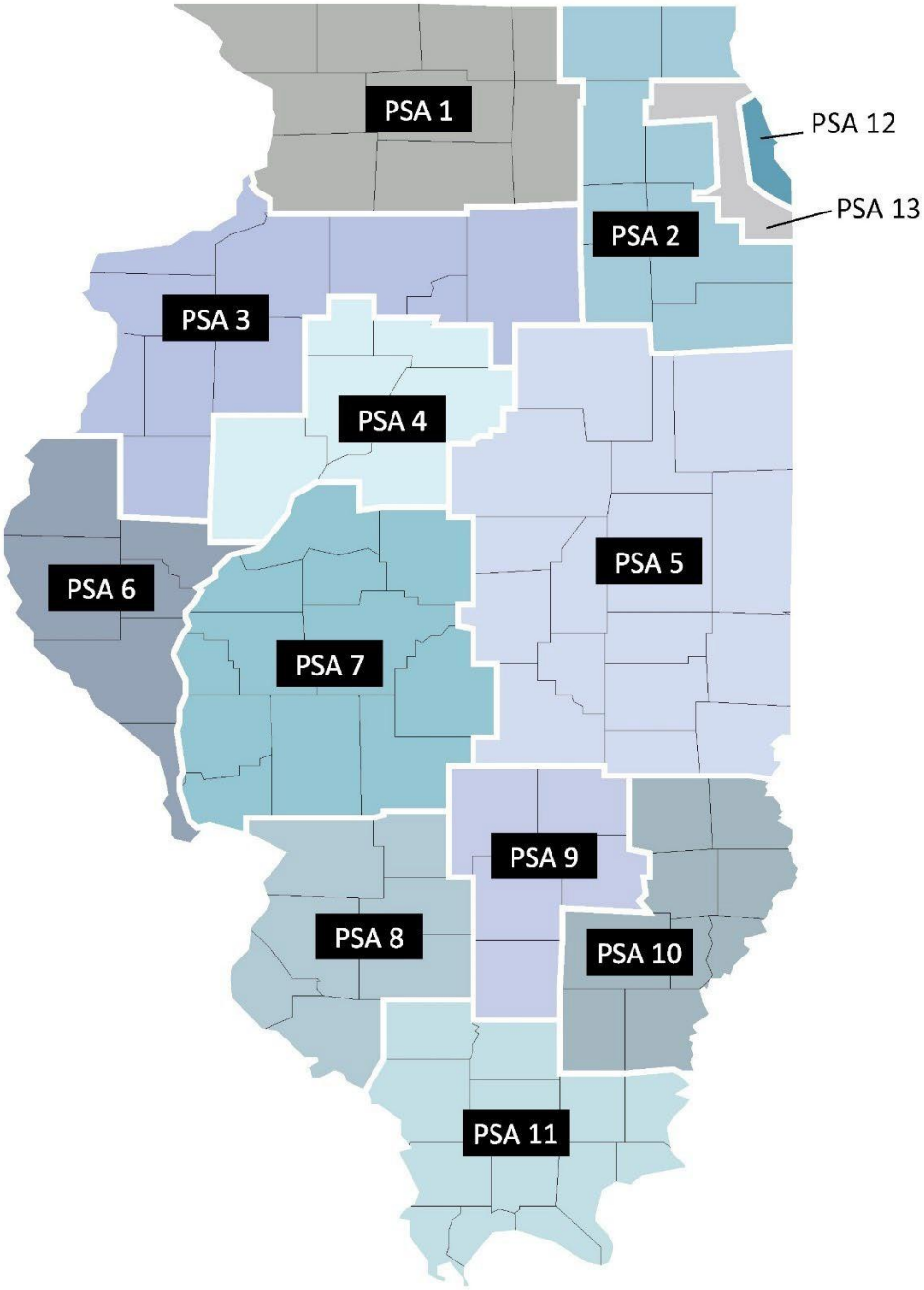
			Greatest Social Need				
PSA	60+ Population	60+ Poverty	60+ Minority	75+ Population	60+ Living Alone	60+ Rural	IFF Weight
01	(0.01)%	0.21%	0.04%	0.04%	0.02%	(0.15)%	0.05%
02	0.27%	0.14%	0.51%	0.60%	(0.20)%	0%	0.22%
03	(0.05)%	0.11%	(0.01)%	(0.10)%	(0.09)%	(0.04)%	(0.01)%
04	(0.01)%	0%	0%	(0.04)%	0.06%	0%	0.01%
05	(0.03)%	(0.24)%	0.04%	(0.03)%	(0.10)%	0%	(0.08)%
06	(0.01)%	0.15%	0.02%	(0.05)%	0.05%	0%	0.03%
07	0.01%	0.34%	0.01%	(0.03)%	0.01%	0.18%	0.10%
08	(0.04)%	(0.17)%	(0.02)%	(0.08)%	(0.01)%	0.09%	(0.05)%
09	(0.02)%	(0.03)%	(0.01)%	(0.04)%	0.03%	(0.10)%	(0.03)%
10	0.00%	0.02%	0.01%	0.01%	(0.03)%	0.03%	0%
11	(0.03)%	(0.04)%	0.02%	(0.03)%	0.10%	(0.01)%	(0.02)%
12	0.03%	(0.17)%	0.04%	0.14%	0.20%	0%	0%
13	(0.11)%	(0.32)%	(0.65)%	(0.39)%	(0.04)%	0%	(0.22)%
TOTAL	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**

Table C-19: Title VII Fatality Review Team (FTR) Overview, FFY25

		Title VII Elder Abuse			Title VII Ombudsman			
PSA	Number of FTRs	FRT Amount1 ($)	IFF Amount2 ($)	FRT Total (FRT Amount + IFF Amount) ($)	FRT Amount1 ($)	IFF Amount2 ($)	FRT Total (FRT Amount + IFF Amount) ($)	FRT Total Title VII ($)
01	1	500	147	**647**	2,000	569	**2,569**	**3,216**
02	2	1,000	472	**1,473**	4,000	1,825	**5,826**	**7,299**
03	1	500	122	**622**	2,000	470	**2,470**	**3,092**
04	1	500	70	**570**	2,000	271	**2,271**	**2,841**
05	2	1,000	162	**1,162**	4,000	628	**4,628**	**5,790**
06	1	500	39	**539**	2,000	152	**2,152**	**2,691**
07	1	500	104	**604**	2,000	402	**2,402**	**3,006**
08	1	500	118	**618**	2,000	456	**2,456**	**3,074**
09	1	500	45	**545**	2,000	176	**2,176**	**2,721**
10	1	500	40	**540**	2,000	153	**2,153**	**2,693**
11	1	500	73	**573**	2,000	284	**2,284**	**2,857**
12	1	500	522	**1,022**	2,000	2,018	**4,018**	**5,040**
13	1	500	440	**940**	2,000	1,703	**3,704**	**4,644**
TOTAL	**15**	**7,500**	**2,354**	**9,855**	**30,000**	**9,107**	**39,109**	**48,964**

1. For Title VII, Fatality Review Teams receive $500 per team for Title VII Elder Abuse and $2,000 per VII Ombudsman. Therefore, FRT Amount in Table C-19 is calculated by taking the number of teams in each PSA multiplied by the base amount for each title.
2. IFF Amount is calculated based on IDoA administrative advocacy Title VII Elder Abuse and Ombudsman funds that are redistributed to providers rather than retained by the agency (see Table C-2: Award Information by Federal Fund Category, FFY 2025 for more information). The amount per PSA is determined using the IFF.

APPENDIX D: IDENTIFICATION OF THE GEOGRAPHIC BOUNDARIES



APPENDIX E: EVIDENCE OF PROVIDING THE MINIMUM PUBLIC COMMENT PERIOD

A draft of this State Plan was published on IDoA's website, with a public comment period open from May 19, 2025, through June 19, 2025. IDoA hosted a virtual public hearing via Webex conferencing, with a call-in option, on May 29, 2025. In collaboration with the Area Agencies on Aging, IDoA held three in-person public comment hearings in the northern, central, and southern parts of the state, including: AgeGuide, Lombard, Illinois, on May 19, 2025; Renaissance Court, Chicago, Illinois, on May 19, 2025; and Senior Adult Services, Carbondale, Illinois, on May 28, 2025. Responses to all comments received are available for viewing on IDoA's website.

Chart F-1: Percent of Older Adults Age 60+, 75+, and 85+ in all Planning and Service Regions (U.S Census Bureau, 2022 ACS 5-Year Estimates, Table DP 05).

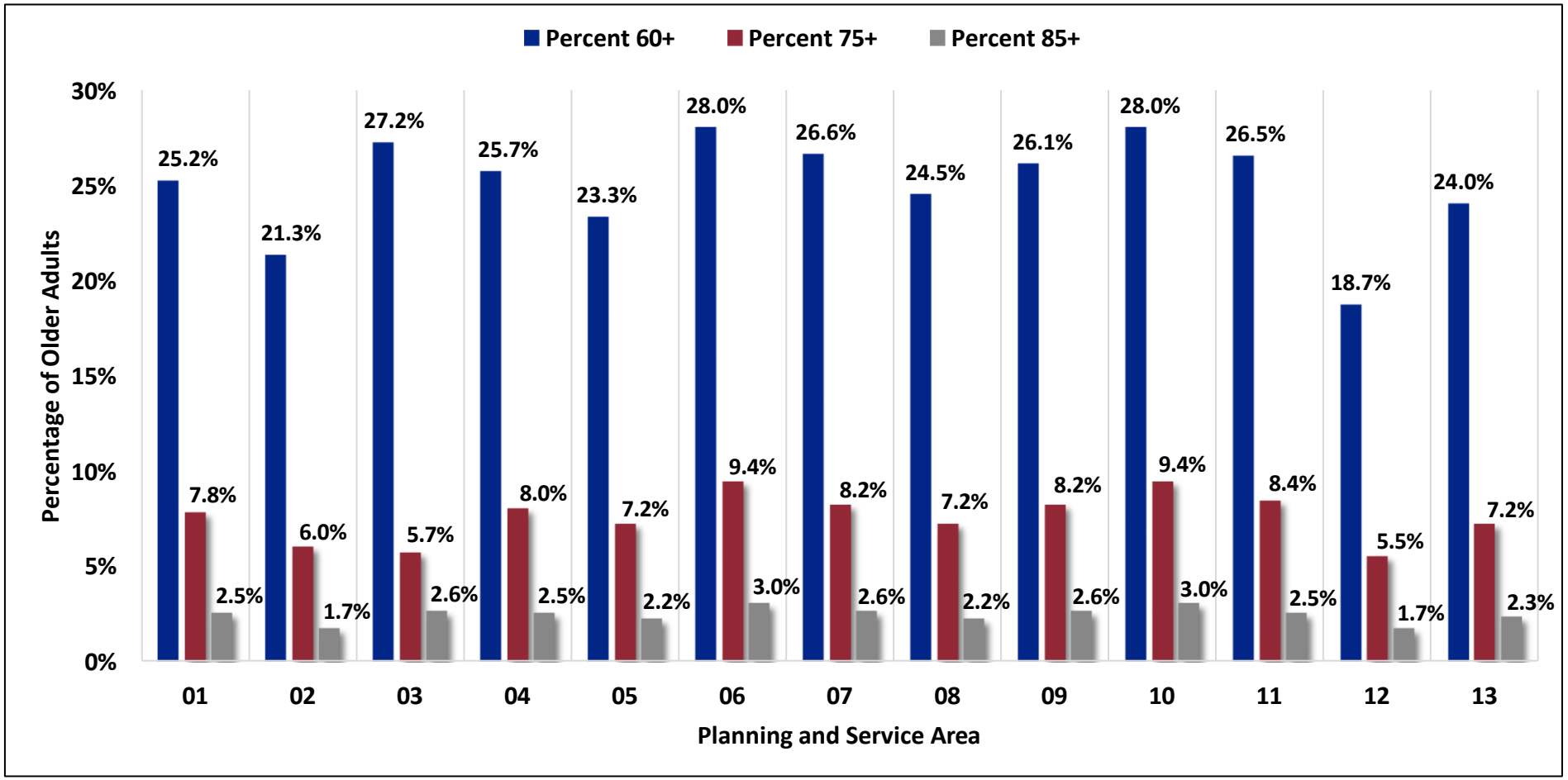


Chart F-2: Percent of Older Adults age 65+ with Physical & Mental Disabilities in All Planning and Service Areas (U.S. Census Bureau, S1810 Disability Characteristics, 2022 ACS 5-year Estimates)

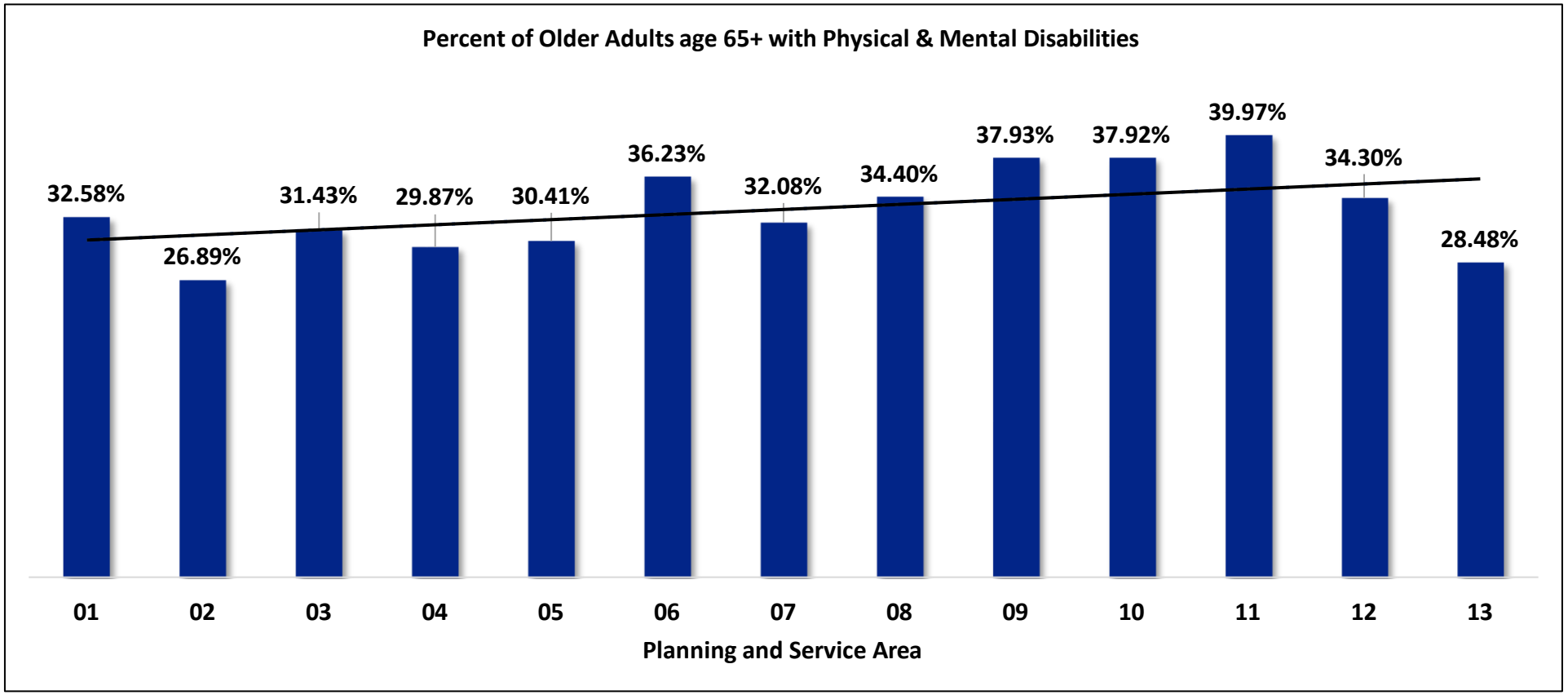


Chart F-3: Older Illinoisans 65+ and 75+ with Additional Physical Limitations (U.S. Census Bureau, S1810 Disability Characteristics, 2022 ACS 5-Year Estimates)

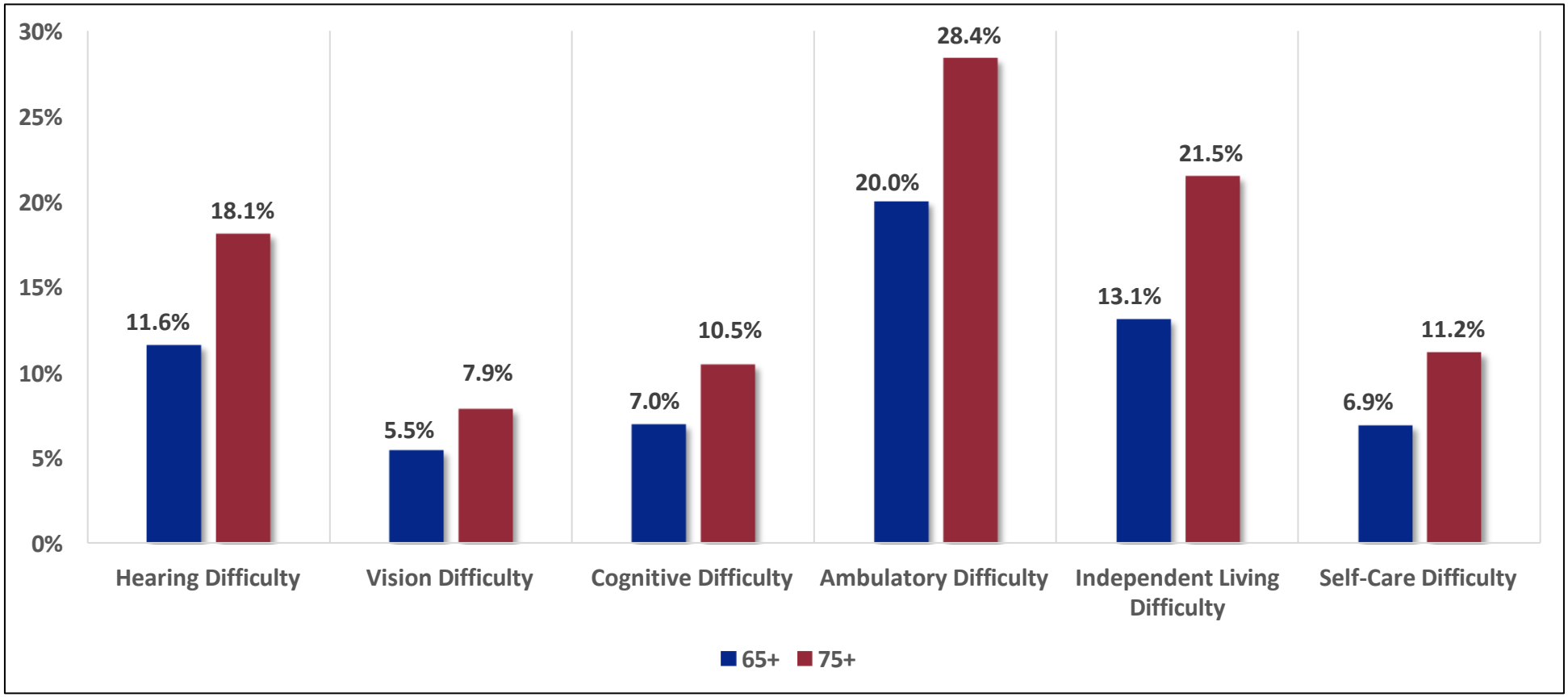
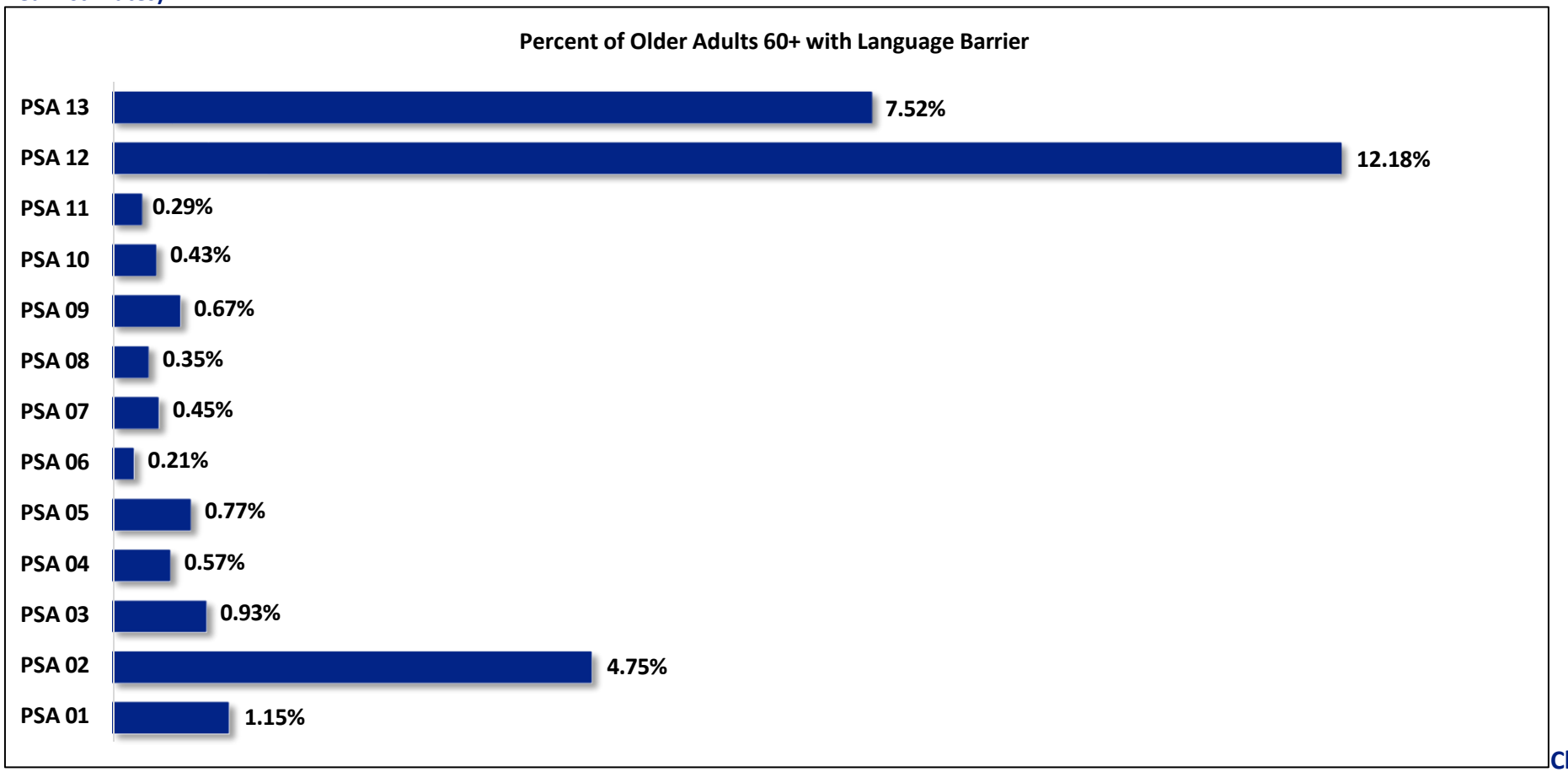


Chart F-4: Community Care Program Participant Characteristics, as of December 2024.

		Community Care Program (CCP)			
PSA	**Waiver Services provided by MCO (all Medicaid)**	**Medicaid**	**Non-Medicaid**	**Total CCP Participants**	**Total CCP & MCO Participants**
01	1,808	2,460	742	3,202	**5,010**
02	8,431	7,644	2,714	10,358	**18,789**
03	1,078	1,273	559	1,832	**2,910**
04	1,067	1,062	342	1,404	**2,471**
05	2,146	2,567	797	3,364	**5,510**
06	294	396	55	451	**745**
07	1,393	1,985	694	2,679	**4,072**
08	1,861	2,206	607	2,813	**4,674**
09	460	644	30	674	**1,134**
10	364	522	50	572	**936**
11	1,357	1,472	129	1,601	**2,958**
12	22,695	20,569	9,476	30,045	**52,740**
13	12,336	13,036	5,908	18,944	**31,280**
Total	**55,290**	**55,836**	**22,103**	**77,939**	**133,229**

F-5: Percent of Older Adults 60+ with Language Barriers in All Planning and Service Areas (U.S. Census Bureau, S21014B Limited English Proficiency, ACS 5-Year Estimates).



Chart

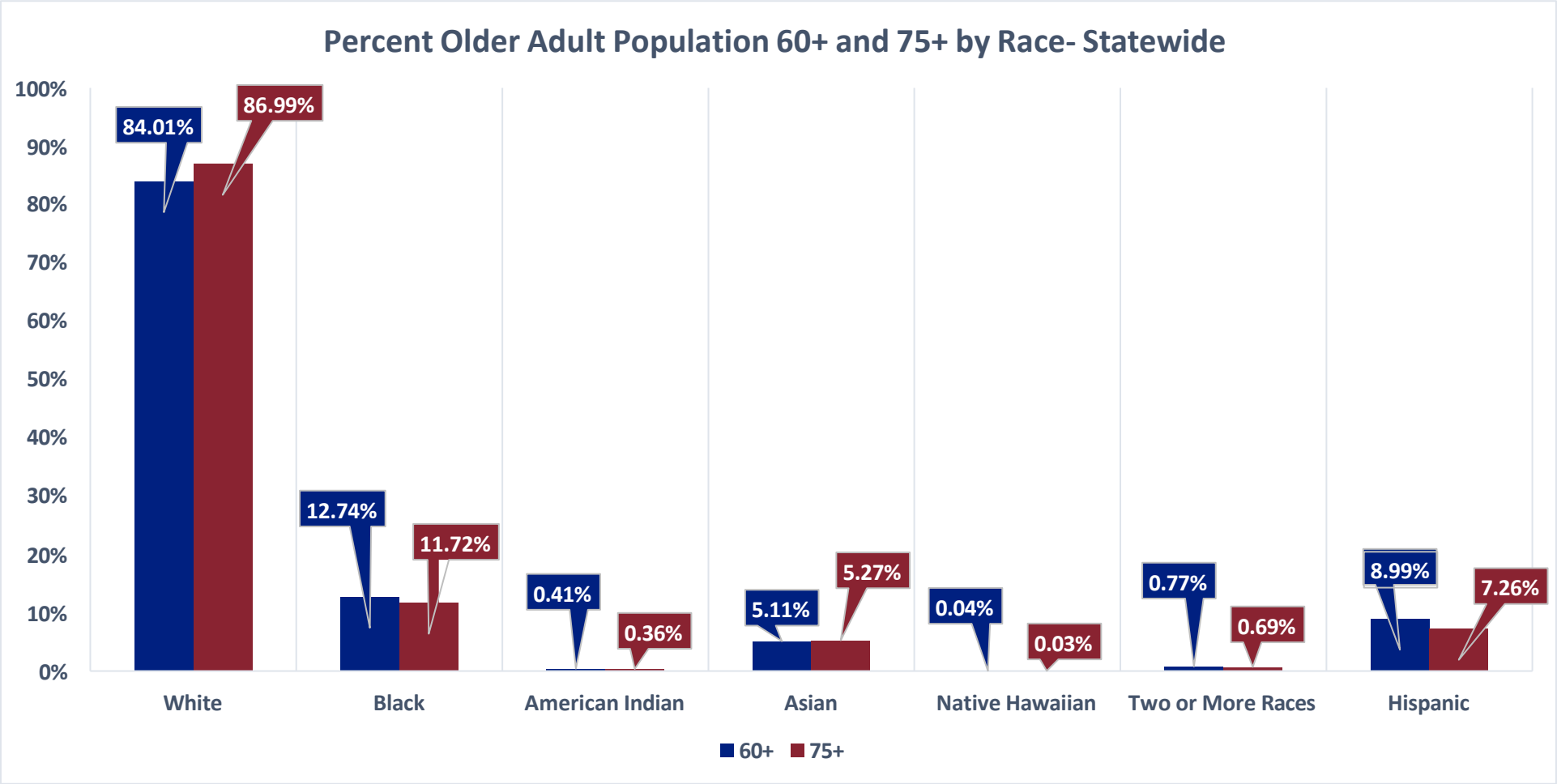


Chart F-6: Statewide Percent of Older Adult Population 60+ and 75+by Race (U.S. Census Bureau, Population and Housing Unit Estimates S0101, ACS 5-year estimates).

Chart F-7: Reported Religious Affiliation of U.S Persons 65+, 2023-24

Christian		Other Religions		Religiously Unaffiliated		Did not Answer	
Total	**78%**	**Total**	**5%**	**Total**	**11%**	**Total**	**2%**
Evangelical Protestant	27%	Jewish	2%	Atheist	2%		
Mainline Protestant	19%	Muslim	<1%	Agnostic	3%		
Historically Black Protestant	5%	Buddhist	1%	Nothing in Particular	10%		
Catholic	23%	Hindu	<1%				
Mormon	1%	Other World Religion	<1%				
Orthodox Christian	1%	Something Else	1%				
Jehovah's Witness	1%						
Other Christian	1%						

Downloaded from Pew Research Center Religious Landscape Study, 2023-24, "People ages 65 and older" available here.

Chart F-8: Reported Religious Affiliation of People in Illinois, All Ages, 2023-24

Christian		Other Religions		Religiously Unaffiliated		Did not Answer	
Total	**62%**	**Total**	**8%**	**Total**	**29%**	**Total**	**%**
Evangelical Protestant	16%	Jewish	2%	Atheist	5%		
Mainline Protestant	13%	Muslim	3%	Agnostic	5%		
Historically Black Protestant	7%	Buddhist	1%	Nothing in Particular	19%		
Catholic	23%	Hindu	1%				
Mormon	<1%	Other World Religion	<1%				
Orthodox Christian	2%	Something Else	2%				
Jehovah's Witness	<1%						
Other Christian	<1%						

Downloaded from Pew Research Center Religious Landscape Study, 2023-24, "People in Illinois" available here

Chart F-9: Falls Among Persons 65+ in Illinois, Compared to Total 65+ Illinois Population, 2012-2020

Year	Number of Older Adults Who Fell	Percentage of Older Adults Who Fell
2012	484,923	28.9%
2014	475,624	27.6%
2016	573,499	31.8%
2018	464,326	24.6%
2020	399,651	19.9%

Retrieved from Centers for Disease Control, Older Adult Fall Prevention website, Table and CSV data file reporting Age-Adjusted Falls Percentage available here and from Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS) available here.

Table F-10: Falls Per 100,000 Persons and Number of Deaths for Persons 65+ in Illinois, 2018-2021

Year	Falls Death Rate Per 100,000	Number of Deaths
2018	49.9	988
2019	52.2	1045
2020	56.8	1150
2021	62.2	1200

Retrieved from Centers for Disease Control and Prevention. National Center for Health Statistics. National Vital Statistics System, Mortality 1999–2021 on CDC WONDER Online Database. Accessed January 24, 2023.available here.

Table F-11: Outcomes of Older Adult Falls in Illinois, 2022

Fall Outcomes	Total Reported Falls	Total Reported Falls Per 100,000
Contributing Cause of Death	1,184	61.5
Hospitalization	21,912	514.7
ED Treated & Released	114,686	12,497.3
Total	**2,163,298**	**-**

Illinois Department of Public Health, "Special Emphasis Report: Falls in Older Adults" (2025), p. 1.

Table F-12: Age-Adjusted[1] Older Adults 65+ Who Experienced at Least 1 Unintentional Fall and Fall-Related Death[2], By Gender and Age, Behavioral Risk Factor Surveillance System 2020 and National Vital Statistics System 2021

Characteristic	# Reporting At Least 1 Fall	Age-adjusted % reporting At Least 1 Fall (95% CI)	No. of deaths	Age-adjusted Fall-related death[3] (95% CI)
Sex				
Men	5,825,344	26.1% (25.2–27.0%)	18,614	91.4 (90.1–92.7)
Women	8,233,496	28.9% (28.1–29.8%)	20,128	68.3 (67.3–69.2)
Age				
65–74	7,765,341	25.6% (24.9–26.4%)	6,409	19.0 (18.6–19.5)
75–84	4,731,620	28.6% (27.5–29.8%)	12,136	74.9 (73.6–76.2)
85+	1,561,879	32.9% (31.0–34.9%)	20,197	338.0 (333.3–342.6)
Total (F-12 to F-14)	**14,058,840**	**27.6% (27.0–28.2%)**	**38,742**	**78.0 (77.2–78.8)**

Retrieved from Centers for Disease Control "Nonfatal and Fatal Falls Among Adults Aged ≥ 65 Years, United States, 2020-2021," available here.

1. Percentages and rates were standardized to the 2000 U.S. Census Bureau standard population with age groups 65–74, 75–84, and ≥85 years using the direct method.
2. *International Classification of Diseases, Tenth Revision* codes W00–W19 were used to identify an unintentional fall as the underlying cause of death.
3. Nationally representative weighted number of adults aged ≥65 years reporting at least one fall in the previous year.

Table F-13: Age-Adjusted[1] Older Adults 65+ Who Experienced at Least 1 Unintentional Fall and Fall-Related Death[2], By Race/Ethnicity, Behavioral Risk Factor Surveillance System 2020 and National Vital Statistics System 2021

Race/Ethnicity[4]	# Reporting At Least 1 Fall	Age-adjusted % reporting At Least 1 Fall (95% CI)	No. of deaths	Age-adjusted Fall-related death[3] (95% CI)
American Indian or Alaska Native	153,540	35.6% (28.9–42.3%)	155	57.3 (48.1–66.5)
Asian	146,878	14.5% (9.8–19.2%)	1058	43.7 (41.1–46.4)
Black or African American	1,100,915	22.6% (20.5–24.6%)	1,572	35.1 (33.3–36.8)
Native Hawaiian or other Pacific Islander	9,373	21.6% (7.6–35.6%)	28	47.1 (31.0–68.5)
White	11,244,263	28.8% (28.2–29.5%)	33,915	89.4 (88.4–90.3)
Hispanic or Latino	968,611	24.3% (21.0–27.5%)	1,875	43.1 (41.1–45.1)
Total (F-12 to F-14)	**14,058,840**	**27.6% (27.0–28.2%)**	**38,742**	**78.0 (77.2–78.8)**

Retrieved from Centers for Disease Control "Nonfatal and Fatal Falls Among Adults Aged ≥ 65 Years, United States, 2020-2021," available here.

1. Percentages and rates were standardized to the 2000 U.S. Census Bureau standard population with age groups 65–74, 75–84, and ≥85 years using the direct method.
2. *International Classification of Diseases, Tenth Revision* codes W00–W19 were used to identify an unintentional fall as the underlying cause of death.
3. Nationally representative weighted number of adults aged ≥65 years reporting at least one fall in the previous year.
4. Persons of Hispanic or Latino (Hispanic) origin might be of any race but are categorized as Hispanic; all racial groups are non-Hispanic.

Table F-14: Age-Adjusted[1] Older Adults 65+ Who Experienced at Least 1 Unintentional Fall and Fall-Related Death[2], By Urban/Rural Residence, Behavioral Risk Factor Surveillance System 2020 and National Vital Statistics System 2021

Urban/Rural Status[4]	# Reporting At Least 1 Fall	Age-adjusted % reporting At Least 1 Fall (95% CI)	No. of deaths	Age-adjusted Fall-related death[3] (95% CI)[5]
Large central metro	3,451,480	25.8% (24.2–27.4%)	9,005	60.4 (59.2–61.7)
Large fringe metro	3,379,369	27.2% (26.0–28.4%)	9,714	69.9 (68.5–71.3)
Medium metro	2,994,019	27.4% (26.3–28.5%)	9,362	76.9 (75.4–78.5)
Small metro	1,486,869	29.5% (27.9–31.0%)	4,084	73.3 (71.0–75.5)
Micropolitan (nonmetropolitan)	1,427,693	28.7% (27.5–29.8%)	3,878	73.4 (71.1–75.7)
Noncore (nonmetropolitan)	1,319,411	31.4% (30.0–32.8%)	2,699	67.0 (64.4–69.5)
Large central metro	3,451,480	25.8% (24.2–27.4%)	9,005	60.4 (59.2–61.7)
Total (F-12 to F-14)	**14,058,840**	**27.6% (27.0–28.2%)**	**38,742**	**78.0 (77.2–78.8)**

Retrieved from Centers for Disease Control "Nonfatal and Fatal Falls Among Adults Aged ≥ 65 Years, United States, 2020-2021," available here.

1. Percentages and rates were standardized to the 2000 U.S. Census Bureau standard population with age groups 65–74, 75–84, and ≥85 years using the direct method.
2. *International Classification of Diseases, Tenth Revision* codes W00–W19 were used to identify an unintentional fall as the underlying cause of death.
3. Nationally representative weighted number of adults aged ≥65 years reporting at least one fall in the previous year.
4. Status follows CDC's National Center for Health Statistics 2013 Urban-Rural Classification Scheme for counties. https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf
5. The 2021 death rates by urban-rural continuum were crude rates because age-adjusted rates are currently not available in CDC WONDER. https://wonder.cdc.gov/wonder/help/ucd-expanded.html#Constraints-Rates

Chart F-15. Adult Protective Service Referrals by Type, FY24

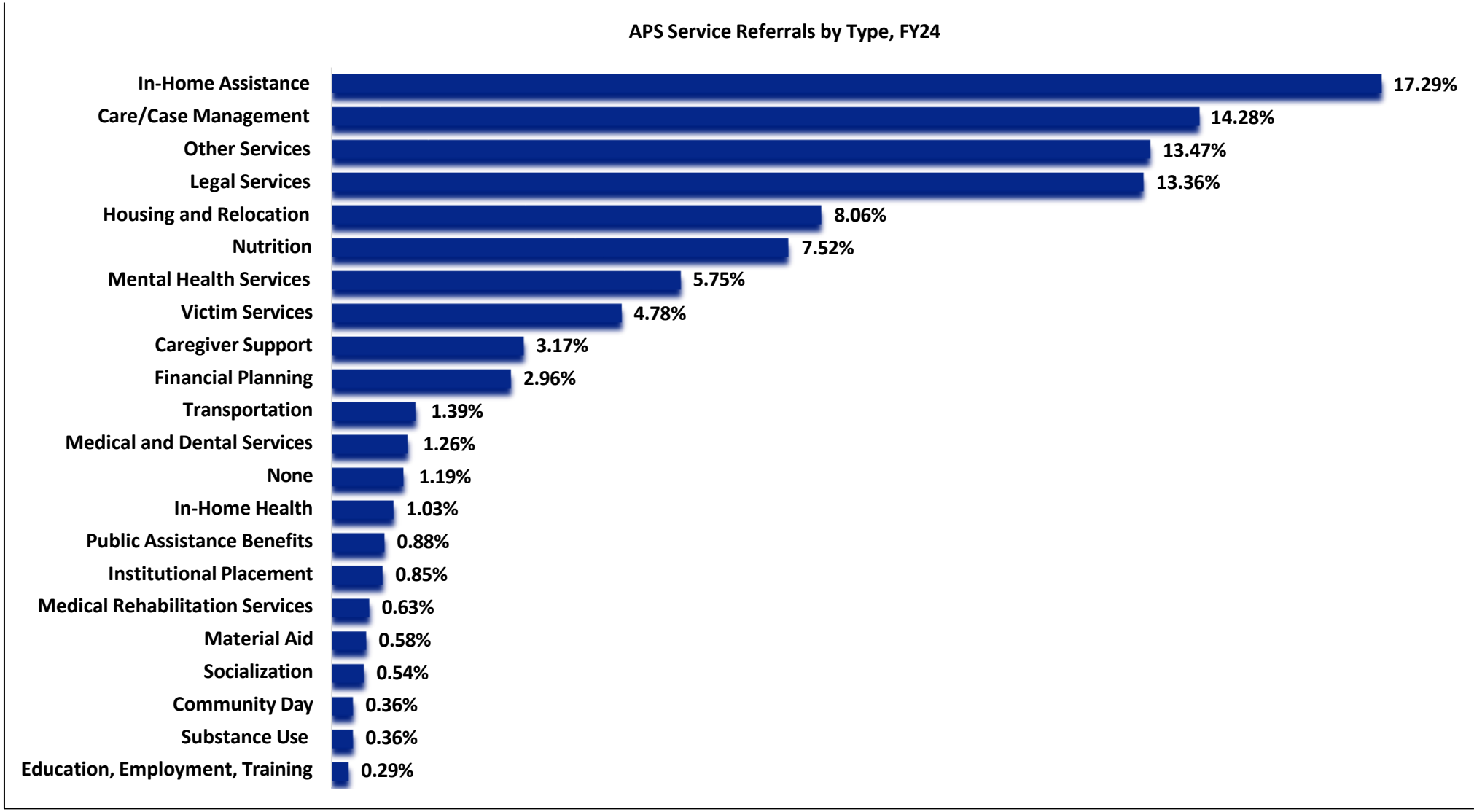


Chart F-16: Prevalence of Alzheimer's Disease and Related Dementias for Persons 65+ in Illinois, by County, 2023

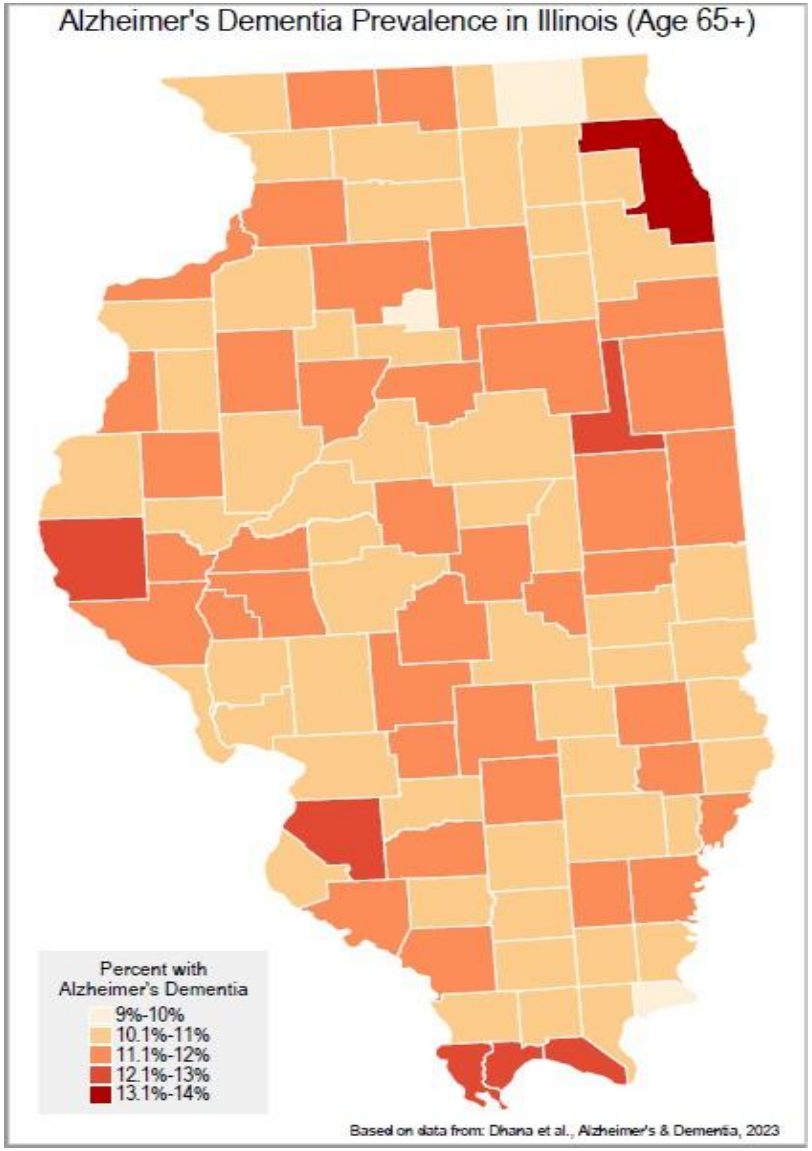
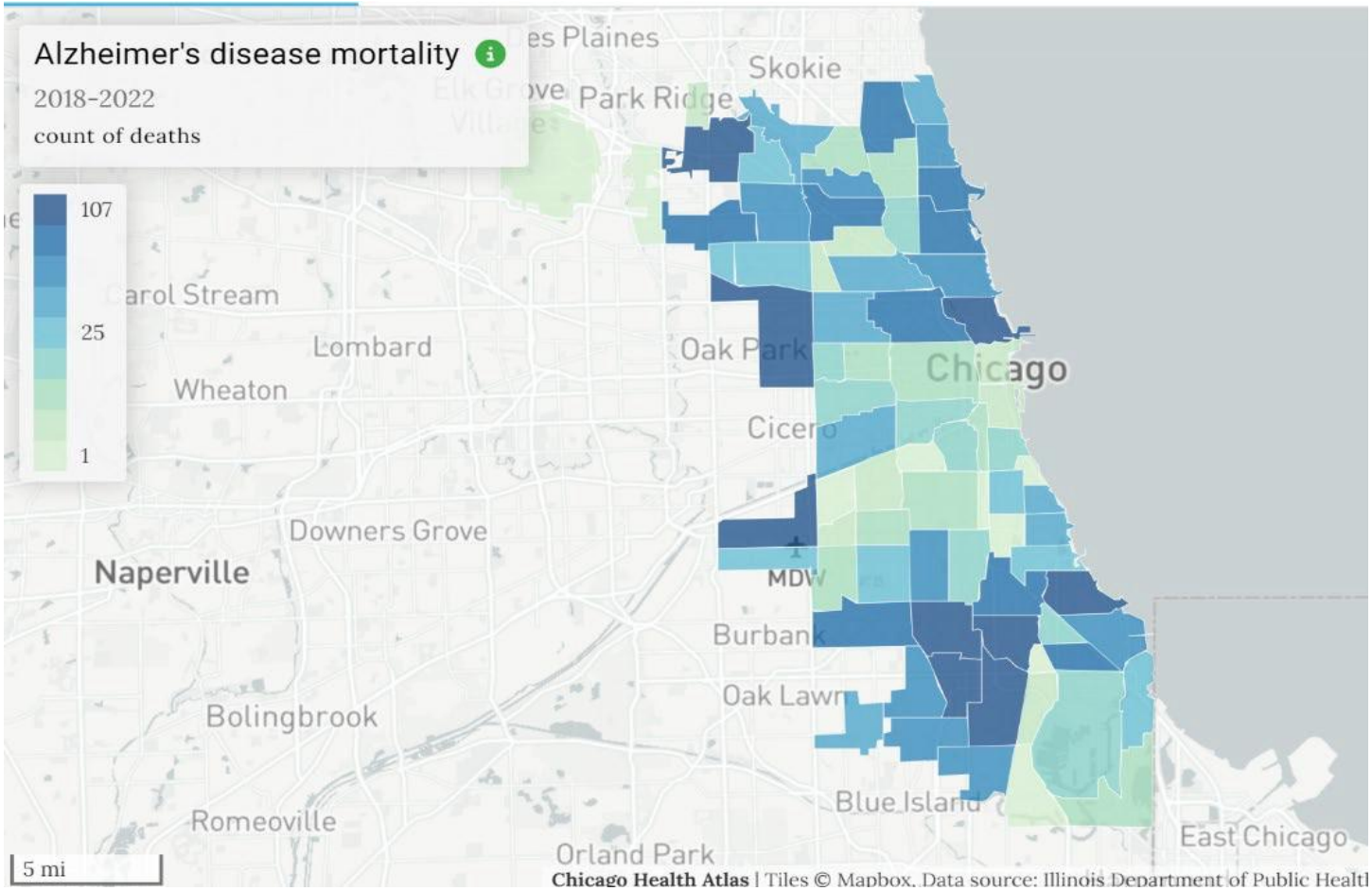
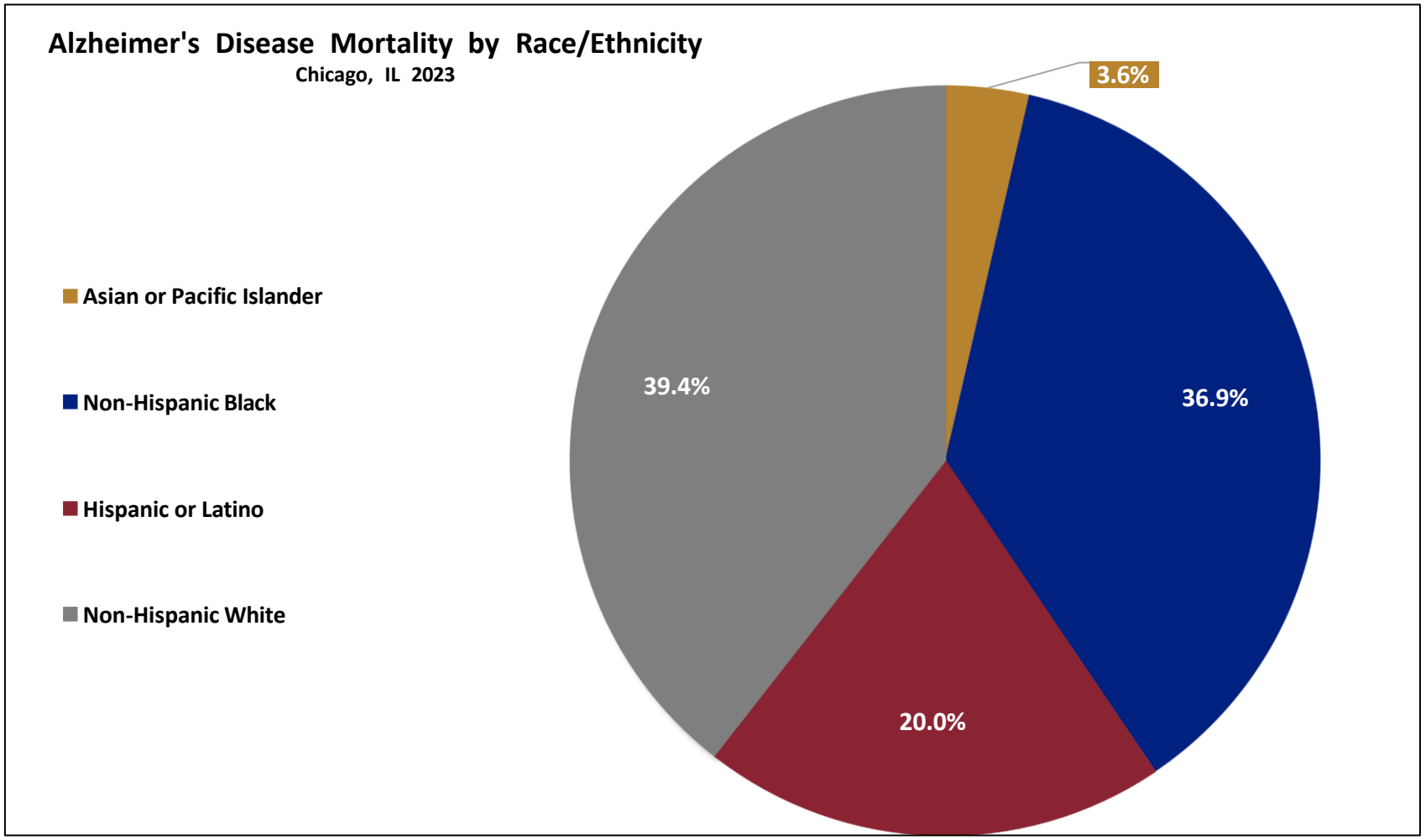


Chart F-17: Alzheimer's Disease Mortality Rate (per 100,000 Population), Age-Adjusted Rate of Chicago Alzheimer's Deaths, 2018-2022



Retrieved from Chicago Health Atlas | Tiles © Mapbox, Data source: Illinois Department of Public Health, Death Certificate Data Files

Chart F-18: Alzheimer's Disease and Mortality Rates in Chicago by Race/Ethnicity. 2023



Retrieved from Chicago Health Atlas :Alzheimer's disease mortality by Race/Ethnicity, Chicago, Il. 2023" available here.

APPENDIX G: CAREGIVER ROUNDTABLES

Summary

Conversations throughout the roundtables demonstrated the **need** for both **additional family caregiver services** and **to increase visibility** for these resources so family caregivers can better access them. Across sessions, attendees discussed caregiving from a holistic lens cutting across systems including healthcare, transportation, community supportive services, and individual (both caregiver and care receiver) needs, values, and preferences. Participants also indicated that **training and education** across the domains that fall in the scope of caregiving are also needed for family caregivers and paid caregivers, including topics like **better understanding** chronic and terminal diseases, **navigating healthcare systems** including palliative care and hospice, physical caregiving (how to lift, transfer, bathe, groom, etc.), available caregiver resources like **respite**, available resources for older people, and **caring for the caregiver**.

Background

Most (58%) of caregivers are women (CDC, 2019). Looking at caregivers by race, 23.1% of Whites, 24.3% of Blacks/African Americans, 17.9% of Hispanics, and 10.2% of Asians/Pacific Islanders are caregivers (CDC, 2019). In the LGBTQ community, 21% of older LGBT have provided care to friends compared to 6% of non-LGBT older adults (AARP & SAGE, 2021). Also, 54% of LGBT elder care recipients receive care from their partner (AARP & SAGE, 2021).

Often caregivers have health concerns of their own: 64.2% of caregivers have chronic health conditions; 29% of caregivers have depression; and 14.3% of caregivers are in poor physical health (CDC, 2019). Of people aged 65 and older, a US Health Human Services (HHS) study found that 70% will need long term services and supports, most will depend on family and friends, however, 48% will need to pay for care services and of this 24% will need more than 2 years of paid care services, and 15% will spend more than 2 years in a nursing home (Johnson, 2019). Just looking at caregiving for older persons with dementia, the Alzheimer's Association (2024) estimates that 312,000 family caregivers bear the burden of the disease in Illinois, contributing 481 million hours of unpaid care which is a value of 9.85 billion dollars.

Family and friends become caregivers sometimes over time as older people in their life need more help, and other times through crisis situations like life-changing health events. Whichever path, caregiving can present many opportunities for stress and feelings of being overwhelmed and isolated. Many family caregivers find themselves as what is known as the Sandwich generation, or lately as the Panini generation, as they are pressed between caring for older adult relatives while also childrearing. Additional stress comes from navigating new family roles, physical, emotional and time demands of the caregiving role, and practical concerns like finding resources and supportive services, and managing doctor appointments, medications, and insurance. Also, with families separated by geography, caregiving from a distance presents an added challenge of managing real-time concerns. Then there is the general emotional toll of caring for a loved one in declining health, many times at the end of their life.

Caregiver Roundtable Goals

The Illinois Department on Aging partnered with the thirteen state Area Agencies on Aging (AAA) to convene 20 in-person caregiver roundtables across the state along with 3 virtual roundtables and one with the Community Care Program Advisory Council (CCPAC). These roundtables provided the Department and AAAs the opportunity to hear from family caregivers about needs (both met and unmet) and challenges they experience and to explore additional support caregivers need to enhance the caregiving journey. The roundtable series was targeted to family caregivers and focused on the resources provided through the AAA networking using federal Older Americans Act funding and state Caregiver Support and Services funds. Providers from both the AAA network and the Medicaid waiver Community Care Program (CCP) network were also invited to attend as they often work in close collaboration with family caregivers to support older individuals through person-centered care plans. Additionally, Lieutenant Governor Julianna Stratton attended a Chicago roundtable as she was interested in hearing from family caregivers directly about the services and support they need and want. Over the course of the roundtables, the Department heard directly from more than 450 Illinoisans whose voices and lived experiences will help the Department develop programs and resources that will better fulfill the needs and preferences of the modern family caregiver.

Existing Caregiver Supportive Resources

1) **Older American Services**

IDoA passes Older American Act funding through to Area Agencies on Aging (AAA), who plan and coordinate services and programs for older people in their respective areas. They create three-year service plans identifying and targeting local needs through the OAA Title III, Title V, and Title VII funding. Then leverage allocated OAA funds and other federal, state, local, and philanthropic funds to meet those goals through grant programs for local direct services agencies that provide services to the older people who live in the same community. Like the Department on Aging, Area Agencies are not, as a rule, direct service providers. There are thirteen Planning and Service Areas (PSA) across the state each are managed and served by an AAA, there are 12 not-for-profit corporations and one unit of local government, the City of Chicago, who work in partnership with IDOA.

The Older American Act funding is allocated to the AAAs from IDOA based on a formula which takes into consideration the number of:

- Total number of older citizens in that area
- older minorities in that area
- older people living in poverty
- older people living in rural areas
- older people living alone

Title III Programs for Caregivers

There are an array of different supportive services and programs for family caregivers to tap into across the state available through the Older Americans Act funding that help ease the burden and stress of day-to-day caregiving.

Caregiver Information Services provides the public and individuals with information on resources and services available to Family Caregivers and Older Relatives Raising Children also known as Grandparents Raising Grandchildren within their communities.

Caregiver Assistance consists of Outreach Services, Information & Assistance, and Case Management aiming to assist caregivers in obtaining access to the services and resources that are available within their communities and establishing follow-up procedures to ensure they receive the service.

Caregiver Counseling, Support, and Training Services are provided to caregivers to assist them in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems relating to their caregiver roles, includes individual and group and caregiver training. This includes counseling, support groups, training & education as well as Alzheimer's disease and related dementias evidence-based education such as *Stress Busting for Caregivers* and *Savvy Caregivers*.

Caregiver Supplemental Services are provided on a limited basis to complement the care provided by caregivers and include Gap-Filling and Legal Services. Additionally, the AAAs oversee ADRCs (Aging and Disability Resource Centers) who act as a no wrong door point of access to aging and disability services.

2) **Community Care Program Resources**

The Community Care Program (CCP) also provides respite for family caregivers, with many participants choosing Adult Day Services to spend their day while their family caregiver goes to work. Or a care receiver may use in-home services, automated medication dispensers, or emergency home response services to help with family caregiving responsibilities. Additionally, some family caregivers choose to become a paid caregiver under CCP, if the person they are caring for is eligible.

Roundtables

"There are only four kinds of people in the world. Those who have been caregivers. Those who are currently caregivers. Those who will be caregivers, and those who will need a caregiver."
-Rosalyn Carter

During the introduction portion of each caregiver roundtable, facilitators asked the attendees to identify where they are at in their caregiving journey using the Rosalyn Carter quote above. Through this basic introduction, we found that our groups represented what caregiver data is showing that one in five adults are caregivers for older family members or friends (CDC, 2019).
The first roundtable was held in late August 2023 in Waukegan, Illinois and the Older American Services team held additional sessions around the state in Joliet, Springfield, O'Fallon, Normal, Moline, Centralia, Marion, Peoria, Champaign, Mount Carmel, Quincy, Rockford, Suburban Chicago (Maywood, Northshore, and South Suburbs), and Chicago (Southwest, near Southside, and Central West). An average of about 25 people participated in each session including family caregivers, Aging Network professionals, academics, and local, state, and federal elected officials or their staff. In addition to the in-person roundtables, the Department held three virtual roundtables and also conducted a roundtable at a Community Care Program Advisory Council stakeholder meeting.

Format

The Department worked with AAAs to convene one or more caregiver roundtables in their Planning and Service Area (PSA). In PSAs 1, 3, 4, 6, 7, 8, 9, 10, and 11, one roundtable was held in each area. For PSA 2, there were two, For PSA 12 and 13, there were three each. The AAAs worked with their community direct service agencies that work with caregivers to target and invite caregivers of older adults to help ensure the roundtables were meeting with the intended audience and family caregiver voices were

heard and reflected. The AAAs also helped the Department reach persons of groups targeted for Older American Act funding by convening the roundtables in areas of their PSA demonstrating greatest economic and social needs, particularly in the Chicagoland area.

Chart G-1: Caregiver Roundtables by Location, Attendance, & Attendee Type, 2023

			# of Attendees by Type			
Date	**PSA**	**Total Attendance**	**Caregiver**	**Aging Network**	**Other**	**Unknown**
08/25/2023	2	**17**	2	8	7	0
08/28/2023	2	**35**	13	15	7	0
09/06/2023	7	**17**	2	7	8	0
09/07/2023	8	**20**	0	3	1	16
09/08/2023	5	**28**	0	3	1	24
09/12/2023	3	**13**	3	6	4	0
09/15/2023	11	**19**	6	8	5	0
09/15/2023	9	**18**	3	14	1	0
09/22/2023	4	**20**	6	14	0	0
09/25/2023	10	**22**	0	22	0	0
09/26/2023	5	**36**	0	6	0	30
09/27/2023	6	**24**	14	8	2	0
10/16/2023	13	**27**	8	18	1	0
10/17/2023	1	**22**	9	12	1	0
10/27/2023	12	**54**	7	19	3	25
10/27/2023	12	**14**	6	4	1	3
11/01/2023	12	**23**	7	10	5	1
11/02/2023	13	**35**	2	20	13	0
11/03/2023	13	**8**	0	6	1	1
Total	**-**	**452**	**88**	**203**	**61**	**102**

At each in-person roundtable, the room was set-up in multiple tables or sections to help sort the participants into smaller discussion groups. The facilitator used a PowerPoint presentation to help guide the discussion. Each roundtable started with an introduction and a brief level-setting about caregiving to help the group understand data, impact, and personal connections to the ebbs and flows of the caregiving journey. The participants were then given 40 minutes of discussion time to discuss the SWOT questions. Each group was assigned a facilitator who took detailed notes. To end each roundtable, the AAA presented on resources available to caregivers in their PSAs.

For the virtual convenings, the same PowerPoint was used, participants were sorted into breakout rooms where an assigned staff facilitated discussion and took detailed notes. To end the virtual roundtables, an overview of caregiver resources and services was discussed.

For the CCPAC (Community Care Program Advisory Council) meeting the same PowerPoint was used, participants were sorted into breakout rooms where a volunteer CCPAC member facilitated discussion, took detailed notes, and then emailed them to the Department.

Questions

The following SWOT (Strengths, Weaknesses, Opportunities, and Threats) questions were used at each roundtable to guide a discussion about the needs and preferences of family caregivers. The roundtable questions also used 4 dementia-specific questions from the Illinois Department of Public Health's Dementia Needs Assessment.

Strength questions:

- What is going well?
- What value do the current caregiver resources provide to you as a caregiver?
- How do aging network resources help support you as a caregiver?
- What current dementia specific services or supports do you know of in your community?

Weakness questions:

- What are barriers or challenges to finding/accessing caregiver resources?
    - Types of services
    - Time of services
    - Location of services/transportation to/from
    - Language of services
    - Cost of services
    - Eligibility
- What can be improved?
- What caregiver needs are not addressed or adequately addressed?
- What is missing from the pool of resources that could help support caregivers?
- What dementia specific services and supports do you think are missing in your community?

Opportunities Questions:

- What is one thing you wish you had/could have as a caregiver?
- What could help caregivers better navigate resources?
- What resources could better support caregivers?
- What companies or organization could be good collaborators for caregiver resources?
- What dementia services and supports would you and your loved one living with dementia most likely use?

Threats Questions:

- What do you view as threats to caregiver resources?
    - Healthcare/ Health insurance
    - Costs

- Accessibility/Eligibility of services
- What do you view as unnecessary contributors to caregiver stress?
- What gets in the way of you providing care for your loved one living with dementia?

Results

The handwritten and typed roundtable notes were transcribed by the Department and placed into a spreadsheet, then were analyzed and coded statewide, by PSA, by virtual meeting, and CCPAC.

The roundtable participants covered a multitude of topics with many concerns resonating across the state. Code and code definitions below were used to help analyze and group each point that was brought up in the roundtables. These were then sorted by the number of times mentioned/discussed in roundtables across the state. Tables G-2 through G-5 below reports the top ten statewide SWAT categories of family caregiver support and funded resources.

Table G-2: Identified Top 10 Statewide Family Caregiver Supports and Resource Strengths

Codes (Strengths)	Number of Times Used
Accessible Support Network • Availability of helpful support system.	**101**
Supportive Community and Employee Assistance • Fosters a supportive community for employees.	**91**
Leveraging Resources • Demonstrating efficiency and effectiveness in utilizing available assets. • Denotes responses suggesting the potential role of schools as resources for caregiving.	**63**
Effective Collaboration Structure • Well-structured collaboration with AAA's	**24**
Increasing Awareness • Indicating growing awareness among the general public/ indicating a positive trend that supports the Aging's mission.	**24**
Dementia Friendly Community Initiative • Exhibiting strength by implementing and contributing to initiatives that establish dementia-friendly environment.	**14**
Caregiver's Self Care • Expressing the importance of taking much needed break	**7**
Adequate Funding • Providing financial stability and resources to effectively meet the needs of the aging population.	**6**
Communication Support • Expressing the desire for service.	**6**
Caregiver Satisfaction • Sense of satisfaction and responsibilities of caregiving and supporting family members.	**5**
Financial Support for Care Providers • Highlights the need for an increase in financial resources.	**5**

Table G-3: Identified Top 10 Statewide Family Caregiver Supports and Resource Weaknesses

Codes (Weaknesses)	Number of Times Used
Inadequate Support System • Insufficient support system, indicating a potential gap in resources necessary to address challenges effectively. • Signifies the level of respite provided may not fully meet the caregiver's needs.	**117**
Lack of Awareness • Lacking knowledge of available resources. • awareness of safety precautions.	**80**
Limited-Service Coverage • Showing reduced service coverage. (i.e. rural areas)	**66**
Information Gap • Overwhelming amount of information.	**54**
Inadequate Transportation Services • Little to no transportation services to caregivers.	**46**
Educational Needs • Emphasizing the need for additional education.	**39**
Communication Gap • Struggling to determine the appropriate person to contact.	**36**
Caregiver's Mental Health and Wellbeing • experiencing stress, indicating a potential risk to their wellbeing and effectiveness.	**35**
Financial Burden • Concern about financial burden associated with payment of services. • Challenges in maintaining affordability and potentially limiting access to essential services.	**20**
Resistance to Assistance • Awareness of needs on the part of patients. • Exhibiting resistance to seeking or receiving help for various reasons.	**19**
Staffing Challenges • Challenges related to staffing/available workforce	**19**

Table G-4: Identified Top 10 Statewide Family Caregiver Supports and Resource Opportunities

Codes (Opportunities)	Number of Times Used
Accessible Support Network • Availability of helpful support system.	**103**
Increasing Awareness • Indicating growing awareness among the general public/ indicating a positive trend that supports the Aging's mission.	**60**
Accessible Resources • Provides useful and needed resources to help caregiver to be efficient.	**59**
Effective Collaboration Structure • Well-structured collaboration with AAA's	**46**
Outreach and Educational Initiative • Implementing opportunities to expand outreach and educational efforts.	**44**
Supportive Community and Employee Assistance • Fosters a supportive community for employees. • Refers to young individuals taking the care giving responsibility.	**39**
Leveraging Resources • Demonstrating efficiency and effectiveness in utilizing available assets. • Denotes responses suggesting the potential role of schools as resources for caregiving.	**32**
Caregiver's Mental Health and Wellbeing • experiencing stress, indicating a potential risk to their wellbeing and effectiveness.	**24**
Professional Development • Highlighting the importance of training and certifications for caregivers.	**24**
Dementia Friendly Community Initiative • Exhibiting strength by implementing and contributing to initiatives that establish dementia-friendly environment.	**11**
Inadequate Support System • Insufficient support system, indicating a potential gap in resources necessary to address challenges effectively. • Signifies the level of respite provided may not fully meet the caregiver's needs.	**9**

Table G-5: Identified Top 10 Statewide Family Caregiver Supports and Resource Threats

Codes (Threats)	Number of Times Used
Inadequate Support System • Insufficient support system, indicating a potential gap in resources necessary to address challenges effectively. • Signifies the level of respite provided may not fully meet the caregiver's needs.	**63**
Caregiver's Mental Health and Wellbeing • experiencing stress, indicating a potential risk to their wellbeing and effectiveness.	**32**
Financial Burden • Concern about financial burden associated with payment of services. • Challenges in maintaining affordability and potentially limiting access to essential services.	**28**
Limited-Service Coverage • Showing reduced service coverage.	**28**
Inadequate Funding • Introducing uncertainty that may impact the financial ability. • Highlighting insufficient funding for caregivers.	**24**
Educational Needs • Emphasizing the need for additional education.	**15**
Information Gap • Overwhelming amount of information. • Lack of knowledges and awareness.	**14**
Lack of Awareness • Lacking the resources about the resources and services available. • awareness of safety precautions.	**13**
Time Constraint • Caregivers have limited time to be on the phone, and also to navigate resources. • Not enough time to perform responsibilities. • Limited time to execute services and programs.	**13**
Communication Gap • Perceived deficiency among assisted living, homecare and hospice nurses. • Struggling to determine the appropriate person to contact.	**11**

Summary

The state received a robust response with more than 2,000 total discussion points raised across the 23 roundtables. Both accessible support network and inadequate support system rose to the top of responses to the SWOT discussion questions. Across the state, feedback included that once people knew about services, they were accessible, however, due to limited resources, there were still gaps in need. Caregiver Mental Health and Wellbeing, Caregiver Self-care, and financial burden were also present across the SWOT discussion and are often intertwined. The discussion also identified barriers to services

include caregivers who a resistant to assistance and may not identify as a caregiver or may feel services are for other people, not them. Other barriers include the communication gap, where caregivers are not sure who to contact or what services are available. The SWOT analysis also raised the need for additional education, both on general resources for caregiver support and about caregiver skill building for specific conditions.

References

AARP & SAGE, 2021. *Disrupting Disparities: Challenges and Solutions For 50+* LGBTIQ Illinoisans. Retrieved from: https://www.sageusa.org/wp-content/uploads/2021/10/disrupt-disparities-lgbtq-report-il-2021.pdf

Alzheimer's Association, 2024. Public Health, State Overview, Illinois. Retrieved from: https://www.alz.org/professionals/public-health/state-overview/illinois

Alzheimer's Association, 2024. 2024 Alzheimer's Disease Facts and Figures: Special report mapping a better future for dementia care navigation. Retrieved from: https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf

Alzheimer's Association, 2023. Alzheimer's Dementia Prevalence, county level data, Illinois.

CDC, 2019. Caregiving for Family and Friends — A Public Health Issue. Retrieved from: https://www.cdc.gov/aging/caregiving/caregiver-brief.html#:~:text=22.3%25%20of%20adults%20reported%20providing,in%20five%20(18.9%25)%20men.

Chicago Health Atlas, 2024. Alzheimer's disease mortality, 2018-2022. Retrieved from: Alzheimer's disease mortality - Chicago Health Atlas

Dhana et al, 2023. Alzheimer's and Dementia. Alzheimer's Dementia Prevalence, county level data, Illinois.

Johnson, R., 2019. What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports? Office of Assistant Secretary for Planning and Evaluation (ASPE). Retrieved from: What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports? | ASPE

Majoka MA, Schimming C. Effect of Social Determinants of Health on Cognition and Risk of Alzheimer Disease and Related Dementias. Clin Ther. 2021 Jun;43(6):922-929. doi: 10.1016/j.clinthera.2021.05.005. Epub 2021 Jun 5. PMID: 34103175. Retrieved from: Effect of Social Determinants of Health on Cognition and Risk of Alzheimer Disease and Related Dementias - Clinical Therapeutics

NCOA, 2021 Top ten chronic diseases data from Centers for Medicare & Medicaid Services, Chronic Conditions Prevalence State/County table; All fee-for service beneficiaries.

[i]. Email reporting provisional top causes of death for Illinoisans age 60+ in 2024, from John Tharp, Vital Statistician, Division of Health Data & Policy, Office of Policy, Planning, & Statistics, Illinois Department of Public Health, April 23, 2025.

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Senior HelpLine (8:30am – 5:00pm, Monday – Friday):
1-800-252-8966, 711 (TRS)

Adult Protective Services Hotline (24-Hour):
1-866-800-1409

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